

Anti-Psychotic Medications in Psychiatric Residential Treatment Facilities: A Case Study

Overuse, Medical Neglect, and Lack of Oversight by Outside Agencies

NOVEMBER 2022



Disability
Rights
Arkansas

INTRODUCTION

Sam is a thirteen-year-old boy. In August of 2021, Sam had been residing in an Arkansas Psychiatric Residential Treatment Facility (PRTF)¹ for seven months. He had been in foster care for five years, residing primarily in congregate settings (PRTF, QRTP,² or Acute hospitals³) for at least three years.

While at the PRTF, he was simultaneously prescribed six different prescription medications, including Haloperidol (Haldol) and Depakote, despite not having any active indication for antipsychotics⁴ or diagnosis of a thought disorder.⁵ Sam is diagnosed with ADHD, DMDD, and ODD.⁶ Beginning in February of 2021 he was prescribed:

- Depakote DR 500mg (1x every morning), 500mg (2x at bedtime)
- Guanfacine (Intuniv ER/Tenex) 4mg (1x every morning)
- Venlafaxine (Effexor XR) 37.5mg (1x every morning)
- Benztropine (Cogentin) 1mg (2x day)
- Haloperidol (Haldol) 10mg (2x day) – (Max dose)
- Hydroxyzine (Vistaril) 100mg (3x day)

"Given the list of his current medications and his reported presentation it is likely that high doses of first-generation antipsychotics are contributing to muscle breakdown resulting in elevated CK.

Considering he does not have a diagnosis of a thought disorder there is no indication for a first-generation antipsychotic in this patient and he would recommend tapering Haldol as this is the medication most likely contributing to the current presentation"

HOSPITAL PSYCHIATRY CONSULT

On 08/26/21, his Division of Children and Family Services (DCFS) caseworker and Court Appointed Special Advocate (C.A.S.A.) visited him at the facility. Due to COVID restrictions, this was the first in-person visit since he had been at this facility. According to them, as soon as they saw Sam walking toward them, they knew something was wrong. Sam could barely walk; he was “wobbly,” and his arms moved a lot. He was “walking like a puppet.” He complained of muscle pain, and his legs hurt. When asked about Sam’s condition, a staff member said that maybe he had slept on his leg.

Not satisfied with that explanation, they insisted that Sam be taken to the Emergency Room. Sam was admitted to the emergency room through the hospital and remained there for two days. He was diagnosed with Rhabdomyolysis, a condition where injured muscles release harmful substances into the bloodstream.

These include potassium, phosphate, creatinine kinase (CK), and myoglobin. Large amounts of these substances may damage kidneys and other organs. The hospital records indicate his muscle breakdown was most likely attributable to the high doses of first-generation antipsychotics he was being given and recommended that his medication be adjusted.⁷

**THE PATIENT IS NOT
BEING TREATED
ACCORDING TO
PSYCHIATRIC
STANDARD OF CARE.
MEDICATIONS AND
DOSES ARE NOT
APPROPRIATE.**

HOSPITAL PSYCHIATRY
CONSULT



The note below is from the facility nurse the day he was taken to the ER:

- 8/26/2021 – “Client continues to have weakness and complain about muscle pain, lab results obtained, drawn on 8/25, were in normal range. APRN advised nurse to notify MD. An order was obtained to taper/dc Depakote. This nurse notified guardian of the test results and tapering of meds. Guardian voiced concerns about getting him further treatment at the hospital. Nurse informed DR of the guardian concerns and order was received to send client to ACH ER for treatment.”

It is unclear if the lab results were, in fact, “in normal range,” as copies of the actual lab results were not provided in Sam’s medical file. Because of this, the record is unclear whether the labs were actually abnormal and a charting error by the nurse or whether the change was a response to Sam’s complaint of muscle pain. In addition, the note does not mention that the guardian was onsite, initiated concerns, and insisted on a transfer to the ER.



Chronology of Deterioration

Upon entry to the Facility in January 2021, Sam was prescribed and continued to take the following:

- Depakote DR 500mg (1x every morning)
- Guanfacine (Intuniv ER/Tenex) 4mg (1x every morning)
- Venlafaxine (Effexor XR) 37.5mg (1x every morning) – ordered 01/05/21
- Benztropine (Cogentin) 1mg (2x day)
- Haloperidol (Haldol) 10mg (2x day) – (Max dose)
- Hydroxyzine (Vistaril) 25mg (3x day)
- Depakote 500mg (2x at bedtime)

Records from the facility indicate he began complaining of drowsiness and sleeping during the day in February 2021. **On 2/9/21, Vistaril was increased from 75mg/day to 300mg/day.** His complaints and drowsiness progressed each month. During this period (February to August of 2021), he also appeared to have stopped eating sufficiently and lost 23 pounds in 5 months (163lb to 140lb).

Sometime in March, the medical director put in an order for Sam to have scheduled naps. Mental Health Professional note on 3/23/21: **"[t]he medical Director put in an order for [Sam] to have a regular Nap time before lunch."** Nursing notes continued to indicate that he complained of tiredness and that his medication was causing the sleepiness.

In April, he continued to skip meals, complained of back pain, and stated he **"wanted to kill himself because he was tired"**. He slept in class and refused to get out of bed.

In May, Sam continued to refuse to get out of bed, sleep during class, and complain of being tired.



In June, he continued to skip meals, slept most of the time, refused school, and would sleep in class. On 6/15/21, Cogentin was increased from 2mg/day to 3mg/day.

In July, he continued to skip meals, slept most of the time, and complained of arm pain and not feeling well.

In August, the facility finally took notice of his weight loss. On August 1st, the Nursing Progress Note (NPN) stated, **“wants to stay in room and sleep, did not eat, weight taken 140lbs.”**

His admission weight was 163. The first mention of him drinking Ensure is found in a nursing note on 8/1/21. On August 9th, an order was received to start Periactin 4MG TID for appetite stimulant and check his Depakote level because of Sam's feet swelling and complaining of pain. On August 12th, he was moved to a room at the front of the hall so he would not have to walk so far. August 20th, nursing notes state that labs came back as normal. On August 26th, the client was taken to the ER at the request of his DCFS caseworker.

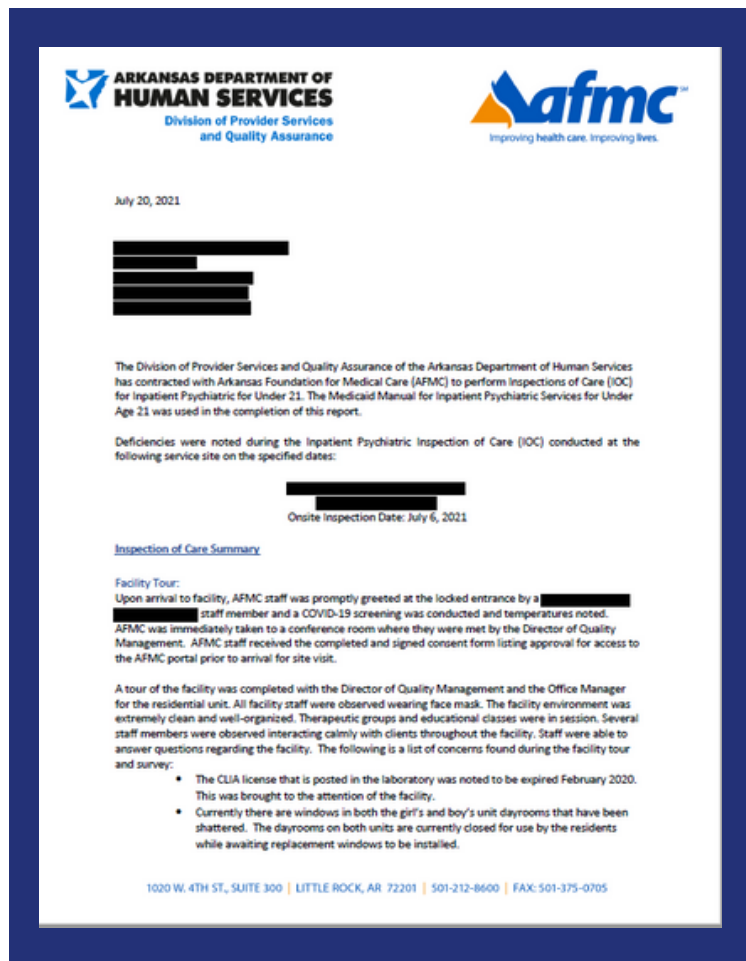
After the client's return to the PRTF on 08/28/21, the facility discontinued his Depakote and decreased the Vistaril from 300mg/day to 150mg/day. On 8/30/21, Haldol was tapered down to 10mg/day for four days, 5mg/day for eight days, and then discontinued on 9/11/21. On 9/20/21, the PRTF discharged Sam and placed him with a relative out of state.

In monitoring these types of facilities, we consistently see residents prescribed multiple high-dose antipsychotics.

Concerns Regarding the Care and Treatment Received:

- Prior to his admission to the ER in August, his medications were never decreased or discontinued, despite months of complaints and physical deterioration.
- Within two weeks of discharge from the hospital, the facility discontinued the Depakote and Haldol and reduced the Vistaril dosage by half. No alternative medication or behavior management appears to have been substituted. Nine days after the medication changes were completed the resident was discharged to a relative placement. This timeline raises doubt about the necessity or appropriateness of the prescriptions.
- At the time of Sam's stay, this facility was not recording all chemical restraints (or physical restraints and seclusions) in a log or always documenting them in the client's record.⁸ Therefore, we have been able to determine that Sam received chemical restraints, but are unable to determine how often they were used in addition to the medication he was regularly receiving.
- He lost 23 pounds before a supplement or appetite stimulant was ordered.
- PRTF staff mischaracterized Sam's condition to Sam's DCFS caseworker, C.A.S.A., and hospital staff, stating that Sam's condition had manifested in a week or less.

- The staff member accompanying Sam at the hospital referenced bathing him.⁹ Residents in PRTFs do not generally require assistance with bathing. It is not noted in his records from the PRTF that Sam had decompensated to the point that he required this level of assistance with daily living tasks.
- During his seven months at this facility, he "refused" or was not available for rounds at least 12 times, according to the Physician's Progress Notes. He was not seen by the doctor on those dates.
- In the month preceding his admission to the hospital, he "refused rounds" and was not seen by the doctor four times.
- The facility records indicate that some medication changes were made on dates that the resident was "not available for rounds."
- No one outside the facility reviewed his medical records or interviewed or assessed him in person.



Medicaid Inspection of Cares (IOCs) are supposed to be performed at least once a year for every inpatient psychiatric provider. IOCs must include “personal contact and observation of each Medicaid recipient” and a “review of each beneficiary’s medical record.”¹⁰

These inspections are different than the inspections performed by the Arkansas Department of Human Services Office of Long-Term Care (OLTC) and Division of Child Care and Early Childhood Education (DCCECE). OLTC and DCCECE do not evaluate the quality of the medical treatment supplied to the youth.

AFMC, the state-contracted agency that conducts the IOCs, completed an on-site inspection in July, the month preceding Sam’s admission to the hospital. They **did not review** Sam’s medical record during their inspection. They **did not interview** Sam. They **did not review** his medications. **They did not do any of those things because although Sam is a Medicaid beneficiary, he receives Medicaid through a PASSE.**¹¹

IOCs are currently conducted at all of the PRTFs however, the state has limited the scope to only looking at Medicaid Fee for Service clients and not clients enrolled in a PASSE. Due to the structure of the PASSE system and the mandatory enrollment of certain individuals in a PASSE, it is highly unlikely that a Medicaid Fee for Service beneficiary will ever be in a PRTF. Since 2021 all Arkansas Medicaid beneficiaries in PRTFs have been enrolled in a PASSE.

IOCs consistent with federal requirements are one of the only ways facilities are inspected for medical abuse and neglect. Quality of care reviews provide at least a thin layer of protection for the children and accountability for providers. That layer appears to no longer exist under the PASSE system. There is no explicit reference to IOCs in the state’s contract with the PASSEs, and we could find no evidence suggesting the PASSEs conduct IOCs at the PRTFs.

Appendix

Sam's deterioration and the attentiveness of the attending physician shown through the PRTF's Nursing Progress Notes (NPN) and Physician Progress Notes (PPN).

February 2021

02.01.21 - Pt not available for rounds (refuses). (PPN)

- "RN notes severe agg with elopement attempts prop dest yest today with im's yest today and secl this am for cont'd severe aggress. Police called last pm.
- Checked "continue" meds, however medication is listed as "Hydroxyzine 50tid agg 2.1.21," other meds are listed same as previous report.

02.05.21 - Client was in class sleeping. MHP notes that he was flat in affect...He expresses being tired, "I am just tired, it's the meds." (PNP)

02.06.21 - "Client has been disruptive and antagonizing peers. Uses poor impulse control. Has been cursing, hitting, and threatening to spit of (sic) staff. Med changes noted." (NPN) Does not indicate what changes were made.

02.08.21 - Medication changes noted Vistaril from 75mg a day to 300mg a day

02.08.21 - "Pt refuses rounds so disregard pn template below." (PPN)

- Medication changes noted: Hydroxyzine 100tid inc 2.8.21
- "PT ON UR AND REQUIRED 2 HOLDS AND 2 IM'S AND SECL FOR SEVERE AGG HITTING PEERS AND STAFF DESTROYING PROPERTY IN THE CLASSROOM SCRATCHING AT THROAT AND WRISTS—meds adjusted today as above." (Physician Report in PPN)

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02.20.21 - Client refused to wake up for lunch. He slept through lunch. (PPN)

02.20.21 - [Client] has been on and off tasks. Struggles with following directions. (NPN) [Client] was hit by peer in the face. His left cheek is reddened. (Nursing Note)

02.21.21 - Client was slow to wake up and "spent lots of time sleep." (02/26/21 PPN)

02.22.21 - Client slept part of class. (02/26/21 PPN)

March 2021

03.05.21 - Staff note states client was sleeping in class before his session w/ MHP. Client reported to the MHP that his medication is making him tired. (PPN)

03.06.21 - [Client] has been on and off task. Has difficulty following instructions and trying to fight peers. Difficulty waking up in the morning. (Nursing Note)

03.10.21 - Client slept the first part of class and went to take his nap at 10 am (PPN)

03.13.21 - Client was slow to follow instructions and spent most of the day asleep. He has a hard time waking up for lunch and refused to eat lunch. He yelled at staff for trying to wake him up. (PPN)

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03.14.21 - Staff note: "[Client] said that he was sleepy in the session and he kept falling asleep. [Sam] reports that he is sleepy most of the day until about lunch time. He reports sleep disturbance at night, but says he just lays in bed until he falls asleep again."

03.18.21 - Client went to sleep in group and did not wake up until the staff member was able to wake him at the end of group. (Therapist Progress Note)
PPN)

03.23.21 - **The medical Director put in an order for Sam to have a regular Nap time before lunch. (MHP note in 03/23/21 PPN)**

03.25.21 - Client was observed sleeping on unit. MHP did not wake client. (staff note in 03/28/21 PPN)

03.31.21 - Client slept in class, did not complete work (PPN)

April 2021

04.01.21 - Client became **aggravated because he could not sleep in class. He started banging his head and said that he wanted to kill himself because he was tired, he was taken to his room to sleep.** (PPN)

04.02.21 - Client became aggravated because he could not sleep in class, staff took him to his room to sleep. (PPN)

04.03.21 - Client slept most of the day and refused to go to lunch. (PPN)

04.06.21 - VPA 111 (PPN)

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04.10.21 - Client struggles some mornings and refuses to get up. (Report to Court in PPN)

04.10.21 - Client would not get up on 1st shift, finally got up and completed hygiene. 2nd shift he was asleep on their arrival, got up ate and went back to bed. (PPN)

04.18.21 - Client slept through lunch time because of meds. (PPN)

4.19.21 - Client struggled to stay on task and complained all day about back problems. (PPN)

04.20.21 - Client complained about back pain. (PPN)

04.21.21 - Observed sleeping in class on 2nd shift. (PPN)

04.22.21 - Client slept most of the shift and complained about back pain throughout the shift. (2nd shift) (PPN)

04.23.21 - Client was given pain relief meds and allowed to lay down for a nap on 2nd shift (PPN)

04.26.21 - Client complained of pain, went to room for a couple of hours. (1st shift). Client slept through class. (2nd shift) (PPN)

04.26.21 - "Pt was not available for rounds, so case was staffed with RN." (PPN)

04.27.21 - Client was mainly asleep during the shift. (1st Shift) (PPN)

04.28.21 - Client woke up late. (PPN)

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04.30.21 - Refused to get out of bed this morning. (PPN)

May 2021

05.03.21 - Client stayed in bed most of 1st shift and ate little breakfast and lunch. (PPN)

05.04.21 - Client was in the classroom when a peer attacked him, hitting and kicking him in the face. Staff intervened and clients were separated. Client has swelling and bruising to bilateral eyebrows, swelling to bilateral cheeks, and swelling and bruising to right wrist. Orders were obtained to send client to the ER and complete neuro checks Q30min until transferred. Client returned to the facility at 1743. At 1441 right pupil was sluggish, left pupil was nonreactive. Client was A&O and grips were even. At 1501 Clients right pupil was still sluggish, left pupil was still nonreactive. Client was A&O and grips were even. MEMS arrived and client left the unit at 1520. (NPN)

05.05.21 - Client woke up late and was in bed most of 1st shift. (PPN)

05.06.21 - Client was in bed all day (1st shift). Client was sleeping upon arrival of 2nd shift. (PPN)

05.07.21 - Client refused to stay in class and stated he was tired. He was in bed all day (1st shift). Client was in bed already upon arrival. (2nd shift) (PPN)

05.10.21 - Client did not want to get out of bed and was sleeping when 2nd shift arrived. (PPN)

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05.11.21 - Client had a difficult time waking up on 1st. (PPN)

05.14.21 - Client went to class and was non complaint and then went to bed for his nap. (1st shift) (PPN)

05.15.21 - Client slept on and off during 1st shift. (PPN)

05.17.21 - Client slept most of 2nd shift. (PPN)

05.18.21 - Client was slow to instructions at the start of the shift. He asked to take his ordered nap at 8:30am (1st shift) (PPN)

05.19.21 - Client was in bed most of 1st shift (PPN)

05.23.21 - Client stayed in bed most of the day, refusing to complete hygiene. (1st shift) (PPN)

05.24.21 - Client had trouble getting up, took his meds and continued to sleep until lunch (1st shift) (PPN)

05.25.21 - Client went to unit after altercation with peer and was in his room the entire day. (1st shift) (PPN)

05.31.21 - Client seen by MD with RN. His **goal for the week was "do what staff says and not get any chemicals."** (PPN)

June 2021

06.02.21 - Client stayed in bed until noon and skipped breakfast. (PPN)

06.05.21 - Client was delayed to wake up, refused lunch, and slept most of the day. (1st shift) (PPN)

Appendix

06.07.21 - Client slept most of the morning and refused breakfast. (PPN)

06.09.21 - Client slept most of the day (2nd shift) (PPN)

06.11.21 - Transition notes in Court Report to DHS states client is "often slow to follow instructions, has a difficult time waking up, often refuses to perform hygiene task, and requires redirection often." Court Report also states "the team believes that [Client] is not appropriate for our program due to his level of functioning. (PPN)

06.12.21 - Client slept on and off during shift. (1st) (PPN)

06.14.21 - "Client had a bad day, he was fighting staff and try (sic) to fight other peers. Client is now sleep (sic) and quiet." (1st shift Unit RN Report in PPN)

06.18.21 - Client refused rounds, case was staffed with RN. (PPN)

06.19.21 - Client was in the Foyer Area laying down upon arrival of 2nd shift. (PPN)

06.20.21 - Client refused to get up to complete his hygiene. Client's appetite seems to be down. He eats very little food. (1st shift) (PPN)

06.21.21 - No documentation in Unit RN Report for 1st shift. Peer knocked client's tray out of his hands, client was taken to foyer to calm down and given Wendy's. (PPN)

Appendix

06.21.21 - Client refused rounds, case was staffed with RN. (PPN)

06.23.21 - Client ate very little breakfast and lunch. (PPN)

06.24.21 - Client mainly slept on 1st shift. (PPN)

06.25.21 - Client was seen with RN. Medications indicated to continue. (PPN)

06.26.21 - Med change noted. Does not indicate changes made. (Nursing Note and staff note on 06/28/21 PPN).

06.26.21 - Client slept on and off during 1st shift. (PPN)

06.30.21 - Client ate very little breakfast and some lunch. (PPN)

July 2021

07.02.21 - Client was not available for rounds, case staffed with RN. (PPN)

07.04.21 - "Client has not been eating his food. When he does eat it is very little portions." (RN Report)

07.05.21 - Client refused breakfast and dinner. (RN Report)

07.05.21 - Client not available for rounds, case staffed with RN. (PPN)

Appendix

07.10.21 - "[Client] seemed to be sleep all throughout the day. CT stayed in one spot." (RN Report 1st Shift) Client was resting in his room when 2nd shift arrived. (RN Report 2nd Shift)

07.11.21 - Client was resting in his room when 2nd shift arrived. (RN Report)

07.12.21 - Client got breakfast and lunch but did not eat. (RN Report 1st shift)

07.12.21 - Client was punched by peer several times after verbal altercation escalated. Client had several red marks on face.

07.12.21 - Pt refused rounds and was not seen. (PPN)

07.13.21 - Client got breakfast and lunch tray but did not eat anything. Client said he was not feeling well. (RN Report 1st shift).

07.15.21 - Client did not complete hygiene, eat breakfast, or take meds. He refused to get out of bed and complained about not feeling good. He woke at 11:30am. (RN Report 1st shift)

07.16.21 - Client complained of hand pain, stated he did not know what happened. No swelling or redness. Given Ibuprofen. (NPN)

07.16.21 - Client seen by MD with RN. (PPN)

07.17.21 - Client stayed in the bed most of the day and night. (RN Report 1st & 2nd shift)

Appendix

07.18.21 - Client refused breakfast and only ate about 25% of lunch. "Client stated that his arm was hurting but there was no bruise or anything when looked at." Client stayed in his room the majority of the shift. (RN Report 1st Shift)

07.19.21 - Client seen by MD with RN. (PPN)

07.20.21 - Client has not been feeling well and stayed in bed. (RN Report 1st shift) Client has been on sick rule. (RN Report 2nd shift)

07.22.21 - Client refused lunch. He slept from 9:45am – 11:30am and then 12:00pm – the end of 1st shift. (RN Report 1st Shift).

07.23.21 - Client ate very little breakfast and lunch. (RN Report 1st Shift). Client stated he didn't feel good and asked to go to bed early. (RN Report 2nd Shift).

07.23.21 - Client seen by MD with RN. During therapy this week client "was very tired...reported he was beat up." (PPN)

07.24.21 - Client threw food in trash and only drank juice. (RN Report 1st Shift)

07.25.21 - Client did not eat anything off his breakfast plate. He only drank the juice. Client did not eat his lunch (RN Report 1st Shift). Client was in bed upon arrival of 2nd Shift. He eventually got up to take meds and asked for dinner around 8 PM. "He did not eat almost any of his food but went back to sleep instead." (RN Report 2nd Shift) (PPN)

Appendix

07.26.21 - Client did not eat breakfast and was in a very bad mood this morning. Client stated he's not feeling well and the nurse is not treating him for feeling ill. (1st shift). Client stated that he did feel good all day. "Client ate 100% but o supper. Still is not feeling good." (2nd Shift) (PPN)

- Client complained of not feeling well this morning during AM med pass and wanted to just go back to bed. Client did not have a fever or any vomiting, this nurse informed client that he needed to eat something and see if that would help him feel better, client was upset because he just wanted to go back to his bed. Will continue to monitor. (NPN)

07.26.21 - Client refused rounds and was not seen. (PPN)

07.27.21 - "Client is currently in his bedroom, he has been complaining about not feeling good." (1st Shift). Client was in his room sleeping upon arrival of 2nd Shift. (PPN)

07.28.21 - Client refused Breakfast. (PPN)

07.30.21 - Client refused rounds and was not seen. Case staffed with RN.

07.31.21 - Client refused to get out of bed, complained of not feeling well, and said his stomach was hurting. He refused lunch and dinner. (PPN)

Appendix

August 2021

08.01.21 - [Sam] has been calm, compliant, and on task for the most time. Non-compliant with completing hygiene. Noted wants to stay in room and sleep. With poor oral consumption. Wants to eat and request junk food. Admit weight 163, did weigh - 140lbs. Will notify appropriate APN. (NPN)

08.01.21 - Client was slow to wake up for breakfast and staff had to go to his room and assist him. He spent most of the day asleep and ate very little food at lunch. Nurse did provide Ensure that he drank.

08.02.21 - Client did not eat breakfast but did drink an Ensure. He was in bed most of the day. He was not feeling well. (1st Shift). Client did not eat dinner, did not do showers, expressed he was not feeling good, and slept all day. (2nd Shift) (PPN)

08.02.21 - Client was seen with RN. (PPN)

08.03.21 - **During the fire and severe weather drill client remained in bed.** (3rd Shift). Client did not eat breakfast but drank Ensure. Client ate half of lunch. (1st Shift). Client mostly slept all evening. (2nd Shift). (PPN)

08.04.21 - Client did not eat breakfast but drank Ensure. (1st Shift). Client slept most of the day. (2nd Shift). (PPN)

Appendix

08.04.21 - **"It appears that [Client] complained of not feeling well the majority of the review period. He was noted to refuse meals and sleep most of the day.** He was non-compliant with completing morning hygiene. Toward the end of the review period, [Client] had been willing to drink Ensure shakes." "In group therapy if he attends he sleeps." (Court Report for DHS included in 08/06/21 PPN)

08.05.21 - Client did not eat breakfast. He did not get ensure for breakfast. Complained about not feeling good. **Slept wherever he could.** No shower. (1st Shift). Client slept throughout the evening and complained of not feeling well. Client complained of body aches. (2nd Shift) Did not eat, complained not feeling well. (PPN)

08.06.21 - Client was seen with RN. "Goal this week: fi" (PPN)

08.07.21 - Client advised nurse he had a stomachache, went to bed shortly after. (PPN)

08.07.21 - [Sam] noted with weight loss, continues on ensure. Non-compliant with personal hygiene. Sleeps most of the time. Noted to be verbally aggressive with peer and staff, redirected. NNO. (Nursing Progress Note)

08.08.21 - During rounds with the MD, this nurse informed MD that client is still not eating very much and doesn't seem to have much of an appetite. Order was received for client to start Periactin 4mg TID for appetite stimulant, also check a Depakote level due to **client complaining of pain/swelling in feet.** (NPN)

Appendix

08.09.21 - Client was seen with RN. (PPN) No indication in PPN of changes in medication, lack of appetite, or weight loss as noted in Nurse Progress Notes from 08/08/21.

08.09.21 - Staff note "[client] refused to fill out the Outcomes measure. He chose to sleep during the session. This writer requested help from RT to roll Sam back to the dayroom..." (08/09/21 PPN)

08.10.21 - Client refused breakfast, slept most of the morning, complained about not feeling well. (1st Shift)
"Client mostly laid around all evening with complaints of not feeling well and complaints of his feet hurting" (2nd Shift) (PPN)

08.10.21 - Received Ibuprofen for ankle pain

08.11.21 - Client did not eat breakfast and slept from 10am to 12:30pm (1st Shift) Client mostly laid around this evening and complained of not feeling well. (2nd Shift) (PPN)

08.12.21 - Client mostly laid around this evening and did not participate in any structured activities. "Client was moved to room 1231 C-side due to walking too far." (PPN)

08.13.21 - "Patient refuses rounds this am, so not seen. Case staffed with rn-as above." Staff note: "[Sam] did not participate in today's session. He slept the entire time in spite of attempts to wake him up." (PPN)

08.13.21 - Client mostly laid around and complained of being tired. (2nd shift) (PPN)

Appendix

08.15.21 - Client refused breakfast, drank ensure, "cursed out staff because he couldn't lay down." (1st Shift). Client asked to go to bed and was escorted to his room. (2nd Shift) (PPN)

08.15.21 - Client was seen with RN. (PPN)

08.16.21 - Client attended class for a short period of time. (1st Shift). "Client showed poor cooperates w/ others by going to sleep in class instead of watching the movie about states." (2nd Shift)

08.17.21 - Client slept through class. "Client have been to himself" (2nd Shift) (PPN)

08.18.21 - "Client have shown poor impulse control by laying on the floor during class." (2nd Shift) (PPN)

08.19.21 - "Client had a meltdown about not going to sleep." (1st Shift). Client was on the floor in front of the teacher's desk sleeping upon arrival. (2nd Shift) (PPN)

08.20.21 - Client took his nap at 10:15am, Client did not go to class this morning. (PPN)

08.20.21 - "Client refused rounds, so case staffed with RN - as above." (PPN)

08.20.21 - 08/08/21 VPA lab 55.

08.21.21 - Client laid on the floor during class, struggled with following instructions. (NPN)

Appendix

08.21.21 - Client was in his room in bed displaying good impulse control by laying down with no issues. (2nd Shift) (PPN)

08.23.21 - "Pt sleeping (daily nap time for pt), so case staffed with RN - as above." A few spaces down it states "[Patient] was seen with RN." (PPN)

08.23.21 - Client went to lay down at 9:50am (1st shift). Client was lying in his bedroom when 2nd Shift arrived. Rejoined peers at 4:20 (2nd Shift) (PPN)

08.25.21 - Blood work done. Client had a great day. (1st Shift). Client went on pass today. Client seemed happy and calm. (2nd Shift) (PPN)

08.26.21 - Client continues to have weakness and complain about muscle pain, lab results were obtained that were drawn on 8/25/21 per APRN order and they were in normal range, this nurse notified the APRN and she stated that it might be from some of his meds to let the MD know. This nurse notified the MD and order was obtained to taper down to DC his Depakote. This nurse notified clients guardian of the test results and of what the DR was going to do and guardian voiced concerns about getting him further treatment at the children's hospital. This nurse informed DR of guardians concerns and order was received to send client to ACH ER for further evaluation and treatment. Will continue to monitor. (NPN)

08.27.21 - "[Patient] was seen with RN" (PPN) **Patient was at ACH on this date.

Appendix

08.28.21 - Returned from ACH at 5:30PM. "Nurse gave ok for him to go to his room at 6:05pm. Staff will make sure client gets up every hour for a drink of water." (2nd Shift) (PPN)

08.30.21 - [Patient] was seen with RN. (PPN). No med changes noted

08.30.21 - Upon arrival on the unit, this nurse was greeted by client who was cheerful and hugging on this nurse and stating "MOM, I missed you." This nurse was given new orders per MD to decrease Vistaril to 50mg TID and decrease Haldol to 5mg BID x4 days then to 2.5mg BID. This nurse changed the order and faxed the pharmacy and updated the MAR. Client was compliant in taking meds and took the lotion that was offered and with the assistance of the BI, applied to feet. (NPN)

08.30.21 - Client antagonizing peers all day. Verbal altercation with peer that became physical. Client had red mark on cheek and bloody lip.

09.03.21 - Patient was seen with RN. Med changes indicated in medications list but "continue" and not "change" checked for "medications." (PPN).

Endnotes

1 A Psychiatric Residential Treatment facility (PRTF) is a separate, standalone entity providing a range of comprehensive services to treat the psychiatric condition of residents under the age of 21, on an inpatient basis under the direction of a physician.

2 Qualified Residential Treatment Services (Q RTP) is a type of placement limited to youth whose needs cannot be met in a traditional foster home, therapeutic foster home, or youth who have reached their treatment goals in a more restrictive setting and are ready to be transitioned to a less restrictive level of care.

3 Acute psychiatric inpatient hospitalization is a highly structured level of care designed to meet the needs of individuals who have emotional and behavioral manifestations that put them at risk of harm to self or others, or otherwise render them unable to care for themselves.

4 "Decrease Haldol to 5mg BID and should taper off this medication eventually as well as another first-generation antipsychotics, as he has no active indication for it." Hospital Discharge Instructions.

5 "Considering he does not have a diagnosis of a thought disorder there is no indication for a first-generation antipsychotic in this patient..." [MD.] Hospital Psychiatry Consult.

6 ADHD stands for attention-deficit disorder. It is a behavior disorder that is characterized by inattention, impulsivity, and, in some cases, hyperactivity. DMDD stands for disruptive mood dysregulation disorder. It is a childhood condition of extreme irritability, anger, and frequent, intense temper outbursts. ODD stands for Oppositional defiant disorder. It is a type of behavior disorder. Children with ODD can be uncooperative, defiant, and hostile toward peers and authority figures.

Endnotes

7 "Reason for Consult - Evaluation of psychotropic medication as cause of elevated CK. Based on chart review and discussion with primary team patient has a PPHx of ADHD, ODD and DMDD. Given the list of his current medications and his reported presentation it is likely that high doses of first generation antipsychotics are contributing to muscle breakdown resulting in elevated CK." Hospital Psychiatry Consult.

8 August 13, 2021, Office of Long-Term Care Complaint survey

9 "Last Friday, his caregiver noticed him limping as he walked and that his feet were swollen and cracking when she bathed him. This Tuesday she noticed that he began to "glide" and was not picking up his feet when he walks. At this time, he began to complain of pain which he states is his "calves", but he points to his hamstrings. He states the pain is bilateral, constant and is currently a 5 out of 10. He characterizes the pain as "being shot"." ER Records

10 42 C.F.R. § 456.608

11 PASSE stands for Provider-Led Shared Savings Entity. A PASSE is a private organization, otherwise known as a "Managed Care Organization," that administers Medicaid for select populations. PASSEs are responsible for organizing and ensuring delivery of services and care for its beneficiaries. PASSEs serve Medicaid beneficiaries with complex behavioral health, developmental, or intellectual disabilities.

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