SB1497

LRB10326129CPF52485b

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

SB1497

Introduced 2/7/2023, by Sen. Karina Villa

SYNOPSIS AS INTRODUCED:

210 ILCS 45/1-112	from Ch. 111 1/2, par. 4151-112
210 ILCS 45/2-106	from Ch. 111 1/2, par. 4152-106
210 ILCS 45/2-106.1	
210 ILCS 45/3-615 new	

Amends the Nursing Home Care Act. Provides that "emergency" means a situation, physical condition, or one or more practices, methods, or operations that present imminent danger of death or serious physical or mental harm to residents of a facility and that are clinically documented in the resident's medical record (rather than only a situation, physical condition or one or more practices, methods or operations that present imminent danger of death or serious physical or mental harm to residents of a facility). Requires the need for positioning devices to be demonstrated and documented in the resident's care plan. Requires that assessment to be revisited in every comprehensive assessment of the resident. Provides that psychotropic medication shall be administered to a resident only if clinical documentation in the resident's medical record supports the benefit of the psychotropic medication over contraindications related to other prescribed medications and supports the diagnosis of the resident. Provides that, notwithstanding any other provision of law, if a resident is in a state of emergency, the emergency shall be clinically documented in the resident's medical record.

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A BILL FOR

AN ACT concerning regulation.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Nursing Home Care Act is amended by changing Sections 1-112, 2-106, 2-106.1, and 3-615 as follows:

(210 ILCS 45/1-112) (from Ch. 111 1/2, par. 4151-112)

Sec. 1-112. "Emergency" means a situation, physical condition, or one or more practices, methods, or operations which present imminent danger of death or serious physical or mental harm to residents of a facility and are clinically documented in the resident's medical record.

(Source: P.A. 81-223.)

(210 ILCS 45/2-106) (from Ch. 111 1/2, par. 4152-106)

Sec. 2-106. (a) For purposes of this Act, (i) a physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to a resident's body that the resident cannot remove easily and restricts freedom of movement or normal access to one's body. Devices used for positioning, including but not limited to bed rails, gait belts, and cushions, shall not be considered to be restraints for purposes of this Section; (ii) a chemical restraint is any drug used for discipline or convenience and

not required to treat medical symptoms. The need for devices used for positioning must be demonstrated by the resident and documented in the resident's care plan. The demonstrated need must be revisited in every comprehensive assessment of the resident. The Department shall by rule, designate certain devices as restraints, including at least all those devices which have been determined to be restraints by the United States Department of Health and Human Services in interpretive guidelines issued for the purposes of administering Titles XVIII and XIX of the Social Security Act.

(b) Neither restraints nor confinements shall be employed for the purpose of punishment or for the convenience of any facility personnel. No restraints or confinements shall be employed except as ordered by a physician who documents the need for such restraints or confinements in the resident's clinical record.

(c) A restraint may be used only with the informed consent of the resident, the resident's guardian, or other authorized representative. A restraint may be used only for specific periods, if it is the least restrictive means necessary to attain and maintain the resident's highest practicable physical, mental or psychosocial well-being, including brief periods of time to provide necessary life-saving treatment. A restraint may be used only after consultation with appropriate health professionals, such as occupational or physical therapists, and a trial of less restrictive measures has led

to the determination that the use of less restrictive measures would not attain or maintain the resident's highest practicable physical, mental or psychosocial well-being. However, if the resident needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed unless the facility has notice that the resident has previously made a valid refusal of the treatment in question.

(d) A restraint may be applied only by a person trained in the application of the particular type of restraint.

(e) Whenever a period of use of a restraint is initiated, the resident shall be advised of his or her right to have a person or organization of his or her choosing, including the Guardianship and Advocacy Commission, notified of the use of the restraint. A recipient who is under guardianship may request that a person or organization of his or her choosing be notified of the restraint, whether or not the guardian approves the notice. If the resident so chooses, the facility shall make the notification within 24 hours, including any information about the period of time that the restraint is to be used. Whenever the Guardianship and Advocacy Commission is notified that a resident has been restrained, it shall contact the resident to determine the circumstances of the restraint and whether further action is warranted.

(f) Whenever a restraint is used on a resident whose primary mode of communication is sign language, the resident shall be permitted to have his or her hands free from restraint

for brief periods each hour, except when this freedom may result in physical harm to the resident or others.

(g) The requirements of this Section are intended to control in any conflict with the requirements of Sections 1-126 and 2-108 of the Mental Health and Developmental Disabilities Code.

(Source: P.A. 97-135, eff. 7-14-11.)

(210 ILCS 45/2-106.1)

Sec. 2-106.1. Drug treatment.

(a) A resident shall not be given unnecessary drugs. An unnecessary drug is any drug used in an excessive dose, including in duplicative therapy; for excessive duration; without adequate monitoring; without adequate indications for its use; or in the presence of adverse consequences that indicate the drugs should be reduced or discontinued. The Department shall adopt, by rule, the standards for unnecessary drugs contained in interpretive guidelines issued by the United States Department of Health and Human Services for the purposes of administering Titles XVIII and XIX of the Social Security Act.

(b) Except in the case of an emergency, psychotropic medication shall not be administered without the informed consent of the resident or the resident's surrogate decision maker. <u>If there is an emergency and the resident or resident's surrogate's informed consent has been obtained, the</u>

psychotropic medication shall be administered only if clinical documentation in the resident's medical record supports the benefit of the psychotropic medication over contraindications related to other prescribed medications and supports the diagnosis of the resident. "Psychotropic medication" means medication that is used for or listed as used for psychotropic, antidepressant, antimanic, or antianxiety behavior modification or behavior management purposes in the latest editions of the AMA Drug Evaluations or the Physician's Desk Reference. "Emergency" has the same meaning as in Section 1-112 of the Nursing Home Care Act. A facility shall (i) document the alleged emergency in detail, including the facts surrounding the medication's need, and (ii) present this documentation to the resident and the resident's representative. The Department shall adopt, by rule, a protocol specifying how informed consent for psychotropic medication may be obtained or refused. The protocol shall require, at a minimum, a discussion between (i) the resident or the resident's surrogate decision maker and (ii) the resident's physician, a registered pharmacist, or a licensed nurse about the possible risks and benefits of a recommended medication and the use of standardized consent forms designated by the Department. The protocol shall include informing the resident, surrogate decision maker, or both of the existence of a copy of: the resident's care plan; the facility policies and procedures adopted in compliance with

subsection (b-15) of this Section; and a notification that the most recent of the resident's care plans and the facility's policies are available to the resident or surrogate decision maker upon request. Each form designated or developed by the Department (i) shall be written in plain language, (ii) shall be able to be downloaded from the Department's official website or another website designated by the Department, (iii) shall include information specific to the psychotropic medication for which consent is being sought, and (iv) shall be used for every resident for whom psychotropic drugs are prescribed. The Department shall utilize the rules, protocols, and forms developed and implemented under the Specialized Mental Health Rehabilitation Act of 2013 in effect on the effective date of this amendatory Act of the 101st General Assembly, except to the extent that this Act requires a different procedure, and except that the maximum possible period for informed consent shall be until: (1) a change in the prescription occurs, either as to type of psychotropic medication or an increase or decrease in dosage, dosage range, or titration schedule of the prescribed medication that was not included in the original informed consent; or (2) a resident's care plan changes. The Department may further amend the rules after January 1, 2021 pursuant to existing rulemaking authority. In addition to creating those forms, the Department shall approve the use of any other informed consent forms that meet criteria developed by the Department. At the

discretion of the Department, informed consent forms may include side effects that the Department reasonably believes are more common, with a direction that more complete information can be found via a link on the Department's website to third-party websites with more complete information, such as the United States Food and Drug Administration's website. The Department or a facility shall incur no liability for information provided on a consent form so long as the consent form is substantially accurate based upon generally accepted medical principles and if the form includes the website links.

Informed consent shall be sought from the resident. For the purposes of this Section, "surrogate decision maker" means an individual representing the resident's interests as permitted by this Section. Informed consent shall be sought by the resident's guardian of the person if one has been named by a court of competent jurisdiction. In the absence of a court-ordered guardian, informed consent shall be sought from a health care agent under the Illinois Power of Attorney Act who has authority to give consent. If neither a court-ordered guardian of the person nor a health care agent under the Illinois Power of Attorney Act is available and the attending physician determines that the resident lacks capacity to make decisions, informed consent shall be sought from the resident's attorney-in-fact designated under the Mental Health Treatment Preference Declaration Act, if applicable, or the

resident's representative.

In addition to any other penalty prescribed by law, a facility that is found to have violated this subsection, or the federal certification requirement that informed consent be obtained before administering a psychotropic medication, shall thereafter be required to obtain the signatures of 2 licensed health care professionals on every form purporting to give informed consent for the administration of a psychotropic medication, certifying the personal knowledge of each health care professional that the consent was obtained in compliance with the requirements of this subsection.

(b-5) A facility must obtain voluntary informed consent, in writing, from a resident or the resident's surrogate decision maker before administering or dispensing a psychotropic medication to that resident. When informed consent is not required for a change in dosage, the facility shall note in the resident's file that the resident was informed of the dosage change prior to the administration of the medication or that verbal, written, or electronic notice has been communicated to the resident's surrogate decision maker that a change in dosage has occurred.

(b-10) No facility shall deny continued residency to a person on the basis of the person's or resident's, or the person's or resident's surrogate decision maker's, refusal of the administration of psychotropic medication, unless the facility can demonstrate that the resident's refusal would

place the health and safety of the resident, the facility staff, other residents, or visitors at risk.

A facility that alleges that the resident's refusal to consent to the administration of psychotropic medication will place the health and safety of the resident, the facility staff, other residents, or visitors at risk must: (1) document the alleged risk in detail; (2) present this documentation to the resident or the resident's surrogate decision maker, to the Department, and to the Office of the State Long Term Care Ombudsman; and (3) inform the resident or his or her surrogate decision maker of his or her right to appeal to the Department. The documentation of the alleged risk shall include a description of all nonpharmacological or alternative care options attempted and why they were unsuccessful.

(b-15) Within 100 days after the effective date of any rules adopted by the Department under subsection (b) of this Section, all facilities shall implement written policies and procedures for compliance with this Section. When the Department conducts its annual survey of a facility, the surveyor may review these written policies and procedures and either:

(1) give written notice to the facility that the policies or procedures are sufficient to demonstrate the facility's intent to comply with this Section; or

(2) provide written notice to the facility that the proposed policies and procedures are deficient, identify

the areas that are deficient, and provide 30 days for the facility to submit amended policies and procedures that demonstrate its intent to comply with this Section.

A facility's failure to submit the documentation required under this subsection is sufficient to demonstrate its intent to not comply with this Section and shall be grounds for review by the Department.

All facilities must provide training and education on the requirements of this Section to all personnel involved in providing care to residents and train and educate such personnel on the methods and procedures to effectively implement the facility's policies. Training and education provided under this Section must be documented in each personnel file.

(b-20) Upon the receipt of a report of any violation of this Section, the Department shall investigate and, upon finding sufficient evidence of a violation of this Section, may proceed with disciplinary action against the licensee of the facility. In any administrative disciplinary action under this subsection, the Department shall have the discretion to determine the gravity of the violation and, taking into account mitigating and aggravating circumstances and facts, may adjust the disciplinary action accordingly.

(b-25) A violation of informed consent that, for an individual resident, lasts for 7 days or more under this Section is, at a minimum, a Type "B" violation. A second

violation of informed consent within a year from a previous violation in the same facility regardless of the duration of the second violation is, at a minimum, a Type "B" violation.

(b-30) Any violation of this Section by a facility may be enforced by an action brought by the Department in the name of the People of Illinois for injunctive relief, civil penalties, or both injunctive relief and civil penalties. The Department may initiate the action upon its own complaint or the complaint of any other interested party.

(b-35) Any resident who has been administered a psychotropic medication in violation of this Section may bring an action for injunctive relief, civil damages, and costs and attorney's fees against any facility responsible for the violation.

(b-40) An action under this Section must be filed within 2 years of either the date of discovery of the violation that gave rise to the claim or the last date of an instance of a noncompliant administration of psychotropic medication to the resident, whichever is later.

(b-45) A facility subject to action under this Section shall be liable for damages of up to $500 for each day after discovery of a violation that the facility violates the requirements of this Section.

(b-55) The rights provided for in this Section are cumulative to existing resident rights. No part of this Section shall be interpreted as abridging, abrogating, or

otherwise diminishing existing resident rights or causes of action at law or equity.

(c) The requirements of this Section are intended to control in a conflict with the requirements of Sections 2-102 and 2-107.2 of the Mental Health and Developmental Disabilities Code with respect to the administration of psychotropic medication.

(d) In this Section only, "licensed nurse" means an advanced practice registered nurse, a registered nurse, or a licensed practical nurse.

(Source: P.A. 101-10, eff. 6-5-19; 102-646, eff. 8-27-21.)

(210 ILCS 45/3-615 new)

Sec. 3-615. Resident emergency; documentation in medical record. Notwithstanding any other provision of law, if a resident is in a state of emergency, the emergency shall be clinically documented in the resident's medical record.