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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case #17-090-9019
Bridgeway

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations involving services at Bridgeway in Kewanee. The allegations were as follows:

1. **Inadequate treatment, including following outdated physician's order, refusal to administer new medication, not providing guardian medication from previous physician's order, arguing with guardian about smoking cessation treatment and medication for blood count, attempted use of personal debit card for food provisions and inadequate food provisions.**
2. **Inadequate transfer procedure, including recipient was sent to hospital without hospital knowledge of guardianship.**

If found substantiated, the allegations would violate The Illinois Department of Human Services (DHS) Rule 132 (59 Il Admin Code 132.150), the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) and The Probate Act of 1975 (755 Ill. Comp. Stat. Ann. 5/11a-23). The agency provides 6-bedroom CILA (Community Integrated Living Arrangement) homes, supportive apartments and 24-hour care apartments, which is where the recipient involved in this complaint is a tenant. The apartments are owned by Bridgeway and are subsidized by U.S. Housing and Urban Development (HUD). They have 9 locations between Galesburg and Kewanee with a total occupancy of 106. The agency also provides vocational employment support, job coaches, substance abuse treatments and crisis treatment. The agency has 800 total employees and has locations in Rockford, Bloomington, Pekin, Kewanee, Galesburg and Macomb.

Complaint Statement

The allegations state that a recipient at the CILA was transferred to a behavioral hospital, returned home and then was transferred to another behavioral hospital. When the recipient returned from the second hospital stay, the guardian visited and there was no pillbox of medication prepared for the recipient. The guardian went to get a new prescription and the staff

were reportedly putting a pillbox together from a bag of old medications and not using the current medications.

Additionally, after the first hospital stay, the allegations state the guardian was told that the Director of Housing picked up all of the recipient's medications and personally filled them but the guardian checked and the Clozapine was missing. Also, the guardian reportedly never received all of the older medications from the facility; she was only provided the Depakote and Haldol. Another allegation stated that for both hospital stays, the facility did not send the hospital the recipient's guardianship papers. Allegedly staff also stated they would no longer administer medication to the recipient because she restricted them from receiving medical information from the hospitals. The staff nurse would fill the pillbox but would reportedly not administer medication.

Also, the allegations state that the guardian supplies the recipient with a personal debit card with $50 for personal use and the staff uses the debit card for food. Allegedly, staff state they only check the balance of the card. Additionally, the recipient is provided enough food by the guardian but the staff call and state that he is running out of food and liquids. The guardian asked what is happening with the food and liquids and staff say that he throws it out or that they do not know.

Additionally, the complaints state that the facility staff and guardian argued because the staff contacted the guardian alerting her that he did not have cigarettes but she thought he was using the patch for smoking cessation. They also argued about the medication for the recipient's high blood count. Allegedly, the recipient's physician changed the medication but the facility staff prefer a higher dosage.

Interview with staff (5/31/2017)

Staff began the interview by explaining that the recipient has been with the facility for a long time and they have similarly been working with the recipient's guardian for a long time. There was a time when they had to ban the guardian from the facility because of her behavior, and police have been to the residence because of her behavior as well. The recipient's guardian (who is also his mother) has not always been his guardian. When the recipient becomes ill, she becomes his guardian but when the temporary guardianship expires, he does not want a guardian. In October, she became the permanent guardian. Staff explained that the guardian will not allow them to provide services to the recipient and she will not sign a treatment plan. After contact from the Office of the Inspector General on similar complaints and the notice from the HRA, the facility had a treatment plan meeting with the recipient's guardian. Staff explained that the guardian was angry during the meeting but a treatment plan was developed regardless and then the next day, the guardian came to the facility and yelled at the receptionist because she did not receive a copy of the treatment plan. The guardian then withdrew the plan and consent for treatment. The guardian once said that she was giving 30 days' notice to leave the facility but then refused to sign the discharge. The facility was going to follow through on the 30 day notice but they did not want to just terminate the recipient for fear of what would happen if the recipient does not live at the facility. Staff expressed concern that the guardian's behavior could be seen as being very condescending and rude to the recipient and treating him like a child. For example, on the day of the treatment plan meeting, the recipient asked if he could stop by the Dollar Store for razors and she said no because it was a family member's birthday. He has friends that are consumers but the guardian intervenes with the friendships. She threatened to

sue once because he was involved with a woman in another building. Staff said that the guardian does not want the recipient involved in services but also does not want him to move. Staff explained that they have had concerns about the guardian's treatment and behaviors towards the recipient and they try to protect and keep him safe. They said the agency is basically just housing him at this time as a tenant.

According to staff, the guardian pulled the recipient from all psychiatric care because she had a disagreement with the agency psychiatrist and took him to an Advanced Practice Nurse (APN). The psychiatrist had the recipient stabilized and then the APN decreased the recipient's Clozapine. After the second hospital stay, the guardian called alleging that the medication box was incorrect. All recipients have a plastic tote where their medications are kept. For this recipient, the Depakote has not changed. When the incident took place, the guardian had not picked up the new medications yet. They needed Clozapine and the guardian came back with a new prescription. The staff had added the old Depakote and the guardian said that she wanted the new Depakote to be used. Staff explained that it was the same Depakote prescription as before, so the medication had not changed. Staff said they were concerned about Medicare and Medicaid not reimbursing for the pills. Staff stated that they do not have a nursing staff at the office, so they do not administer medication. Staff will assist in skill training and tasks like cooking. The recipient's guardian does give the recipient his medication and prior to that, he would self-administer medication at the office. Recipients go to the facility office to self-administer medication but this recipient is not allowed to participate by the guardian. Staff said that they do not know why the Clozapine was missing; they dropped off all the prescriptions from the hospital. They could not pick them up. They said that it is not unusual to have the guardian come to the facility several times per day. She completes spot checks of the medication box.

According to staff, during the second hospital stay, the physician adjusted the Clozapine and increased the dosage. The recipient has been improving with the increase. Bridgeway told the guardian that they can no longer provide the recipient his medication without having knowledge of his treatments. They also said that Rule 132 dictates that a treatment plan is needed and the guardian would not allow the treatment plan. The recipient has been on the increased medications since the hospitalization and they have not received any new medications. They did not provide her the older pills from the recipient's tote because it was the same as the new pills. Staff said that usually old medications are taken back to the pharmacy if they are discontinued. The guardian now fills the medication boxes and they no longer work with any of the pills.

The recipient was a lifelong smoker and the guardian decided that he was not going to receive cigarettes and that he needed to use a nicotine patch for smoking cessation. The guardian said that the recipient would either use the patch or go without. Staff said that the recipient would steal cigarettes from other consumers and take them from ashtrays and they made the guardian aware of this. Staff reported an incident in which the recipient walked to a local gas station and said that he was the owner. The recipient would go to the gas station and ask them to buy cigarettes. On one instance, the police were called to the gas station and Bridgeway contacted the guardian about the situation and she said that the hospital would have to call her this time.

Staff thought that the medications should have been increased because of the laboratory results. The APN was ordering laboratory tests to be completed and the recipient had a high blood count. The APN faxed the orders to decrease the medications which the staff questioned.

The facility psychiatrist said that the high blood cell count could be a sign of infection but staff were told by the APN that they must lower the medications. The guardian then called and said they were not able to talk to the APN anymore. At that point, the staff did not interfere and the recipient was eventually hospitalized. The recipient was threatening staff, other recipients, and spitting while on the lower dosage.

The debit card was given to the recipient when he was purchasing cigarettes but the card was not to be used for cigarettes. Staff said that when the recipient starts to not feel well, he throws items away and even discarded all of his dishes. He recently threw away his cell phone and the recipient's guardian believed that someone stole the phone and the guardian also believed the other recipients were taking his food. When she asked about the phone, he said that he did not know what happened with it. Staff said that he also threw away the debit card. Staff had taken the card and put it on a desk in the main office on one occasion when they found it had been thrown away. When the guardian came into the office, they gave her the debit card and she said that staff could not take the debit card any longer. On the second visit to the hospital, the guardian took the recipient's wallet with the debit card in it.

The guardian has a friend that takes the recipient shopping every two weeks and staff are not allowed to assist. Staff asked if they would guide him while at the grocery store and the guardian said that he was faking an illness and he will buy what he wants. The guardian believes that he is faking illnesses in order to get what he wants and that is why items are taken away, the cigarettes being the most recent. Staff explained that they suggested TV dinners because the food is not lasting and because the recipient sometimes eats uncooked meat. Staff stated that when the recipient returned from the hospital, the guardian did not bring him food that entire weekend. The guardian would come once a day to take him to eat and then drop him back off. In a later email, the staff clarified that with apartment residents, the staff will assist the consumers with their grocery lists but for group shopping, the residential staff go with the consumers and provide advice and guidance as needed. For one-on-one grocery shopping, the staff will work with the consumer on his or her shopping list, getting the items on the list and staying within budget. There is a formal, documented procedure for group homes to provide direction and assistance but the apartments do not have a written procedure.

Staff said that they called the guardian before each hospitalization. The guardian even made the hospital staff frustrated because she called on an hourly basis. Part of the protocol when someone is hospitalized is that the guardianship papers are handed to the entity that is taking the recipient to the hospital and then Bridgeway staff meet the recipient at the hospital because their agency staff from Galesburg perform the Crisis screening. They said they even warned the Crisis team when they saw the recipient decompensating because of the medication changes. The Bridgeway Crisis team is hired by the hospital to assess patients who may need mental health services and meets them at the hospital. The hospital medically clears the recipient and then they are assessed by the Crisis team. Both times the recipient originally went to a local hospital and then moved to a psychiatric hospital. The guardian would not let Bridgeway staff have contact with the recipient while he was in the hospital.

The staff said that when he returned home, he was still experiencing some psychosis and decompensated a second time. Staff said on the second occasion, the recipient was accepted to the hospital quickly and the guardianship documentation was provided to the hospital. The guardian would not provide the facility information about the hospital stay and the facility went two weeks without knowing what was happening with the recipient because they were prohibited. Bridgeway followed up with the HRA via email regarding the transfer procedure and

received the following information: There is not a specific policy/procedure regarding transfer from the emergency room/assessment to the admitting psychiatric hospital. Once the Crisis team completes the assessment and locates a hospital to admit, most of the conversation then moves between the ER hospital and the admitting hospital as the Crisis team is not involved in transportation. Also, there may be times when the Crisis team and/or the hospital ER does not even know if an individual has a guardian or power of attorney (POA). The usual process is that the admitting psychiatric hospital will directly ask the Crisis worker or ER hospital if there is a guardian or POA. In this situation, with both hospitalizations, it is not documented that the admitting hospitals posed that question. In the two instances of hospitalization with this individual, Bridgeway's residential program did communicate with the guardian that the resident had been transferred to the ER for assessment. The guardian then consistently communicated with the local hospital regarding the resident's situation, and the hospital, aware that the resident's guardian is his mother, continued to update her.

FINDINGS

Complaint #1 - Inadequate treatment, including following outdated physician's order, refusal to administer new medication, not providing guardian medication from previous physician's order, arguing with guardian about smoking cessation treatment and medication for blood count, attempted use of personal debit card for food provisions and inadequate food provisions.

The HRA reviewed the Facility Log and Progress Notes in regard to following outdated physician's order. The progress notes dated 8/26/2016 through 2/22/2017 were associated with a treatment plan that was presented to the HRA as unsigned. The HRA also reviewed progress notes dated 2/23/2017 through 4/15/2017 that had the same format as the previous progress notes but were not associated with a treatment plan and described as an "Interim Service Log". Finally, the HRA reviewed progress notes from 4/26/2017 through 10/23/2017 that were associated with a treatment plan but were also unsigned.

The resident was first hospitalized at a Galesburg hospital on 2/23/2017 and admitted at a second Chicago hospital on 2/28/2017 following a crisis screening. The resident was discharged on 3/3/2017. The resident was hospitalized again at a Galesburg hospital on 3/7/2017 and accepted at a different Chicago hospital on 3/8/2017, and discharged around 3/21/2017.

In the Facility Log for the resident's apartment, 1st shift staff noted on 2/2/2017, "[The recipient] had [medication] decrease: per [the doctor] – changed on all logs and [computer] – info note put in." Pertinent Progress Notes read as follows:

- In staff Progress Notes on 12/07/2017 "Coordinator received a call from [the recipient's] mom. [The guardian] yelling on phone states, 'I have pulled [the recipient's] meds from [pharmacy one] and I have meds being ordered through [pharmacy two]. [Pharmacy two] has been informed they are not to provide any information to Bridgeway on [the recipient's] meds and no one is allowed to pick up his meds but me, I am his guardian and [pharmacy two] is aware of this.'"
- In staff Progress Notes on 3/03/2017, after the recipient was discharged from the hospital staff stated, "RSA staff notified me that [the recipient] was dropped off at [the apartment] with some discharge paperwork and a script. I went to [the apartment] to set up a med box for [the recipient]. I reviewed the paperwork from the hospital which was very

minimal. I then was able to set up meds with what we had prior to his hospitalization until Monday am . . . I took the script to [pharmacy two] for his mother to pick up as she has instructed staff that she will pick up meds."

In the recipient's file his medication log and three "Medication Change Forms" for 1/12/17, 2/2/17, and 3/21/17 indicate a change in medication. The first and second changes were made by the recipient's Primary Care Physician and noted in the Medication Change Forms 1/12/17, and 2/2/2017. The latter change follows the second hospitalization and is indicated on the form dated 3/21/17. The recipient's "Medication Chart" noted the changes as well. A progress note reads "Previously medication was administered to this recipient through Bridgeway staff; however, on March 3, 2017, the guardian informed Bridgeway through a letter sent by her attorney that the guardian is refusing her permission for Bridgeway's staff to have any further involvement in [the recipient's] medical treatment. She also withdraws her consent for Bridgeway or Bridgeway's staff to communicate with, give directions to or ask information from [the recipient's] primary physician(s), and his physicians at [the hospital]." It is noted that Bridgeway gave the guardian the Medication Log for the recipient as well as the current medication he was taking and amounts as of 4/4/17. Another progress note, dated 4/4/2017, reads "We then explained to [the guardian] due to her refusal as guardian to update [the recipient's] MHA (Mental Health Assessment) and CCP (Consumer Centered Plan) we can no longer be responsible for [the recipient's] meds and watching himself administer them as we have no MHA and CCP allowing us to do so and [the guardian] has prevented us from contacting [the recipient's] PCP [Primary Care Physician] for clarification of med orders which we have to have. We explained to [the guardian] that she would have to take the meds and ensure that [the recipient] took his meds as guardian. [The guardian] at first disagreed and stated she would not take meds. We explained that we would then return them to [the pharmacy] as we have no permission from a MHA or CCP to complete med training as previous documents have expired and [the guardian] refuses to renew."

The Facility's medication management procedure is supervised self-administration. The Bridgeway Policy Guide on Medication Services states how recipients are to be assessed for the ability to self-medicate and procedures for self-medication. Staff involved with medication administration are trained in dealing with and keeping watch on recipients taking psychotropic medication. The Bridgeway policy states, "The supervision of self-administered medication involves the individual consumer in an active role of responsibility in the process of taking his/her own medications while under the supervision of a staff member. Staff members never administer medications unless they are licensed by the State of Illinois as an R.N., L.P.N, M.D. or D.O.. Unlicensed staff may only provide monitoring, training or as needed hand-over-hand assistance to the consumer and may not remove medication from bubble packs, bottles, or any other container for medication . . . Self-medication training occurs as an individual actively participates in the process of learning to take medicines independently."

The HRA reviewed the facility procedure for medication disposal labeled as "Drug Destruction Procedure" and facility Progress Notes on medication administration.

Regarding not providing the guardian with medication from a previous physician's order, the program's Drug Destruction Procedure lists how non-narcotic medications (which include the medications the resident was taking) are to be destroyed and how to document their destruction. "Non-narcotic medications will be destroyed by: Placing in medication bin or sharps container and then will be taken to local Health Department for destruction, the local pharmacy or will be picked up by the Waste Disposal Company…Staff will use black marker to cover the consumers name and medication ordered before placing empty bottle, card, or bubblepack in the

garbage for consumer." If the medications are empty, "bottles/bubble or cartridges packs will be: Free of all consumer information prior to discarding to ensure confidentiality."
Progress Notes pertinent to medication disposal are as follows:

- On 3/31/2017, one staff member stated, "[the guardian] called tonight at 7pm, yelling stating staff did not give me all [the recipient's] old meds. Staff had given [the guardian] [the recipient's] meds that she replaced with new bottles from Pharmacy. I told [the guardian] first if there is an issue she needs to discuss with Coordinator or Director during business hours. Coordinator then told [the guardian] as [the recipient] has used some of his meds the bottles were disposed of. [The guardian] states that is not true and that she has a witness that seen bottles of meds two weeks ago in [the recipient's] tote. Once again Coordinator stated as meds are used old bottles that are emptied are disposed of. [The guardian] stated she will report this. Coordinator stated to [the guardian] that [the recipient] is taking the meds she has given the doctor orders and if [the guardian] is not trusting the meds are given properly and unhappy with residential she has a right to move [the recipient]. At that time [the guardian] hung up the phone."
- On 3/31/2017 another staff member reported, "[The guardian] came in today and brought medications for [the recipient] from [a pharmacy] . . . [The guardian] demanded [the recipient's] old medications. Staff contact Residential Coordinator to make sure it was okay to give these to [the guardian]." Staff gave the guardian opened Aspirin, cold medicine, laxatives and two psychotropic medications no longer being used. "[The guardian] was not satisfied and told staff there should be more medications. Staff informed [the guardian] that she was more than welcome to come talk to the Residential Coordinator on Monday during business hours. [The guardian] appeared to become agitated and told staff she had a feeling she would talk to her before then. Staff told her that was up to her. [The guardian] just continued to repeat herself for several minutes before walking out; talking under her breath about this staff being a liar."
- On 4/04/17, one staff member stated, "[staff] were in the office at [the apartment] today when [the guardian] came to speak with [staff] about [the recipient's] meds. [The guardian] again wanted meds that she felt we had taken. [Staff] explained to [the guardian] that the bottles of pills when empty were thrown away after the label was taken off."

In regards to arguing with guardian about smoking cessation treatment, the HRA found the following notes in staff Progress Notes:

- On 2/24/2017, staff reported the guardian calling stating, "that [the recipient] is to have his debit card because she puts money on it for cigarettes.[The guardian] stated that she will punish [the recipient] if he does not keep his apartment clean then she will not give him money on his card and that is how he will be punished. Then [the guardian] called again and wanted to know if she would need the nicotine patches prescribed and CSS stated yes and she stated that she was going to get [the recipient] patches because she knows she is going to have to hold his money from him."
- On 3/07/2017 staff stated, "I reported to [the guardian] that [the recipient] has been having behaviors and has been bothering peers for cigarettes. I reported that a peer was so upset by him begging her that the peer gave him a pack. [The guardian] stated that she will make sure his peer receives the $5.00 back."
- On 3/07/2017 staff reported, "[the guardian] asked if [the recipient] started the Nicotine

patches she provided from his Dr. and she was informed [the recipient] refused the patches and has refused any of his medications since returning from the hospital."

- On 3/07/2017 staff reported, "[The recipient] has been asking all his peers for cigarettes and staff tried to redirect him and explained that he is breaking the rules, [the recipient] told staff to shut up or she would be sorry . . . [the recipient's] peers feel very uncomfortable and don't understand why he keeps getting by with this."
- On 3/21/2017 staff reported, "[the recipient] took off his nicotine patch today and told staff multiple times that he could not wear it because it was causing him to almost poop his pants. [The recipient] stated that he will not use the patches because he does not want this to happen and stated that he read that it was one of the side effects on the box. [The recipient] showed no understanding of staff's education regarding the actual possible side effects of the nicotine patches."
- On 4/11/2017 staff reported, "[The recipient] was very quiet all day. He did engage in conversation about how hard it is to not smoke. He asked staff for a cigarette and staff educated him on not asking staff or peers for cigarettes and gave him some education regarding tools he can use when having severe cravings, such as breathing exercises, chewing gum, watching a movie, taking a walk. [The recipient] told staff that he wishes his mom would let him smoke. Staff guided him to talk to his mother/Guardian about his feelings. Staff educated him regarding the Nicotine Patch's his Guardian/Mother provided. [The recipient] stated that he is not using the patches."

The HRA found evidence in the Medication Chart of the recipient refusing to take Nicotine patches 13 out of the 16 days (excluding days in the hospital) since starting the patches on 3/07/2017 and the guardian taking over medications on 4/05/3017. The HRA did not find evidence of the Bridgeway staff and guardian arguing over the smoking cessation treatment.

The HRA reviewed facility staff's Progress Notes that were written by various staff members. These contain notes regarding the recipient's blood count and the subsequent medication changes. Notes pertinent to the case read as follows:

- On 8/31/2016 there was a note which read "I received a call from [The recipient's family member] today in Galesburg office upset because she had called [apartment complex] about [recipient's] blood work being high and felt she was treated disrespectively as she was hung up on. [Recipient's family] state she was planning on calling the doctor and having meds discontinued. I explained to her that this particular med this is just part of the process and the doctor monitors and makes changes based on the blood draw. [The recipient's family member] stated that she is his guardian and when I asked her to send us the paperwork she stated that the court has the highest authority and she ended our conversation. I then contacted [Physician] office and checked with [Staff]. White blood cell count was again high and [Physician] is recommending that Clozaril be lowered to half a tab in morning and two tabs at 2pm. [Staff] will fax the orders over to the residence. I explained to [Staff] that my staff believe that [Recipient] has been doing very well and the medication is helping outside of the side effect."
- On 10/28/2016 there was discussion between Bridgeway staff and the recipient's Primary Care Physician's office. The Bridgeway staff reported, "[The recipient's] clozaril has been again reduced and is now taking only 50 mg in am and 50 mg in the evening and [the recipient] is displaying an increase in symptoms. I talked with [a nurse] about facial tics, duck noises and rambling on and on. [The nurse] discussed that WBC [white blood

cell] count on 9/15/2016 was 14 and retested on 10/25 and was 17, [the nurse] states meds had to be lowered. I clarified with [the nurse] that clozaril is lowered if WBC is low but [the recipient's] is high. [The nurse] states it has to be lowered for high or low."

- As per 11/14/2016 reports, "Followed up with a second phone call to [the nurse] . . . Discussed that [the recipient's] symptoms are getting worse. He is not oriented to time [and] place, is not sleeping, is very disorganized and appears to be responding to internal stimuli according to notes from residential. [The nurse] states will have to check with [the doctor] and [the guardian] about meds as meds decreased due to WBC being too high. [The nurse] states [the doctor] would probably recommend screen for hospitalization but we are not sure that [the guardian] would agree."
- According to 11/14/2016 reports, "I discussed the current behaviors with [the recipient's] mom and shared that I had also shared them with [the doctor's] office. I expressed my concern that [the recipient] could be headed to a hospitalization if we did not make some sort of intervention. [The guardian] was adamant that [the recipient] not be considered for or taken to the hospital unless 'SHE SAYS SO.' [The guardian] states that as long as [the recipient's] WBC is high that he can't have med increase, that she won't okay it. I will continue to consult with [the guardian] about [the recipient's] current symptoms."
- On 11/21/2016 staff reported, "I consulted with [a doctor], Bridgeway's medical director, about my concerns about changes in [the recipient's] meds by PCP. I explained that Clozaril was lowered twice because white blood cell count was high and that [the recipient] has become much more symptomatic. Dr. shared that a high white blood cell count often suggests an infection and that low white blood cell count is a concern for Clozaril. Dr. suggested talking with PCP and see if an ANC (Absolute Neutrophil Count) was done as neutrophil level is important with Clozaril as well. Dr. suggested to have [the recipient] see his PCP for rule out of an infection and the possibility he might need a referral to a hematologist. We discussed my concerns about [the recipient's] mom becoming his permanent guardian and he echoed senior administrations suggestion to involve [an outside agency]."
- On 12/05/2016 staff reported, "called [the guardian] at 1:30pm and reported to her about [the recipient's] doctor visit today with [the doctor]. [The guardian] stated that she will get lab results from [the doctor] tomorrow and will take it to her lawyer because she is going next week to court to get permanent guardianship over [the recipient]. [The guardian] stated that [the recipient] is only to get lab work done at [the doctor's] office and that Bridgeway cannot get results."

In summary, the staff at Bridgeway expressed concerns over the recipient's lowering medication dosages to the guardian. The guardian wanted to follow the medication orders that the outside PCP was giving and also expressed a strong aversion to hospitalization. Both the staff and guardian disagreed over the course of action regarding medication affecting white blood cell count. Additional testing and consults were recommended by Bridgeway's medical director. The Bridgeway staff were in contact with the PCP staff until the guardian dictated they are no longer allowed to speak with that staff, examine lab results or take the recipient to obtain lab work.

The HRA reviewed the facility staff's Progress Notes in regard to an attempted use of personal debit card for food provisions and inadequate food provisions.

- A progress note, that is part of the treatment plan dated 8/26/2016 through 2/22/2017, that has a date of 9/6/2016 reads "Staff guided [Recipient] in the process of cooking his

dinner. Staff educated [Recipient] on the importance of practicing safety while using his stove. Staff guided [Recipient] in the process of following the directions to begin meal prep. Staff guided [Recipient] in the process of cooking his meal thoroughly and safely. Staff also educated [Recipient] on proper cleanup of his kitchen and proper storage of his leftovers." Another section on the same date reads "[Recipient] has difficulty learning and practicing healthy nutrition due to the interfering barriers created by his mental illness. [Recipient] was in a good mood and showed a linear thought process. He asked staff if they would guide him in making dinner. [Recipient] showed understanding of the education provided. He did great with following staff's guidance while cooking. [Recipient] is working toward his goals by learning and practicing proper nutrition."

- Another progress note that is part of the treatment plan 8/26/2016 through 2/22/2017 treatment plan, dated 9/8/2017 has a section on a narrative and cooking group which reads "This group prepares a meal that was planned by its members for healthy eating, affordability, and ease of preparation. A social atmosphere is created in which peers share cooking tips and develop camaraderie by working together and respecting cultural differences among its members regarding eating habits, rituals and practices. Skills are learned that can be used on an independent level." The description also reads that "The stages or steps for food preparation are reviewed and guidance is given on distinguishing between good foods/health choices and foods to avoid due to high fat and calorie content." It also reads that help is given in reading/following recipes and "greater comprehension on how to cook a meal from beginning to end." Another progress in the treatment plan, dated 10/9/2016, states that guidance is given on assuring that the meal is thoroughly cooked.
- Another passage of progress notes, dated 10/13/2016, from the same treatment plan reads "That when I asked [Recipient] if he had his meal plan for tonight and how he was doing because I noticed [Recipient] appeared to be having symptoms such as responding with irrational statement and make grimacing facial expressions. I reported that [Recipient] stated that he does not like women helping him and that I stated that I will be simply providing him with suggestions for meals. I reported that I observed his food in the refrigerator and noticed some of his meat needed thrown out due to him microwaving it to thaw out. I reported that I instructed [Recipient] to throw out the one hamburger patty and cooking up his tenderloins for tonight." Another passage on 10/14/2016 states they coached the recipient with making a grocery list to teach him how to budget. Another passage dated 11/7/2106 reads that the recipient reported that he ate a raw pork chop and eggs and staff educated him that he needed to cook the pork chop fully or he would get sick. The recipient replied that he could eat pork uncooked. Another progress note on 11/8/2016 read that the staff checked to see if the resident had eaten breakfast and he had because the pork chop and eggs were gone from the day before and they also noticed that his refrigerator needed cleaned out. On 11/14/2017 there was an instance documented where the recipient had uncovered food in his refrigerator that had dried out as well as some potatoes that were two days old and an open can of chili. On 11/17/2017 it is documented that the recipient had put all the meat in his freezer into his fridge.
- In another passage of the progress notes, dated 11/27/2017, it was stated that the recipient was eating a hamburger that had not been thoroughly cooked and staff went to his apartment and to make sure he had a healthy dinner and he had "multiple bags of ground beef already unthawed in his fridge and had a large ground beef package that he had

removed from the freezer and opened on the table." He also had other food items that were not properly stored. In the passage, the recipient said "Just throw my food away like everyone else does."

- In a passage on 12/12/2016 it reads that the resident had enough food for a few more meals but staff emailed the Coordinator regarding his meals left "as requested." Another note on 12/12/2016 states that the staff contacted the guardian and told her the exact food that the resident had. One 12/13/2016, another informational note reads that the resident currently had one egg, bread and 4 cans of green beans and no liquid. It was stated that the agency director would be contacting the recipient's guardian. On 12/29/2016 it was documented that staff took the recipient grocery shopping and he purchased enough food for two weeks.
- In a note dated 1/23/2017, it reads "Staff instructed [Recipient] choosing only one meal to eat at a time. Staff discussed with [Recipient] that he has to make his groceries last until the next time he went shopping. Staff spoke with [Recipient] about appropriate portion sizes and eating on a regular schedule." Another note on 1/25/2017 reads "Staff spoke with [Recipient] about eating his own food and not giving it away to peers. Staff discussed with [Recipient] that he was wasting his money when he gives away his food. Staff educated [Recipient] on appropriate portion sizes and eating on a regular schedule." Later in the same note it reads "[Recipient] was not interested in staff's education and offered his food to peers."
- On 2/14/2017 first shift staff consulted with the guardian at the facility. The guardian said she had slid $30.00 under the recipient's door last week for new pillows which he did not buy. The guardian stated "that she took the Credit card away from [the recipient] that had $50.00 on it and she stated that she sees [the recipient] smoking top of the line cigarettes." Staff said they saw "[the recipient] walking back from [the convenience store] this week and [the staff member] stated that he did have . . . coffee from [the convenience store] that same day." The guardian stated that she "feels that [the recipient] does not have food because he had $80.00 last week and did not purchase food for himself. She states that when the minister takes [the recipient] shopping [the recipient] has no limits to purchase groceries and she knows what [the recipient] buys because she always has the receipts."
- On 2/14/2017 staff checked the recipient's fridge, freezer and cabinets because second shift reported the recipient was completely out of food. Staff reported, "She [second shift staff] gave him some of her lunch so he would have something to eat." First shift staff spoke to the guardian and explained the situation. The guardian said the recipient "should still have food and that she has given him cash and his $50.00 spending card." The guardian came and took the recipient to a fast food restaurant and reported "she would bring him something for dinner and the Pastor will be taking him tomorrow for groceries."
- On 2/15/2017 the guardian called stating she responded to staff calling about the recipient having no food. The guardian stated that "[the recipient] had $30 cash and $50 on his debit. [The guardian] was asking why staff had wanted [the recipient's] debit card which has been stored in the med cabinet for some time." Staff told the guardian that "[the recipient] was telling staff that he had no money and no food was in his apartment so they were going to take him to get some food if his debit had any money on it. [The guardian] states that the pastor will be taking him shopping soon."

- On 3/04/2017 the guardian called and stated "that she is leaving us with a paper stating that we cannot handle [the recipient's] debit card or money or take him to see anyone with Bridgeway. [The guardian] also stated that their pastor will be coming to take [the recipient] for grocery and he only is going to get a week at a time and that is his punishment from her and she can do that to him." The HRA reviewed the letter which did say to not remove money cards, cash, or cell phone or transport him without consent.

The HRA read the handbook for the apartments where the individual resides. In the "Finances" section of the handbook, it reads "If Bridgeway staff are acting as your Representative Payee and/or assisting you with money management, an agreed upon schedule of receiving spending money will be worked out with you. If you need assistance with grocery shopping, a weekly shopping day will be scheduled." The HRA reviewed the facility logs for the resident's apartment and a note on 2/14/2017 stated that staff contacted the guardian because the resident was out of groceries and she brought him lunch and said she would bring him dinner later. Another note on 2/16/2017 states that it looks like the guardian's friend bought him groceries and some of them are noted and it is stated they are all put away nicely. The day before there was a note that the guardian stopped by and said they would take the resident grocery shopping. Another note on 2/21/2017 states that they made the resident brats for lunch and he ate all four and then noted to see if staff will make him grilled cheese for dinner. A note on 2/22/2017 reads that the resident refused to have staff help him with lunch and the resident said that he has eaten but no food is missing.

The HRA reviewed treatment plan progress notes dated 6/8/2017, which were part of the most recent treatment plan dated 4/26/2017 through 10/23/2017 and also occurred after the HRA interview with staff. The progress notes read read "[Recipient's] legal guardian asked to speak to the [Staff] and included me in the conversation. Guardian had completed a treatment plan updated back in April but within two days rescinded the plan and the releases signed as well. We discussed the plan that was put in place and I answered all the guardian's questions." Another part of the entry reads "[Recipient] has only been living in our facility due to no active CCP" and another section reads "[Recipient's] guardian has not allowed us to treat [Recipient] for several months. [Recipient] sees [Medical professional], APN for medication however Guardian won't sign a release for us to communicate with [Medical professional]. Guardian has been the one giving [Recipient] his medications daily due to our inability to communicate with the doctor. We addressed that if Guardian wants us to do so then he will have to allow us the ability to communicate to the PCP about meds and symptoms. Guardian agreed that releases in place can allow communication." Another passage reads "[Recipient] has named no progress on his CCP as it was rescinded as soon as it was established. However guardian now gives us permission to work with [Recipient] on skills training, med training and monitoring of his mental status."

The HRA was provided an "Inventory/Shopping Completion Procedure" policy for the facility but it was clarified that the policy was for group homes and apartment living situations did not have a formal, documented shopping procedure.

The "Bridgeway Policy Guide" on "Consumer Centered Plan Development, Review and Modification" reads each consumer needs to have an updated and accurate CCP at all times to receive any sort of treatment or interaction. This plan needs to be developed in participation with both the consumer and the consumer's guardian (if applicable). This plan is the basis for implementation of services "which will support the individualized plan for recovery and/or

stabilization of the person receiving services and provides measures by which the consumer's progress can be evaluated" This plan is necessary for all services administered by Bridgeway and it includes "problems, goals, objectives, specific Bridgeway services, frequency of services, and identification of staff responsible for delivering the services" This plan is to be reviewed semi-annually or when needs change. The policy also reads that a guardian's participation in the plan development will be documented by their signature and if they refuse to sign the plan, the reason will be documented as a progress note.

The Mental Health and Disabilities Code reads, "(a) 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" (405 Ill. Comp. Stat. Ann. 5/2-102). Rule 132 also reads "1) The services shall be provided: A) Following a mental health assessment or Admission Note, as applicable, and consistent with the client's ITP or Admission Note, as applicable" (59 Il Admin Code 132.150).

Rule 132 reads "C) Psychotropic medication shall be administered by personnel licensed to administer medication …" (59 Il Admin Code 132.150). Rule 132 also reads "6) Psychotropic medication training service. A) Psychotropic medication training includes training the client or the client's family or guardian to administer the client's medication, to monitor proper levels and dosage, and to watch for side effects. B) Psychotropic medication training may be provided face-to-face or using video conferencing. C) Psychotropic medication training shall be provided by staff designated in writing by a physician or an advanced practice nurse per the collaborative agreement. D) Psychotropic medication training shall be provided to clients in the following areas: i) Purpose of taking psychotropic medications; ii) Psychotropic medications, effects, side effects and adverse reactions; iii) Self-administration of medications; iv) Storage and safeguarding of medications; v) Communicating with professionals regarding medication issues; or vi) Communicating with family/caregivers regarding medication issues. E) Services may be provided individually or in a group setting. F) Specific documentation of the delivery of psychotropic medication training service must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP" (59 Il Admin Code 132.150). Rule 132 also states "c) Treatment plan development, review and modification service is a process that results in a written ITP, developed with the participation of the Client and the Client's parent/guardian, as applicable, and is based on the mental health assessment report and any additional evaluations. The ITP may be known also as a rehabilitation treatment plan or a recovery treatment plan. Active participation by the Client and the Client's parent/guardian, as applicable, is required for all ITP development, whether it is the initial ITP or subsequent reviews and modifications. The Client may choose to actively involve Collaterals in the ITP process. Participation by the Client and the Client's parent/guardian, as applicable, shall be documented in the plan and confirmed by the Client's and the parent's/guardian's, as applicable, dated original signature on the ITP. In the event that a Client or the Client's parent/guardian, as applicable, refuses to sign the ITP, the LPHA, QMHP or MHP shall document the reason for refusal and indicate by his or her dated original signature with credentials on documentation in the record that the ITP was developed with the active participation of the Client and the Client's parent/guardian, as applicable, and that the Client or the Client's parent/guardian, as applicable, refused to sign the ITP" (59 Il Admin Code 132.148).

According to the Probate Act of 1975, health care providers are reliant on the decisions made by the guardian "as though the decision or direction had been made or given by the ward" (755 Ill. Comp. Stat. Ann. 5/11a-23). This Act also states, "(e) Decisions made by a guardian on behalf of a ward shall be made in accordance with the following standards for decision making. Decisions made by a guardian on behalf of a ward may be made by conforming as closely as possible to what the ward, if competent, would have done or intended under the circumstances, taking into account evidence that includes, but is not limited to, the ward's personal, philosophical, religious and moral beliefs, and ethical values relative to the decision to be made by the guardian. Where possible, the guardian shall determine how the ward would have made a decision based on the ward's previously expressed preferences, and make decisions in accordance with the preferences of the ward. . . . In determining the ward's best interests, the guardian shall weigh the reason for and nature of the proposed action, the benefit or necessity of the action, the possible risks and other consequences of the proposed action, and any available alternatives and their risks, consequences and benefits, and shall take into account any other information, including the views of family and friends, that the guardian believes the ward would have considered if able to act for herself or himself" (755 Ill. Comp. Stat. Ann. 5/11a-17).

Complaint #1 – Conclusion

The HRA reviewed Progress Notes written by the Bridgeway staff after interactions with the recipient or the recipient's guardian or in reference to either one, the recipient's Medication Chart, the staff Facilities Log, and pertinent Bridgeway procedures and policies. The HRA did not find evidence to substantiate the claim of inadequate treatment, including following an outdated physician's order, refusal to administer new medication, not providing guardian medication from a previous physician's order, arguing with guardian about smoking cessation treatment and medication for blood count, attempted use of personal debit card for food provisions and inadequate food provisions; and, therefore, the HRA finds the claim **unsubstantiated.** The HRA **strongly suggests**:

- In reviewing the newest treatment plan, it appears that there has been some services restored to the recipient and the facility is allowed access to the recipient's healthcare. The HRA recognizes that there is a conflict between the facility and the resident's guardian but encourages, for the sake of the resident's well-being, that these compromises continue to occur so that the recipient is provided as many services needed through the facility and so that the recipient is able to benefit from these services.

Complaint #2 - Inadequate transfer procedure, including recipient was sent to hospital without hospital knowledge of guardianship.

The HRA reviewed Progress Notes written by Bridgeway staff, Incident Reports, and hospital records during and around the time of hospitalization.

In the Progress Notes for 2/23/2017, the day of the recipient's first hospitalization, Bridgeway staff state the guardian arrived at the hospital around 1:30pm, before the recipient was evaluated by Crisis staff. Staff stated the guardian was yelling at nurses stating the guardian did not want Bridgeway evaluating the recipient. Staff also stated the guardian asked the recipient for his keys and wallet and turned to staff and said, "she had to go pick up her grandson

and that she had so much stuff going on today with her family members and that she was leaving everything in staff hands' as long as it was not [Staff] who was going to see [the recipient] for his evaluation." After the recipient was seen by both a nurse and the contracted Crisis team it was decided he would be hospitalized and they started looking for placement. In the hospital records where the recipient was evaluated, there is an emergency contacts section which state the guardian's name, home phone number, and indicates that the contact is the patient's legal guardian. On the "State of Illinois Department of Human Services Uniform Screening and Referral Form" filed for this hospitalization the guardian's information and relationship as guardian is provided under both "Family/Contact Person" and "Guardian." Crises worker paperwork state the guardian's name and phone number and includes the reference of "mother/guardian." The HRA also reviewed the petition for involuntary admission and certificate that was filed on 2/27/2017 for the first hospital which also has the guardian's name and telephone number. In reviewing the petition, it was filed on 2/27/2017 but the petition was signed by Bridgeway staff on 2/23/2017 and the certificate was signed by a physician on 2/23/2017. The HRA reviewed three other sets of petitions signed by Bridgeway staff and certificates signed by a physician on 2/25/2017, 2/26/2017 and 2/27/2017 that did not appear to be filed. In the progress notes with a date range of 2/23/2017 through 4/25/2017, on the date of 2/24/2017 it reads that "This writer went to the hospital to update the client's Petition and Certificate." On that same date, it was stated that the recipient was moved from the emergency department to the medical floor. Another note on 2/25/2017 states that the petition and certificate was renewed as "Worker continued to find placement at several hospitals, who continued to deny client based on acuity on units." Another note states that the recipient was rescreened on 2/26/2017. There is another note on 2/27/2017 that "Worker filed original petition at [Courthouse]" which is consistent with the timestamp on the petition and that the original signatures have the date of the 23rd. The HRA also reviewed admission documentation into the hospital that the recipient transferred to and the recipient signed into the facility voluntarily. The admission form reads, in the informed rights section of the document, that "I further understand that a copy of this form will be given to anyone who accompanied me and to any parent, guardian, relative, or attorney whom I indiciate."

The guardian had some issues with where the recipient was placed for this hospitalization. In Progress Notes for 2/24/17 the recipient's guardian "called this writer to let me know that she is unhappy with the crisis process in that they are looking far from home for placement and that as his guardian she believes she has a say in his placement," and on 3/4/2017, "[The guardian] complained that we had placed [the recipient] without her consent and sent [the recipient] to a hospital far away. I explained that once there was a petition and a certificate in place a guardian or person does not have a choice."

On 3/07/2017 the recipient was hospitalized for a second time. In the progress notes, staff stated they informed the guardian through a phone message stating what was occurring and why. The Bridgeway Incident Report notes that the guardian stated she would "just wait until the hospital called her before she did anything." In the conclusion of this incident report staff state, "Guardian as of 3/08/17 had not been to hospital only communicating by phone." In the 3/08/2017 Progress Notes, staff stated that CSS staff had spoken with a nurse in the ED of the hospital where the recipient was being evaluated. The nurse told staff that, "[another hospital] has accepted [the recipient] and that she had spoken with [someone] from [the other hospital] and informed her that [the guardian] is [the recipient's] guardian and that [the other hospital] was going to get a hold of [the guardian]." The hospital records for where the recipient was evaluated

show the guardian's name, home phone number, relationship to patient, and noted that the individual is the patient's guardian, in the emergency contact section. The HRA reviewed another petition signed by Bridgeway staff and a certificate signed by a physician on 3/8/2017, and in the petition, the guardian's name and telephone number were provided. The HRA saw no other petitions and certifications. The document did not have a stamp that is was filed like the previous petition.

The HRA reviewed the "Mental Health Crisis Follow Up and Linkage" policy which reads "In order to create a consistent process under all possible conditions so that internal and external stakeholders can reliably expect a consistent process for post-crisis contact for your and adults evaluated by a Bridgeway crisis/SASS team member. Post initial evaluation contact will be attempted with all persons evaluated by a Bridgeway crisis/SASS team member unless the person refuses to be contacted at the initial screening or a direct linkage has been made with another treatment provider. If the outcome of the initial evaluation is inpatient mental health treatment, Bridgeway will make contact with the inpatient treatment facility unless the person refuses Bridgeway's participation in their care." The policy also states "If the person is going to be linked to another provider for post-crisis care, such as a nursing home, another treatment provider, or is leaving the area, the crisis/SASS evaluator is responsible for providing linkage to the next provider. Agency practice is that we still provide crisis follow up contact even if transferred to another provider." The policy also reads "For persons who are referred to inpatient mental health treatment, the crisis evaluator will attempt to get a signed release prior to transfer to the inpatient unit for coordination of care. If the patient is unwilling or unable to consent a release may not be obtained. Bridgeway's Crisis/SASS evaluations will contact tie inpatient unit within 72 hours of admission to coordinate care. If the unit is unable to speak to the evaluation due to HIPAA rules, contact information will be left and an offer to fax a release for the person to sign should they consent to coordination."

The Mental Health and Developmental Disabilities Code reads "(a) When a person is asserted to be subject to involuntary admission on an inpatient basis and in such a condition that immediate hospitalization is necessary for the protection of such person or others from physical harm, any person 18 years of age or older may present a petition to the facility director of a mental health facility in the county where the respondent resides or is present. The petition may be prepared by the facility director of the facility … (b) The petition shall include all of the following: 1. A detailed statement of the reason for the assertion that the respondent is subject to involuntary admission on an inpatient basis, including the signs and symptoms of a mental illness and a description of any acts, threats, or other behavior or pattern of behavior supporting the assertion and the time and place of their occurrence.2. The name and address of the spouse, parent, guardian, substitute decision maker, if any, and close relative, or if none, the name and address of any known friend of the respondent whom the petitioner has reason to believe may know or have any of the other names and addresses. If the petitioner is unable to supply any such names and addresses, the petitioner shall state that diligent inquiry was made to learn this information and specify the steps taken" (405 ILCS 5/3-601). The Code also reads "§ 3-611. Within 24 hours, excluding Saturdays, Sundays and holidays, after the respondent's admission under this Article, the facility director of the facility shall file 2 copies of the petition, the first certificate, and proof of service of the petition and statement of rights upon the respondent with the court in the county in which the facility is located. Upon completion of the second certificate, the facility director shall promptly file it with the court and provide a copy to the respondent. The facility director shall make copies of the certificates available to the attorneys for the parties

upon request. Upon the filing of the petition and first certificate, the court shall set a hearing to be held within 5 days, excluding Saturdays, Sundays and holidays, after receipt of the petition. The court shall direct that notice of the time and place of the hearing be served upon the respondent, his responsible relatives, and the persons entitled to receive a copy of the petition pursuant to Section 3-609" (405 ILCS 5/3-611)

Complaint #2 – Conclusion

The HRA found no evidence that the first hospital or the second hospital was not notified that the patient had a guardian. Documentation shows that the guardian was physically present at the first hospital on 2/27/2017 and later documentation showed she was aware of the location of the second hospital. Also, involuntary commitment documentation was filed for the first hospital that had the guardian's telephone number. For the 3/7/2017 admission, there is documentation that the guardian was made aware of the situation by the first hospital, that the first hospital staff made staff at the second hospital aware there was a guardian and that they were supposed to contact the guardian. Additionally, the HRA found no regulations stating that it is Bridgeway's responsibility to contact the second hospital, where the patient was transferred, with guardianship information.

The HRA finds this complaint **unsubstantiated** and offers the following **suggestion**:

- According to documentation, the patient was first taken to the emergency room on 2/23/2017 but there did not appear to be a petition and certification filed until 2/27/2017. The Code states that a petition and certificate must be filed within 24 hours of admission, excluding Saturdays, Sundays, and holidays. In this case Bridgeway was the crisis team and participated in the signing of all petitions. This is non-compliant with admission standards and the HRA **strongly suggest** that Bridgeway work together with the hospital to comply with regulations.
- When there are questions or concerns regarding a guardian, consider consulting with an attorney to determine the need to notify the Probate Court.