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Informed Family Member Involvement to Improve the Quality of Dementia Care in Nursing Homes

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Conflicts of interest Disclosures

	Personal Conflicts	JT		CAL		AB		CC		KP		TF		KM		JNH		KLL		JG	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Employment or Affiliation			X		X		X		X		X		X		X		X		X		X
Grants		X			X		X		X	X			X		X	X		X			X
Honoraria			X		X		X		X		X		X		X		X		X		X
Speaker's Bureau			X		X		X		X		X		X		X		X		X		X
Consulting			X		X		X		X		X		X		X		X	X			X
Stocks			X		X		X		X		X		X		X		X		X		X
Royalties			X		X		X		X		X		X		X		X		X		X
Employment			X		X		X		X		X		X		X		X		X		X
Board member			X		X		X		X		X		X		X		X		X		X
Patent			X		X		X		X		X		X		X		X		X		X
Personal Relationship			X		X		X		X		X		X		X		X		X		X

For all "Yes" responses, provide a brief explanation here:

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Author Contributions

Tjia: study design, data analysis, interpretation of findings, drafting the article, final approval of version to be published.

Lemay: study design, drafting and critical revision of article for important intellectual content.

Bonner: study design, interpretation of results and findings, drafting and critical revision of article for important intellectual content.

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Field: study design, drafting and critical revision of article for important intellectual content.

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Hunnicutt: interpretation of results and findings, drafting and critical revision of article for important intellectual content.

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Abstract

Objectives—To describe the extent to which nursing homes engaged families in antipsychotic initiation decisions in the year before surveyor guidance revisions were implemented.

Design—A mixed-methods study based on semi-structured interviews

Setting—20 U.S. nursing homes from five CMS regions (III, IV, VI, VIII, IX)

Participants—41 family members of nursing home residents

Measurements—Family member responses to close- and open-ended questions regarding involvement in resident care and antipsychotic initiation. Two researchers used a content analytic approach to code open responses to themes of family involvement in behavior management, decision-making, knowledge of risks and benefits, and informed consent.

Results—Overall, 54% of family members felt highly involved in decisions about behavior management. Forty-two percent recalled being asked how to manage resident behavior without medication and 17% recalled receipt of information about antipsychotic risks and benefits. Sixty-six percent felt highly involved in the process of initiating antipsychotic medication; 24% reported being asked for input into the antipsychotic initiation decision and knowing before the antipsychotic was started.

Conclusion—Under existing federal regulations, but before guidance revisions were implemented in 2013, over 40% of families reported being involved in non-pharmacologic behavior management of family members, but fewer than 1 in 4 reported being involved throughout the entire antipsychotic prescribing process. Interventions that standardize family engagement and promote adherence to existing federal regulations are needed. Our discussion builds on these findings to weigh the policy options of greater enforcement of existing regulations versus enactment of new legislation to address this challenging issue.

Keywords

Nursing home; dementia; antipsychotics; family involvement; off-label

INTRODUCTION

Dementia is a common progressive neurologic disease that affects approximately 25 million people globally,¹ over 5 million Americans 65 years (11% of the older adult population),² and over half of all nursing home residents in the United States.³ Characterized by a progressive decline in cognitive and functional abilities,⁴ behavioral and psychological symptoms of dementia (BPSD) are common and include verbal and physical aggression,

agitation, restlessness, wandering, inappropriate behaviors, psychoses such as delusions, hallucinations and delirium, and depression.⁵

The management of BPSD in nursing homes has been controversial due to the high prevalence of the off-label use of antipsychotics. Antipsychotics provide only a mild to moderate benefit for treating BPSD,⁷ while conferring an increased risk of stroke and death.^{8,9} Prior concerns about the overuse of unnecessary medications in nursing home residents led Congress to pass the Nursing Home Reform Act¹⁰ which called for nursing home residents to be free from chemical restraints. Unfortunately, prior legislative and regulatory efforts aimed at limiting antipsychotic use in nursing homes had mixed and limited effects. While legislation initially decreased antipsychotic use,¹¹ there has been a slow rise over the following decades,¹² prompting a report by the Inspector General of the U.S. Department of Health and Human Services in 2011 that found that over 83% of all Medicare claims for antipsychotics in nursing homes were for off-label uses.¹³

Efforts to respond to congressional pressure and concern about this ongoing issue included both proposals for new federal and state legislation for informed consent for antipsychotic use,¹⁴ and strengthening of the surveyor interpretative guidance used to enforce existing regulations.¹⁵ Specifically, the Centers for Medicare and Medicaid Services (CMS) updated the State Operations Manual (SOM) in 2013, including nursing home interpretive guidance, to make CMS' expectations on antipsychotic use even more explicit. The SOM states that antipsychotic medications: 1) "may be considered for elderly residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes have been identified and addressed"; and 2) must be "prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review."¹⁶ Toward this goal, the CMS revised guidance requires nursing homes: 1) to contact (and document attempts to contact) family members/representatives to help understand potential causes of behavioral distress to help guide non-pharmacological interventions; 2) to involve them in the development of the resident's care plan; and 3) to inform them of the benefits and risks of pharmacologic treatment strategies, the expected course of treatment, expected duration of medication use, what individualized approaches are to be used, the plans to evaluate treatment effects, and alternatives to psychopharmacologic medication. The extent to which these existing regulations have resulted in meaningful family involvement in antipsychotic decision-making is unclear. Further, experts in decision-making argue that for residents lacking decision making capacity,¹⁷ family should provide informed consent.¹⁸

We sought to focus attention on the debate regarding the need for greater enforcement of existing regulations versus the need for new informed consent legislation by describing the extent to which nursing homes engaged families in antipsychotic initiation decisions in the year before surveyor guidance revisions were implemented. In the context of a larger study exploring antipsychotic use in nursing homes, we conducted semi-structured interviews with family members of nursing home residents with dementia regarding antipsychotic medication initiation. The data collection period coincided with the year before the changes to the SOM, providing unique and detailed contextual information to inform the ongoing policy debate. The study purpose is to illustrate the extent to which nursing homes engaged

family members in issues relating to antipsychotic prescribing for residents with dementia and to describe family members' suggestions for improving the engagement process.

METHODS

Setting and Study Sample

We conducted a mixed-methods analysis of qualitative and quantitative data derived from a larger study examining the rationales provided by providers and family members for antipsychotic medication use in nursing home residents with dementia. Details of the parent study and the sampling strategy are described elsewhere.¹⁹ Briefly, between February–July 2012, a sample of NH residents with dementia who had been or were being treated with antipsychotics were identified. The goal was to identify at least 200 residents residing in at least 25 NHs in five states across the continental United States. One state was selected from each of five CMS Regions (Regions III (Mid-Atlantic), IV (Southeast), VI (South Central), VIII (Mountain), and IX (Southwest)). We identified nursing homes from each state that had a diverse and representative sample of facilities meeting the following criteria: Minimum Data Set (MDS) 3.0 data from January 2011 to September 2011; Nursing Home Compare ratings in October 2011; 50 beds; and, 6 residents with dementia on antipsychotic medication based on MDS data. Five nursing homes were randomly selected from one state within each region from pools stratified by facility size and tertile of antipsychotic use prevalence.¹⁹ One state included 6 nursing homes for a total of 26 facilities.

In each of the 26 facilities, we conducted on-site visits solely related to the review care for residents prescribed antipsychotics; these visits were not regulatory site visits. At each facility, a total of 8 residents were selected, including 6 residents who were randomly selected for inclusion with a dementia diagnosis and no concomitant diagnosis of Huntington's disease, Tourette's syndrome, and/or schizophrenia; 2 additional residents were identified by the facility's Director of Nursing for whom a gradual antipsychotic dose reduction had been attempted. From the resulting sample of 204 residents, nursing home staff identified a convenience sample of "family or legal representatives" (defined as either the health care proxy or known family member; referred to as "family members" hereafter) willing to answer questions related to a resident's antipsychotic use. An attempt was made to interview two family members at each facility. Six facilities provided no family interviews, 2 facilities provided only 1 interview, 3 facilities provided 3 interviews, and the remaining 15 provided the targeted 2 family interviews. The final sample included 41 interviews from 20 nursing homes.

Semi-structured Interviews

An interdisciplinary research team with expertise in geriatric medicine, nursing home care, qualitative methods, nursing home regulation, and medication safety developed interview guides for nursing home stakeholders (including healthcare team members and family members) using an iterative process in which drafts were reviewed by members of the team, and changes made in response to feedback from team members and the funder (CMS). Interview guides were piloted with family members from a non-participation nursing home.¹⁹

Data collection and interview instruments included closed- and open-ended questions aimed at eliciting descriptions of family member perceptions about why their loved one was started an antipsychotic medication. Questions addressed the family members' involvement in understanding and managing problematic behaviors, awareness of antipsychotic initiation, involvement in the antipsychotic initiation decision making, whether information was provided about the risks and benefits, and whether permission was requested. (Table 1)

Seven registered nurses who were Surveyor Minimum Qualification Test qualified surveyors conducted the interviews between February–July 2012. Each had at least four years of surveying experience and was trained in research interview and data collection techniques relevant to this study. The trainings introduced the field protocol for subject engagement, data collection, and interviewing developed for this project. We conducted multiple live trainings on all aspects of the protocol, including sessions on research interview methods with an interviewer qualitative expert (CL) to standardize interview techniques and procedures. This involved practice interviews with CL that included real time feedback on interviewing techniques, probing, pacing, and answer restating prior to note taking. Prior to actual data collection, all field protocol procedures and interviews were pilot tested in a non-study NH where the interviews were audio-recorded. Pilot interviews lasted approximately 30–40 minutes, and all recordings were reviewed by CL for adherence to the protocol and individual feedback provided to each interviewer. Throughout the course of the actual study, we conducted monthly conference calls with interviewers to review protocol procedures, troubleshoot challenges, and standardize approaches to solutions.

After completion of the pilot testing, one-on-one interviews conducted at study NHs were not audio-recorded due to concerns about respondents' openness to answering questions in this CMS-sponsored project. Interviewers captured both responses to closed-ended questions and open-ended questions in real time on the interview guides, with verbatim responses written for open-ended questions. When possible, in-person interviews were conducted at the nursing homes during the on-site visits, otherwise interviews with the family members were conducted by telephone.

Data Analysis

Quantitative data analysis—We used descriptive statistics to enumerate the responses to the open ended questions that asked for yes/no/unsure responses in addition to open explanations. (Table 1) We also enumerated responses to close-ended questions using 10-point Likert scales where 1 indicated “not at all” and 10 indicated “very”. Responses were categorized from 1–3 to indicate low, 4–6 to indicate moderate, and 7–9 to indicate high levels of involvement and satisfaction.

Qualitative data analysis—Responses to open-ended interview questions were coded using directed content analytic techniques. The domains were defined *a priori* based on the 2013 CMS SOM revisions¹⁶ state that for residents with dementia, nursing homes considering antipsychotic prescribing should (Table 1): 1) involve family members to help nursing home staff understand current and prior behavioral patterns; 2) inform family of risks and benefits of pharmacological and non-pharmacological interventions; 3) involve

family in the decision-making process; and 4) solicit informed consent from families (in states with relevant laws). Responses were coded independently by two research team members (JT; KP); disputed responses were reviewed by a third team member (CL) and reconciled by consensus until 100% agreement was reached.

This study was conducted under the direction and authority of the CMS Survey and Certification Group. A letter from CMS introducing the study was provided to each nursing home. Exemption was obtained from the University of Massachusetts Medical School institutional review board.

RESULTS

Of the final sample of 41 interviews, 66% of family member respondents were women. Fifty-one percent were 60 years old. Seventeen percent were spouses, 51% were children, 7% were siblings, and the remaining 25% were other family or non-family respondents. All but two were family members, and all but three described themselves as the resident's healthcare proxy.

Quantitative Results

Two questions addressed family involvement with behavior management. (Table 1) Responses indicate that forty-two percent (n=17) reported being asked about resident-specific techniques for behavioral management without medication, and 54% (n=22) felt highly involved in decisions about staff response to behaviors.

While 66% (n=27) of families reported being both highly involved and satisfied with their level of involvement in the antipsychotic decision-making process, the actual types of involvement varied in response to different questions. Overall, 56% (n=23) reported that they knew about the plan for antipsychotics before initiation and 49% (n=20) reported having "a say" in the decision. However, only twenty-four percent (n=10) reported being involved throughout the entire process, which included being asked for input about the decision to initiate the antipsychotic, having a say in whether or not it was initiated, and actually knowing about the antipsychotic before it was started.

Reports of receiving information about risks and benefits of antipsychotic medications were relatively uncommon. When asked "What kind of information were you given about [antipsychotic] medication?", 12% (n=5) family members specifically recalled getting no information, 12% (n=5) reported getting only risk information, 12% (n=5) reported getting only benefit information, and 29% (n=12) were unsure. The remainder provided no response.

When asked "Were you asked permission for [your family member] to receive this medication?", fifty-six percent (n=23) reported that they were asked for permission before the antipsychotic was initiated. Seventeen percent (n=7) reported they were not asked for permission, 12% (n=5) were unsure, and 14% (n=6) provided no response.

Qualitative Results

Family Involvement in Behavior Management and Decision-Making—While the quantitative results indicates that many (42%) family members reported being asked about how to manage resident behaviors without medication, some family members reported wanting more opportunity to exchange information with staff. At least 6 family members wanted a chance for greater communication and involvement, and 2 wanted more information about medications and their alternatives. One family member noted that “[there was] no concrete discussion about alternative approaches to management of behaviors.” Another family member indicated that though they did not want their loved one on antipsychotic medication, they did not know about any other options: “No one has asked for my suggestions but I wouldn’t know what to tell them.” Several commented that enhanced communication is needed: “Call me, let me know what is going on.” A theme that emerged called for an increase in communication regarding decision-making. As one family member commented, “They need to make more of an effort. They need to call.” Even those who described themselves as very involved recognized a need for improvement: “[I wish the nursing home] would allow me to be more involved in the decisions about medication administration before it’s prescribed.”

Antipsychotic Risks and Benefits—From responses to open-ended questions, benefits described by family members included “calming,” “alleviate the agitation” and “leveling her out.” Risks described by family members included “shaking” and non-specific information like “the side effects.” None reported that the nursing homes told them about FDA black box warnings such as death or stroke. A strong desire for more information was communicated by family members: “They did not tell me what the medication was, or [what it was] for,” and “They don’t have people there to call you and inform you about drugs, possible dangers of taking it.”

Permission for Antipsychotic Initiation and Informed Consent—While only slightly more than half (56%) of families recall giving permission for antipsychotic initiation, responses to open-ended questions suggest that some trusted physicians and may not have felt a need to give permission. Specifically, some family members had a hands-off, ‘doctor knows best about medications’, attitude towards the antipsychotic decision. These comments included statements like: “I don’t know [why an antipsychotic was prescribed], the doctor knows better,” and “I have to trust and respect their decisions”. This was reported 29% (n=12) and seemed consistent with reports that family members were “satisfied” with the decision-making process and that they had been kept informed and involved (n=27).

DISCUSSION

Our study provides a unique evaluation of family members’ perspectives regarding engagement with nursing homes during the decision-making process of antipsychotic prescribing. Despite long-standing federal regulations for family involvement in antipsychotic decision-making, our findings suggest that family members were not adequately included in the resident care planning process and in the period before the new SOM guidance was implemented.

Our findings are in agreement with a previous report by the Office of the Inspector General.²⁰ Among 375 randomly selected nursing facility records of residents who received atypical antipsychotics, geriatric psychiatrists found that 91% lacked evidence that the resident, resident's family, or resident's legal representative participated in care planning, and 59% lacked documentation as to why there was no participation. Our study extends these findings by demonstrating that even when family members are involved in some capacity with the care planning process, they may not be asked to help with managing behaviors non-pharmacologically or given the information necessary to provide informed consent for antipsychotic medication use.

Nursing homes may be hesitant to ask family members to help implement non-pharmacological alternatives to managing BPSD. Perceived barriers to implementation of non-pharmacological approaches include lack of time, low staff-to resident ratios, high staff turnover, and the perceived unpredictable and potentially short-term effectiveness of the effort.²¹ A culture of prescribing which uses antipsychotics to control nursing home residents with BPSD as a first line treatment has been described.²² Residents admitted to nursing homes that prescribe a higher amount of antipsychotics are at an increased likelihood of being prescribed antipsychotics after entering a nursing home.²³ One hope has been that regulatory and legislative changes would motivate nursing homes to move from a culture of prescribing to one of holistic, resident-centered care that actively seeks resident and family involvement and ensures that family members and healthcare proxies are able to make informed decisions and provide consent in the care planning process. However, the effect of regulations and informed consent legislation about antipsychotic use in nursing homes has not, to our knowledge, been studied.

There is a current discussion in policy circles regarding the need for informed consent legislation at the state and federal levels. Issues related to determining legal competence and informed consent are determined by local jurisdiction (state law).¹⁴ Table 2 shows that the states with more stringent informed consent laws than proposed federal legislation¹⁴ have two characteristics in common: 1) an explicit definition and affirmation that nursing home residents have the right to informed consent for medical treatment, and 2) a requirement for proxy decision maker involvement when the resident is deemed incompetent. Attempts to pass federal legislation to require informed consent for antipsychotic medications in all nursing homes have been unsuccessful to date. The most recent attempt did not pass in the 112th Congress.²⁴ Issues raised by the industry and provider groups include: increased workload and nursing home burden without additional reimbursement; lack of provider availability to interact with families in a timely manner; and challenges of locating family members/legal representatives in a timely manner when medications are urgently needed. While many of these issues could be addressed in regulatory language, the potential negative unintended consequences of such legislation could be that nursing home staff will feel pressured to "check the box" and ensure paper compliance, without families having a meaningful conversation with providers about the risks and benefits of the medication, non-pharmacological alternatives, monitoring, target symptoms and endpoints for re-evaluation of the therapy. Further, the requirements for these elements of the conversation are already in the interpretive guidance¹⁶ although not referred to as "informed consent." If state surveyors enforce these requirements, residents and families would have a better understanding of the

risks and benefits of antipsychotic medication use in dementia, and could make an informed choice. Without proper enforcement, the extent to which any new legislation on informed consent would be effective in reducing antipsychotic use in nursing homes remains unclear.

We note that our findings should be considered in the context of several limitations. First, the study's convenience sample included family members who were involved in the resident's care; coupled with likely social desirability bias,²⁵ our data may overestimate the level of family involvement in antipsychotic prescribing. Second, interviews were not audio-recorded due to privacy concerns. Study nurses transcribed responses in real time as they conducted the interviews. The quotations included must be considered paraphrases that characterize the general sentiments of responses. Finally, we were unable to determine the amount of time a resident was cared for in a facility. Recall bias is possible because we were unable to ascertain the time elapsed between family-nursing home staff conversations regarding antipsychotic initiation relative to our interviews. However, because standard practice calls for ongoing care plan meetings between families and NH staff at least every 90 days, the concern of recall bias is somewhat mitigated because there should be recent antipsychotic-related conversations about residents regardless of their length of stay in the nursing facility. (<https://www.medicare.gov/what-medicare-covers/part-a/care-plan-in-nursing-home.html>)

Our findings demonstrate the need for enhanced enforcement of current guidance for resident and family involvement in resident care planning. Before the changes in the SOM and national initiatives to reduce antipsychotic use in nursing homes, family members were not fully engaged in decision-making around antipsychotic initiation in nursing homes. Our findings support the need for shared decision-making models rather than paternalistic ("doctor knows best") approaches to off-label prescribing of antipsychotics with limited efficacy and known risks.

Evidence exists that families can be a valuable resource for understanding a resident's lifelong habits, preferences for everyday routines, and personality characteristics; this detailed knowledge can inform selection of effective non-pharmacological approaches to BPSD.^{26,27} Nonpharmacologic interventions show promise for treating BPSD and lowering antipsychotic use in nursing homes.^{28–30} In 2011, CMS established the National Partnership to Improve Dementia Care in Nursing Homes, a public-private partnership dedicated to reducing antipsychotic use.³¹ The National Partnership encourages resident and family involvement in care planning. Early findings note a decrease in antipsychotic use nationally for long stay nursing home residents by 21.8% (the rate decreased from 23.9% to 18.7%) over the period from Quarter 4 2011 through Quarter 1 2015.³²

Advocates remain concerned that surveyors are not enforcing regulations consistently, or citing deficiencies at the appropriate scope and severity.^{31,33} CMS mandated 3 hours of surveyor training to help surveyors better recognize and cite deficient practice related to dementia care, non-compliance with federal regulations and to take appropriate enforcement action in those cases. The extent to which reductions in antipsychotic use realized with recent policy changes will be sustained in the absence of adequate state and federal enforcement remains unknown and deserves further study.

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Table 1

Map of CMS F309 and F329 State Operations Manual Guidance on “Review of Care and Services for a Resident with Dementia - Resident and/or Family/Representative Involvement” to the Content Analytic Study Domains and the Interview Guide Questions^a

CMS Guidance from State Operations Manual ^b	Content Analytic Study Domain	Interview Guide Questions Open ended	Interview Guide Questions Close ended
“CMS expects that resident and family/representatives, to the extent possible, are <i>involved in helping staff to understand the potential underlying causes of behavioral distress</i> and to participate in the development and implementation of the resident’s care plan.”	Families should be asked to assist staff in understanding <i>resident behavior patterns</i> .	Did anyone from the nursing home talk to you about how they might care for [your person] and manage [agitation/problematic behaviors] without medication? For instance, did they ask you about ways to calm [your person] down, or make [your person] feel more comfortable or secure? Please explain.	On a scale of 1 to 10, where 1 is “not at all,” and 10 is “very much,” how involved have you been in decisions about how staff should respond when [your person] seems distressed, agitated, or is difficult for staff to manage?
“Facilities should be able to identify how they have involved residents/families/representatives in <i>discussions about potential approaches to address behaviors and about the potential risks and benefits of a psychopharmacological medication</i> (e.g., FDA black box warnings), the proposed course of treatment, expected duration of use of the medication, use of individualized approaches, plans to evaluate the effect of the treatment and pertinent alternatives.”	Families should be informed of all <i>risks and benefits</i> and given enough information about antipsychotic medications to make informed decisions.	According to the records, the nursing home [your person] started on [medication name] in [month year]. Were you aware that [your person] started on this medication? Please explain.	[On a scale of 1 to 10] how satisfied have you been with your level of involvement? [On a scale of 1 to 10] how involved have you been in decisions about giving [your person] [med name]?
“The facility should document attempts to <i>include the family/representative, to the extent possible, in the decision-making process</i> . “	Families should be involved in the <i>decision-making process regarding prescription of antipsychotic medications</i> .	What kind of information were you given about this medication?	n/a
“Some states have specific laws/licensing rules regarding the provision of informed consent...”	Families should give informed consent (or the opportunity to provide permission) before any medication is administered to the resident	Were you asked permission for [your person] to receive this medication?	n/a

^aFull interview guides are available at <http://onlinelibrary.wiley.com/store/10.1111/jgs.13230/asset/supinfo/jgs13230-sup-0005-AppendixS5.pdf?v=1&s=889ee4705fda05b4aca847a38ed212dc306ef241>

^b Available at: <https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/survey-and-cert-letter-13-35.pdf>

Table 2

Examples of state legislation and minimum requirements for nursing home informed consent from states thought to have more stringent legislation

State (Year legislation enacted)	Provisions/Minimum Requirements					
	Defines Informed Consent	Proxy decision maker allowed	Alludes to timing of consent and drug initiation	Requires written consent	Penalties	Responsibility for obtaining informed consent
Alaska ^a (1992)	X	X	Before administering psychotropic drugs			Nursing home
California ^b (2010)	X	X	Before administration of psychotherapeutics			Licensed healthcare practitioner
Illinois ^c (2010)	X	X	Before administering psychotropic drugs	X	In addition to any other penalty prescribed by law, facilities will have to obtain 2 licensed health care professionals signatures on every informed consent form for the psychotropic medication administration.	Physician, pharmacist (not associated with nursing home), or nurse
Iowa ^d (before 2007)	X	X	Before administering chemical restraints	X		Administrator or physician
Nevada ^e (1983)	X	X				Physician
Washington ^f (2008)	X	X		X		Nursing home
Wisconsin ^g (2009)	X	X	Before administering psychotropic drugs	X		Nursing home

^a Alaska Statutes 47.30.825; Patient medical rights and 47.30.837; Informed Consent

^b California Code of Regulations, Title 22, Social Security, Section 72527; Patients' Rights and 72528; Informed Consent Requirements

^c Illinois Compiled Statutes Nursing Home Care Act (210 ILCS 45/2-106.1); Drug Treatment

^d Iowa Code Title IV, subtitle 3, 147.137; Consent in Writing and Iowa Administrative Code 481-58.39(135C); Residents' Rights in General

^e Nevada State Code and Statutes 40.449.710; Specific Rights: Information Concerning Facility; Treatment; Billing.

^f Washington Administrative Code 388.97.0260; Informed Consent and Revised Code of Washington 74.42.040; Resident's rights regarding medical condition, care, and treatment.

Wisconsin Statutes 50.08: Informed Consent for Psychotropic Medications and 50.09: Rights of Residents in Certain Facilities

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