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Egyptian Regional Human Rights Authority
Report of Findings
Chamness Care
Case #21-110-9005
March 23, 2022

The Egyptian Regional Human Rights Authority, a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegation concerning Chamness Care Community Integrated Living Arrangement (CILA) home (Chamness).

Inadequate treatment planning

If found substantiated, the allegation represents violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2 et al.) and regulations that govern Community Integrated Living Arrangements (CILAs) (59 Il Admin Code 115 et al.).

Chamness Care is in Anna, Illinois and provides residential services to persons with developmental disabilities. To investigate allegations, an HRA team met with administration, examined pertinent chart information, and reviewed policies and other documents.

COMPLAINT STATEMENT

According to the allegation received, the agency provided inadequate treatment planning by neglecting to complete advance directives prior to hospitalization of a recipient, who quickly declined and passed away. The recipient had no guardian and allegedly, the hospital was advised that he could make his own medical decisions upon admission. However, when the hospital consulted with him, he reportedly agreed to put a do not resuscitate (DNR) order in place. Chamness staff allegedly stated he was unable to make that decision for himself and likely agreed to a DNR out of fear of medical treatment that would have been necessary if it were not in place. Chamness staff visited the recipient in the hospital, and during that visit, the recipient completed a power of attorney (POA) for medical decisions naming Chamness Care as his agent. When it was given to the hospital, the POA was not honored due to the hospital's belief that he was incapable of making that decision at that time due to being medicated with Morphine. The hospital also contended that the signature on the POA did not match the signature on the DNR signed upon admission.

FINDINGS

Record Review: The HRA obtained records via subpoena since the recipient had passed away before the investigation began and written consent could not be obtained. Records were subpoenaed from the hospital, Chamness Care and the Independent Service Coordinator (ISC) Agency for review.

According to hospital records, the recipient was taken to the local hospital and received a treatment of Tylenol and intravenous antibiotics (IV) for hypoxemia (low oxygen), pneumonia and tachypnea (shortness of breath). The patient was transferred to another regional hospital approximately 7 hours later for higher level of care in the intensive care unit and to be seen by a pulmonologist. The patient had been tested for COVID-19 and the results were pending at the time of transfer but later returned as positive. The admission notes at the second

hospital listed a history of hypertension, intellectual disability, mixed anxiety and depression, GERD and noted he had presented at the other hospital with shortness of breath. The note also stated that the recipient was *"alert and oriented and is his own power of attorney, he maintains the ability to make his own decisions at this point."* Regarding Code Status, the notes documented *"we had a lengthy discussion regarding his code status and wishes regarding end of life care. He states that he does not want to be on a mechanical ventilator and wishes to be allowed to pass naturally should his heart stop. He is completely alert and oriented and able to make his own decisions. Poor overall prognosis."* The form is signed by a nurse practitioner. Another progress note from a physician, from the morning following admission, stated *"patient with an intellectual disability currently lives in a group home. However, he is able to answer all directed questions in [sic] appears to be able to make his own decisions."* On the second day of admission there was a note signed by the physician that stated, *"the intensivist just saw the patient he reiterated again to him that he did not want to be intubated."* The physician also documented that the recipient continued to take off his oxygen and was desaturating, so he was started on Airvo (high flow nasal oxygen therapy). It was noted that the recipient was better overnight, but he was anxious. Regarding orientation, it was documented that the recipient did not know the name of the hospital or the date and due to intellectual disability *"I suspect he is at baseline. He does answer all questions appropriately."* It was documented that *"yesterday someone from the group home called and reaffirmed that he is his own power of attorney but they wanted us to reverse his DNR/DNI order but after discussion with the patient he did not want to do that."* On day two around 11:33 a.m. it was documented that the recipient *"was found to have covid pneumonia. He has deteriorated over the last 24 hr... The patient is refusing intubation. He refuses to assume a prone position. He is now refusing injections and some oral medications. When I spoke to him today, he vehemently refused to allow intubation and more aggressive care."* This note was signed by a second physician. A "quick note" signed by the first physician documented that one of the caregivers from the CILA home came to see the recipient and noted that there have been ongoing discussions today (day 2 of admission) with the administration in risk management about the recipient's advanced directives. *"Patient signed a form for DNR and DNI on admission. The caregiver from the group home did reiterate that this patient has capacity to make his own decisions and is his own POA. However, they feel in this situation he may not be able to make the appropriate decisions for himself. Therefore, the caregiver has come to see him to see if she is able to talk to him and convinced him to changes mind [sic] or perhaps allow her to serve as his POA. The caregiver also indicated that they spoke to an attorney through their facility and may also pursue an emergency ordered. [sic] I did reassure the caregiver that whenever decision is arrived at we would honor that so long as the person is the acting POA. [sic] I also reiterated that each day that I have seen him and the intensivist/pulmonologist has seen him we have discussed his advanced directives. [sic] This morning we were considering intubation and the pulmonologist/intensivist asked the patient once again and he declined intubation. He also suggested perhaps lying in the prone position may help but the patient declined to do that as well. As far as I have seen the patient he does seem to be able to understand what it means to be on a ventilator and we have discussed the risks and we have particularly discussed the benefits but he still has declined. If at any time they were able to secure the appropriate POA we will act in a manner as directed by that person. This meeting took place with the house supervisor, director of nursing, and risk management. Per the director of nursing and risk management administration had been involved in these discussions today as well. I will update the nighttime provider which is coming on to service in 10 min about the current situation."* Approximately an hour later, the nurse practitioner entered a note that stated *"I discussed the case with the intensivist who states that the patient has adamantly refused intubation on multiple occasions and has been consistent with his desires regarding this. He does not agree with honoring a POA agreement obtained while the patient is clearly in respiratory failure with SpO2 level of 70% with recently administered opioid medications. I also agree with honoring the patient's repeatedly stated wishes regarding end of life care and discussed the case with the remote hospitalist providing oversight who is supportive of maintaining DNR/DNI status as per the patient's wishes. Administrator on call notified of situation. The case worker was also informed of the decision to honor the patient's wishes at this time."*

The patient care notes documented that the nurse from the CILA home contacted the hospital to check on the recipient and asked to facilitate a call with him. A call was arranged, and the nurse also stated she would like to have a conference call with the case manager regarding the DNR status. The nurse requested that the Chief

Operating Officer (COO) of the CILA be able to speak to the recipient regarding the possible reversal of his DNR. Notes documented that the nurse was trying to stabilize the recipient at that time but contacted case management regarding the request. On day 2 at 5:17 pm, it was documented that the recipient was lying on his abdomen, was removing his Airvo and was anxious and upset. The physician was notified about the situation and at 5:33 pm, 4 mg of Morphine was ordered via *"IV push now"* and 2 mg via IV every 2 hours for dyspnea (shortness of breath). At 6:05 pm it was documented that the COO from the CILA home visited the recipient in his room *"to discuss with Pt [patient] about POA and reversing his signed DNR. Pt's O2 sat is between 60-70's, dyspneic with RR [respiratory rate] of 80 per minute even after Morphine 4 mg IV push was given at 5:42 pm. Pt refused to lay on his abdomen. I left the room Pt is left with [COO]. Will continue to monitor."* At 6:30 pm it was documented that the RN from the CILA home had told the hospital's RN that the recipient had signed a POA form and that he had agreed to be intubated if needed. The CILA RN referred to the recipient stating *"You are agreeing for the nurse/healthcare provider to put you to sleep and put a tube in your mouth so you can rest your body and lungs, right?"* The hospital RN documented that the recipient *"Mumbled and unable to comprehend what he said as he appears to be dyspneic."* At 6:40 pm the CILA COO provided the RN with a copy of the POA form which was placed in his chart. A note from another RN at 8:30 pm documented that the attending physician, a tele-health physician and the nurse practitioner all agree on the recipient's continued DNI status and stated they would speak with the recipient and verify mental status and DNI status. At 9:12 pm a phone call with the CILA COO was documented in which a hospital RN told the COO that the hospital *"will not honor the paperwork that was obtained while he was on Morphine and hypoxic today."* The COO argued that she had spent an hour in his room talking about current events in his life which showed that he could make that decision for himself to sign the POA. The COO stated that he arrived at the hospital as a *"full code and he should stay that way."* The hospital nurse contended that the paperwork from the CILA home indicated that he was competent, and his own guardian and the recipient signed a DNI at the time of admission. At 10:10 pm the RN spoke with the recipient concerning intubation. The recipient verified his name, date of birth, town he lived in and who the President of the United States was. The nurse asked if he knew what a ventilator was, to which he replied yes. The nurse went on to explain that *"A breathing tube is a tube that goes down your breathing tube/hole into your lungs to help you breathe better. Pt [patient] states 'I'm not breathing bad' the nurse states, your [sic] kind of struggling. I just want to make sure if you get worse, you do not want us to put a breathing tube down your lungs to help you breathe? Pt states, 'no.'"* At 11:18 pm it was documented that the recipient's oxygen saturation had decreased, and he was not alert to name or to touch. *"Due to DNI status per medical doctors, pt's hand was held and comforting words were said to ease his passing…pt passed away peacefully at 2321."*

The Discharge summary documented a Code status of DNR/DNI. At 7:00 pm on day 2 the physician was called to bedside due to oxygen decline since 5:00 pm. The physician was notified that the COO had been in his room attempting to get him to sign a POA after the patient had received intravenous Morphine. The physician obtained an ABG (arterial blood gas) at that time which confirmed oxygen level of 35. The case was discussed with the intensivist who stated the patient had adamantly refused intubation on multiple occasions and had been consistent with his desires regarding that. The intensivist did not agree with honoring a POA agreement *"... obtained while the patient is clearly in respiratory failure with SpO2 level of 70% with recently administered opioid medications."* The physician also agreed with honoring the patient's *"repeatedly stated wishes regarding end of life care"* and discussed the case with the remote hospitalist providing oversight who was supportive of *"maintaining DNR/DNI status as per the patient's wishes."* The Administrator on call was notified of situation, the case worker was also informed of the decision to honor the patient's wishes at this time. The discharge summary also documented concerns regarding the *"validity of the power-of-attorney agreement as it was obtained while the patient was severely hypoxic and after intravenous narcotics were given."*

The HRA reviewed the recipient's vital signs printout. On day 2 of admission the COO was visiting between 5:40 and 6:45 pm, the oxygen levels ranged from a low of 64% to a high of 95% mostly staying in the mid to upper 70s. There are blank lines for the oxygen saturation readings from 6:06 pm until 7:18 pm when it registered at 73%.

The HRA reviewed a typed summary from the hospital's Risk Manager documenting the discussion with Chamness Care's CEO regarding the DNR/POA situation. It was dated on day two of admission. There were several calls back and forth that were documented between 1:00 and 6:00 pm. In one of the discussions between the hospital CEO, CNO and the Risk Manager and the Chamness Care's COO, RN and the house manager, it was agreed to bring in a third party to act as an Ombudsman to represent the patient. It was agreed that the ISC agency should be contacted to act as Ombudsman as they were familiar with the recipient as well. After discussing with supervisors at the ISC agency, it was agreed to allow the COO of Chamness Care to personally visit and advocate for the recipient while hospitalized. 30 minutes later the COO arrived along with the RN and CEO who waited in the car. The physician, CNO, House Supervisor and Risk Manager met with the COO. The physician provided an account of the care being provided and informed the COO that the recipient *"does understand what it means to be intubated and supported by mechanical ventilation and each time he has been approached about it, [recipient] has declined."* The COO stated she knew the recipient wants to live and argued that the recipient is only refusing intubation because he is afraid of the procedure. The COO brought POA papers with her and the hospital explained that employees of the hospital do not participate in the completion of advanced directives, and they do not witness signing the documents, so it was agreed to have the CILA RN witness the signature through the window of the ICU while the COO was in the room with the recipient. Approximately 2 hours later the Risk Manager was notified that the COO obtained the recipient's signature on the POA paperwork after he had received 4 mg of IV Morphine and the providers were not going to honor it due to recipient's condition at the time the signature was obtained. The Risk Manager reviewed all the documents in the chart and documented in this summary that the signatures on the DNR/DNI signed with staff as witness upon admission did not match the signature on the POA.

ISC documentation that was reviewed consisted of case notes regarding this situation. The CEO of the hospital contacted the ISC and explained the recipient was in distress and ventilators and codes were explained to him and the recipient stated he did not want either one and had signed a DNR. The CEO informed the ISC that the hospital had received calls from Chamness administration demanding to speak with the recipient because they believe "he probably doesn't understand what was being explained to him." He was reaching out to the ISC to act as a third-party Ombudsman for the recipient to assist on the decision whether the hospital should allow someone from Chamness Care to speak with the recipient. The ISC consulted the supervisor and it was agreed that the COO should be allowed to speak with the recipient to assure he understands what is happening. The ISC called the COO to confirm she would be the one speaking with the recipient and she indicated she would be and was already in route to the hospital. The CEO was informed that the ISC supported the COO speaking with the recipient. The CEO had been in touch with the public health department and requested something in writing stating the ISC supported this because *"He does not support the idea of someone coming in and coercing someone from decisions they've already made."* The supervisor for the ISC stated she would send an email to the CEO stating the ISC's support. The COO contacted the ISC at 7:11 pm and informed her that she spoke with the recipient for over an hour about the ventilator and if he wanted help from them to make decisions and he "… said yes to the ventilator and for help making decisions." The recipient signed a POA for Chamness Care to help with decisions while in the hospital. It was also documented that the recipient spoke to the CILA house manager on the phone and told him the same thing. Everyone agreed that he was lucid and stable to make these decisions at this time. "He was in distress but holding his own." The recipient smiled and waved to the COO and RN from the CILA home when they left. At 8:42 pm the ISC received another call from the COO, CEO and RN stating that the recipient was "crashing" and they were not going to honor the POA or the decision to have the vent. It was discussed to get him transferred to another hospital, but due to his oxygen levels and STATs he would not be able to survive a transfer. It was also noted that the recipient was admitted to the hospital as a "full code" and it was questionable why they would ask him if he wanted that changed upon admission. The ISC contacted the CEO of the hospital for an explanation and was told that it was agreed to let the COO speak with the recipient, but not to go in with a POA and if his doctors are telling him that the POA is not legal or valid then that is what he has to go with, therefore, what was discussed between the recipient and the COO cannot be honored. He stated the recipient had made his wishes known and that is what they must go with. He stated that the recipient was on his belly and on Morphine and not lucid when he made those decisions

with the COO and signed the POA. The COO contended that he was lucid and sitting up in his bed when he signed the form. The COO told the ISC that they would be at the courthouse at 8:00 am the next day to make the POA legal, but the recipient passed away at 11:15 pm.

The HRA reviewed the email from the ISC supervisor to the hospital which stated *"Chamness Care is responsible for the overall health and wellbeing of [recipient]. We understand that [recipient] is very anxious at this time and distrustful of those with whom he is not familiar. Given the seriousness of [recipient's] condition, we support the decision for [COO] to be able to personally visit and advocate for [recipient] while he is hospitalized."*

CILA documentation included detailed notes from the Sunday the recipient was admitted to the local hospital until Wednesday after the recipient had passed away. It was documented that this summary was also given to the Department of Public Health due to Chamness Care's belief that this was a wrongful death situation. The recipient had worked on Saturday but had been quarantined and was being monitored on Sunday due to exposure to COVID-19 by a housemate. His oxygen dropped but all other vitals were normal. The recipient stated he felt fine. Suddenly later that evening he began having shortness of breath and 911 was contacted and he was taken to the local hospital. While there, a fever developed, and he became tachycardic. The CILA was contacted at 12:18 am to notify that the recipient was being transferred for higher level of care. He arrived at 2:30 am. After providing a report of the recipient's condition around 10:30 am informing Chamness that the recipient was non-compliant with most requests, the RN at the CILA requested a phone call which might help with his cooperation. The call occurred around 2:30 pm and the recipient spoke with his CILA nurse, house manager and the COO. The recipient told them he was afraid they had forgotten about him and that *"I told them not to resuscitate me."* He was reassured that he would be ok and he was just scared. He talked to the house manager about coming to pick him up and he was assured they would pick him up as soon as he was healthy. He seemed reassured following the discussion. The hospital nurse spoke with the RN at the CILA and informed her that a DNR was signed and the RN at Chamness Care stated that he is a full code and did not agree with that. The hospital nurse indicated she would have a case manager contact the CILA RN. The case manager stated that the recipient was adamant about not being resuscitated and the nurse explained that he has a history of becoming depressed and making statements about not wanting to live during depressed times and insisted this would not be his wishes. However, the case manager stated her "hands were tied." Other notes documented several calls with the hospital consistent with the hospital's documentation outlined above. The CILA contended that he was admitted as a "full code" and did not agree with a DNR being signed under sickness and distress/fear; the hospital contended that he was lucid and adamant about not being resuscitated.

Upon arrival to see the recipient, the COO presented another copy of the recipient's face sheet showing he was a "full code" and asked if they received that from the transferring hospital and was told that they had received it. The COO explained that he was admitted as a "full code" and that has always been his wishes and her concern was the DNR was signed out of fear and/or lack of understanding of the ultimate consequences. The COO was under the impression from the meeting with hospital staff that they were all aware she was going in to speak with the recipient about signing a POA for them to help make decisions and even discussed that they could not witness the signature, but the CILA RN could witness it from the window and even showed the COO what box needed to be checked on the form. The meeting ended around 5:25 pm. The recipient was lying on his left side when she entered the room and was on nasal oxygen and a mask. She showed him a video on her phone that a friend had made for him to encourage him. At this point, the hospital nurse stated she was busy and needed to leave. He discussed how long he had been friends with her and waved to the CILA RN through the window and stated that was his nurse and called her by name. The recipient also talked about other staff being on vacation. Around 6:30 pm they called the house manager and the recipient had a conversation with him. The COO explained the POA paperwork to the recipient again and he agreed to sign so they could help advocate for him while in the hospital. They attempted to get a hospital staff in the room to hear his wishes. After several attempts, the hospital nurse came to the window. It was noted that the COO had been trying to see what his oxygen level was, but it was not on the monitors. She saw that the oxygen cord from his finger was not attached to anything and asked the hospital nurse about this and she stated it should be hooked up and the nurse

said she would get it in a minute. The nurse walked away before the recipient signed the form. The house manager was a witness, via telephone, and had documented in his own case notes that the recipient stated *"I'm gonna let [COO] help me because I don't think I'm making good decisions at this point."* The CILA RN witnessed his signature through the window and signed as a witness on the form. It was noted at first that he just signed his first name and they asked him to sign his last name which he did. The signed form and face sheet showing the recipient as a "full code" was given to the hospital nurse then CILA staff left the hospital.

Around 8:30 pm the hospital called the COO to inform her that they will not honor the POA "because of the way it was handled" and stated they would be calling public health the next morning. The hospital nurse stated that the recipient was not competent because he was on Morphine and had low oxygen at the time.

Both the DNR/DNI form and the POA form were reviewed by the HRA. The first name was identical on both forms. The DNR form was signed with a middle initial whereas the POA form was not. There was a difference in a couple of the letters in the last name signature on both forms. The HRA also reviewed the face sheet that accompanied the recipient to the hospital showing his status as "full code."

The recipient's 2020 Medical Review form for the CILA showed diagnoses of Anxiety, Mild Intellectual Disability, history of Hypertension, GERD, Hiatal Hernia and Esophageal Motility Disorder. The nursing recommendations included observation for side effects of medication, monitoring behaviors, weight and blood pressure monthly and to encourage exercise and health snacking.

The Individual Service Plan (ISP) documented in the history section that the recipient *"has a history of hoarding and depression. [recipient] does make statements such as 'I just don't want to live anymore' After receiving attention for a brief time period, [recipient] goes back to normal interaction with staff/peers and appears happy. He then states that he does want to live and go bowling. It can be hypothesized that [recipient] demonstrates behavior due to depression diagnosis and/or the function of the behavior could be attention maintained."* In the honoring choices section, it was documented that the recipient *"... understands that there is a balance between rights and ability to make informed decisions. Chamness Care makes an ongoing effort to inform [recipient] of potential harm, suggest alternative and minimize potential harm when choices may result in harm. His choices are honored, however, if a time occurs when they cannot be, the reasons would be documented in this area."* In the rights section it is stated that the recipient *"... has the right to refuse any treatment or procedure, unless it is immediately life threatening."*

Interview:

The HRA met with the administration of Chamness Care to discuss the documentation provided. The agency consists of 13 homes and 59 residents. Chamness staff will help residents with advance directives if needed or requested, but if the person is healthy, they generally will just speak with nurses about that at the annual physician appointments. This recipient did not have an advance directive or DNR prior to hospitalization. He never showed interest in having a DNR but would have depressive states where he would say "I want to die" but he would come out of it quickly with counseling and support. He was 50 years old and healthy other than GERD, a Hernia and High Blood Pressure. He held a job in the community daily and earned money. The agency contacted the department of Public Health to look into this situation but the only outcome they were made aware of was that the hospital "substantially meets federal requirements" for participation in the Medicare program, specifically the Condition of Participation of Patient Rights. Equip for Equality was also contacted and completed an investigation. Specifics of the investigation could not be shared, but the agency was told that concerns about this situation was shared with both state and federal agencies with recommendations about how to avoid this type of situation from happening again. The CILA home expressed concern that no explanation was provided as to why the "full code" face sheet was not honored and a DNR was pursued. They had questions as to why the CILA was not consulted/contacted or at the very least why the hospital did not ask the recipient to sign a release allowing the hospital to speak with Chamness Care. The agency has never had an issue with hospitals communicating with them about clients and typically will accept a verbal acceptance from

the client allowing the hospital to speak with Chamness Care staff. Typically, the hospital nurses communicate with the CILA home nurse and collaborate. The COO denied the claim that the recipient was on his back during their visit. The COO also did not agree with the rationale of denying the POA due to low oxygen levels and Morphine being administered. They spoke for an hour or more about current events and things in his life and he held a conversation on the telephone with his house manager during this time as well and verbally expressed his desire for Chamness Care to be his POA to help make decisions during this hospital stay. Furthermore, the oxygen monitor was not hooked up during their visit so there was no way to tell what his levels were during that time. This was pointed out to the hospital nurse who just stated she would fix it soon.

STATUTES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) guarantees the right to *"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."*

Regulations that govern CILAs (59 Ill. Admin. Code 115.200) describe the community-integrated living arrangement (CILA) as "*a living arrangement which promotes residential stability for an individual who resides in his or her own home, in a home shared with others, or in the natural family home and who is provided with an array of services to meet his or her needs…*

c) Services shall be oriented to the individual and shall be designed to meet the needs of the individual with input and participation of his or her family as appropriate. Individuals are recognized as persons with basic human needs, aspirations, desires and feelings and are citizens of a community with all rights, privileges, opportunities and responsibilities accorded other citizens. Only secondarily are they individuals who have a mental disability.

d) Based on their needs, individuals shall receive supervision and supportive services which may range from continuous to intermittent. CILAs shall be designed to promote optimal independence in daily living, economic self-sufficiency and integration into the community through the interdisciplinary process"

There is no requirement that advance directives need to be completed as part of the individual services plan.

The Power of Attorney Act (755 ILCS 45/2-8) states the following about reliance on a document purporting to establish an agency. *"(c) Any person dealing with an agent named in a copy of a document purporting to establish an agency may presume, in the absence of actual knowledge to the contrary, that the document purporting to establish the agency was validly executed, that the agency was validly established, that the named principal was competent at the time of execution, and that, at the time of reliance, the named principal is alive, the agency was validly established and has not terminated or been amended, the relevant powers of the named agent were properly and validly granted and have not terminated or been amended, and the acts of the named agent conform to the standards of this Act. No person relying on a copy of a document purporting to establish an agency shall be required to see to the application of any property delivered to or controlled by the named agent or to question the authority of the named agent.*
(d) Each person to whom a direction by the named agent in accordance with the terms of the copy of the document purporting to establish an agency is communicated shall comply with that direction, and any person who fails to comply arbitrarily or without reasonable cause shall be subject to civil liability for any damages resulting from noncompliance. A health care provider who complies with Section 4-7 [755 ILCS 45/4-7] shall not be deemed to have acted arbitrarily or without reasonable cause"

The Act (755 ILCS 45/4-5) prohibits a Health Care Provider from serving as a POA Agent and states "Neither the attending physician nor any other health care provider or health care professional may act as agent under a health care agency; however, a person who is not administering health care to the patient may act as health care

agent for the patient even though the person is a physician or otherwise licensed, certified, authorized, or permitted by law to administer health care in the ordinary course of business or the practice of a profession."

The Act (755 ILCS 45/4-4) defines "Health care provider", "health care professional", or "provider" as *"the attending physician and any other person administering health care to the patient at the time of reference who is licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or the practice of a profession, including any person employed by or acting for any such authorized person.*

The Act (755 ILCS 45/4-7) states this about the duties of health care providers and others in relation to health care agencies: "*Each health care provider and each other person with whom an agent deals under a health care agency shall be subject to the following duties and responsibilities:*
(a) It is the responsibility of the agent or patient to notify the health care provider of the existence of the health care agency and any amendment or revocation thereof. A health care provider furnished with a copy of a health care agency shall make it a part of the patient's medical records and shall enter in the records any change in or termination of the health care agency by the principal that becomes known to the provider. Whenever a provider believes a patient may lack capacity to give informed consent to health care which the provider deems necessary, the provider shall consult with any available health care agent known to the provider who then has power to act for the patient under a health care agency.
(b) A health care decision made by an agent in accordance with the terms of a health care agency shall be complied with by every health care provider to whom the decision is communicated, subject to the provider's right to administer treatment for the patient's comfort care or alleviation of pain; but if the provider is unwilling to comply with the agent's decision, the provider shall promptly inform the agent who shall then be responsible to make the necessary arrangements for the transfer of the patient to another provider. It is understood that a provider who is unwilling to comply with the agent's decision will continue to afford reasonably necessary consultation and care in connection with the transfer…

The Act (755 ILCS 45/4-8) states this about immunities of health care providers. "*Each health care provider and each other person who acts in good faith reliance on any direction or decision by the agent that is not clearly contrary to the terms of a health care agency (a "reliant") will be protected and released to the same extent as though the reliant had dealt directly with the principal as a fully-competent person. Without limiting the generality of the foregoing, the following specific principles shall also govern, protect and validate the acts of the agent and each reliant:*
(a) No reliant shall be subject to any type of civil or criminal liability or discipline for unprofessional conduct for complying with any direction or decision by the agent, even if death or injury to the patient ensues…"

CONCLUSION

The complaint alleged inadequate treatment planning due to Chamness Care lacking advance directives in place prior to hospitalization. During interviews, Chamness administration explained that they do not automatically discuss DNR/DNI with each individual unless the individual is in poor health and it may be necessary. When individuals are generally healthy, as was the case for this recipient, they discuss advance directives during annual physical examinations with the physician and unless the recipient or guardian chooses to put a DNR in place, they leave the individual as a "full code" meaning all life saving measures will be taken. This is noted on the face sheet that is sent with each individual when they are taken to the hospital for emergency care. This recipient's face sheet documented that he was a "full code" and administration explained that this is all that the other hospitals they utilize requires to honor the full code status. The recipient's individual service plan documented that the recipient has bouts of depression but can typically be redirected easily with encouragement from trusted people. It also documented that the CILA home makes an ongoing effort to inform the recipient of potential harm, suggest alternatives and minimize potential harm when his choices may result in harm. It was noted that if there was a time his choices could not be honored it would be noted in the plan. Finally, the treatment plan stated that the recipient has the right to "refuse any treatment or procedure, unless it is

immediately life threatening." This indicates that Chamness Care staff assist or at least guide the recipient with some choices especially if or when a choice may be immediately life threatening. Therefore, there would be no reason for Chamness to believe that the recipient's "full code status" would not be honored at this hospital as other hospitals in the region have and there are no specific CILA mandates related to advance directives. Therefore, this allegation is **unsubstantiated.**

The HRA offers the following suggestions:

1. Chamness staff/administration should consider further discussions with clients regarding DNR/DNI orders to clarify what that means and ensure any education that may be needed is provided by nursing staff or physicians, especially those clients who are their own guardian, and may not have the staff assistance needed to make that decision in an emergency situation.
2. If there are concerns about a patient's understanding of medical issues, consider petitioning for the appointment of a limited guardian or supported decision maker (new law effective February 2022), with the understanding that: "The court shall not appoint as guardian an agency or employee of an agency that is directly providing residential services to the ward." (755 ILCS 5/11a-5).
3. Given the definition of healthcare provider in the Power of Attorney Act (755 ILCS 45/4-4), the HRA questions if a CILA provider or staff person in a CILA is prohibited from serving as a POA agent just as residential providers are prohibited from serving as guardians under the Illinois Probate Act and service providers are prohibited from serving as Supporters in the Supported Decision-Making Act. At the very least, the HRA sees the potential for a conflict of interest for a CILA provider/staff being a POA agent. In the future, if there is a need for a POA Agent, the CILA should consult with its attorney before serving as a POA agent. With this being said, the hospital did not point to an issue with the POA being that a CILA is a healthcare provider, but rather made the decision that the POA was not valid due to capacity, which is not the hospital's role to determine the legitimacy of the POA
4. When there are visitation restrictions at hospitals, request a virtual visit, and if not granted reach out to the hospital attorney, complaint mechanism or patient advocate and request immediate resolution.
5. If there is a question of capacity in the future, and there is a need for proof to legitimize, consider the use of collateral documentation such as evaluations, etc., that Chamness has in its possession. It is also suggested that CILA administration contact the hospital risk manager for consultation and also inquire about an ethics committee review.