FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
HILLCREST HEALTHCARE CENTER— 08-040-9005
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary—— Although the Authority did not substantiate the complaints presented, the facility violated its policy. Findings are recorded below, and the facility's response immediately follows.]

INTRODUCTION

The South Suburban Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Hillcrest Healthcare Center. The 168-bed skilled nursing and intermediate care facility is located in Joliet. The complaint stated the following:

1. A resident cannot receive phone calls and messages from her personal psychiatrist.
2. The staff refuses to call the resident's personal psychiatrist regarding her care.
3. The resident's chart lacks adequate documentation regarding her psychiatric goals and progress.
4. Residents lack reasonable access to communication because the facility's pay phones are broken.

If substantiated, these allegations would be violations of the Nursing Home Care Act (NHCA) (210 ILCS 45/2 et seq.), the Illinois Administrative Code (77 Ill. Admin. Code (77 Ill. Admin. Code 300.1210 [a]) and the Centers for Medicare and Medicaid Services, Department of Health and Human Services' (CMS) Requirements for Long Term Care Facilities (42 C.F.R. Sections 483.10 and 483.25).

METHODOLOGY

To investigate the complaint, a site visit was conducted on December 11th, 2007. The Facility Administrator, the Director of Nursing and the Clinical Director of Nursing were interviewed. Four of the facility's residents were privately interviewed. Information was obtained from a staff person and the recipient's personal psychiatrist by telephone with written consent. Portions of a resident's record were reviewed with written consent. Relevant facility policies were also reviewed.

FINDINGS

Complaint #s 1, 2 and 3: The complaint stated that calls and messages between the resident and her personal psychiatrist have been restricted. She asked the nursing staff to call her personal psychiatrist on September 5th and 12th 2007 because of auditory hallucinations, but they refused. The complaint stated that the resident was hospitalized because her psychiatrist was not timely notified about blood work results, which was ordered on September 19th, 2007 to determine whether Lithium needed to be increased. Additionally, the complaint alleged that the resident's record lack sufficient goal documentation regarding her psychiatric progress.

The resident involved in this case is an adult who maintains her legal rights.

Information from the record, interviews and program policies

According to the resident's face sheet completed at intake, she was admitted to Hillcrest Healthcare Center on July 20th, 2007, having been transferred from a local hospital. She had previously been a resident of the facility and discharged to the community in March 2007. Her admitting diagnoses were Bipolar Disorder, Self-Mutilation and Obesity. An updated copy of the resident's face sheet was subsequently provided by the facility because some copies of the intake form found in the record lacked information regarding those physicians involved in her care.

Trileptal 600 mg twice daily, Clozapine 50 mg four times daily, and Haldol as needed were ordered by the facility's psychiatrist at intake. A form indicated that medication consent was secured on July 24th, 2007. But, Medication Administration Records (MAR) reflected that Trileptal and Haldol were started on July 20th and Clozapine on July 21st with no documented emergency in the record. The HRA noticed that the facility's psychiatrist was listed on the printed physician's order sheets although the resident's private psychiatrist reported that he has been providing care since March 2007. Her personal psychiatrist also said that Clozaril (whose generic form is Clozapine) was restarted without consulting him.

There was no documentation found in the record regarding a phone restriction between the resident and her personal psychiatrist. According to the facility's administrative staff, a resident would never be restricted from communicating with a physician of choice. The Clinical Director of Nursing explained that residents are paged at least twice when they receive calls on the facility's phone. She said that the staff person who answers the phone will take a message if the resident does not respond when paged. Upon questioning, the resident's private psychiatrist remembered calling the resident twice and that she did not answer the facility's page. Her personal psychiatrist emphasized that calling the facility was not a problem, and that the resident has his pager number for emergencies.

The resident's August 7th care plan listed targeted behaviors such as problems with decision making, depression, and coping skills. Her plan of care consisted of many interventions to manage her physical and psychiatric symptoms such as medication, counseling, therapy groups and community outings. Her goals included: 1) making appropriate choices, 2) seeking staff's assistance to avoid harming herself 3) utilizing effective coping mechanisms, 4) a gradual weight loss by following her prescribed diet and exercising 5) no fall related injury, and, 6) developing a safe discharge plan. The record contained many notes written by staff members reflecting that the resident's goals were being implemented.

A Consultation Report (the date is unclear) signed by the resident's personal psychiatrist stated that the resident was doing well at the facility. She reportedly had denied hallucinations

and suicidal ideations. According to the report, the resident's personal psychiatrist suggested that Clorazril should be discontinued and Abilify 10 mg nightly should be restarted. The MAR does not reflect that the facility's psychiatrist made any medication changes based on her personal psychiatrist's suggestions.

An order written by her personal psychiatrist indicated that Clozaril was discontinued, and Abilify 20 mg every morning was added to her treatment plan on August 8th. The MAR reflected that his orders were followed. A Thyroid Stimulating Hormone (TSH) test and Electrocardiogram (EKG) were also ordered. Medical reports documented that these tests were completed on August 9th and 10th respectively, and the EKG's findings were abnormal. Her personal psychiatrist said that the facility's psychiatrist should have checked a previous EKG because Clozaril was contraindicated. This medical report was not found in the record.

Nursing entries recorded that the resident visited her private psychiatrist about five times between August and November 2007. Although her personal psychiatrist reported that he completes a progress note after each visit, the record contained only one note written on September 4th. Upon questioning, the Administrator told the investigation team that the resident's friend escorts her to medical appointments and that her friend sometimes refuses to give the psychiatrist's notes to the facility. This issue was reportedly discussed with the resident's friend who became upset when informed that the facility could not disclose information without the resident's consent. The resident confirmed that consent for sharing information had been discussed with her. However, she wanted her friend to attend her care plan meetings only.

According to the September 4th progress note, the resident reported mood swings, decreased sleep, visual hallucinations and suicidal ideations. Abilify was increased to 30 mg, Trileptal was discontinued, and Lithium 300 mg twice daily was ordered by her personal psychiatrist. These changes were reflected on the MAR. On that same day a nurse documented that the resident's private psychiatrist wanted to be called first regarding her care. The next day, Haldol 5 mg IM (intramuscularly) was administered upon the resident's request for auditory hallucinations, and she reportedly had "no further complaints." Although the resident informed the HRA that a nurse refused to call her psychiatrist, there was no documentation of her request. According to the Director of Nursing, staff are required to document significant events in residents' record, and residents who require crisis intervention are first assessed by Psychiatric Counselors. Residents may be offered as needed medication, and they are reassessed before calling their assigned physician.

On September 18th, the resident's private psychiatrist ordered that her Lithium level should be checked on the following morning and every three months. A September 19th laboratory report revealed that the resident's Lithium blood level was within the normal range. There was no written evidence when the resident's private psychiatrist was notified about her test results. The Director of Nursing said that laboratory reports are timely faxed to physicians; the resident's personal psychiatrist did not voice any concerns about this issue.

Documentation on September 28th stated that the resident's private psychiatrist was called after she complained of visual and auditory hallucinations. A covering psychiatrist returned the facility's call and ordered the resident's transfer to a local hospital's emergency room for an evaluation. On that same day the resident was hospitalized and another EKG's findings were abnormal. She was readmitted to the facility on October 1st. Her private psychiatrist increased

Lithium to 900 mg daily and added Lithium Extended Release 450 twice daily to her medication regimen on October 9th. These changes were reflected on the MAR.

Nursing entries indicated that the facility's psychiatrist may have still been providing care on some level. The resident signed a change of physician form on October 10th releasing the facility's psychiatrist, and her personal psychiatrist was named as the attending physician. Upon questioning, the administrative staff said that the change of physician form was not new to the facility. The facility's procedures for changing physician/psychiatrist is as follows 1) A resident should request a change form from the Social Services Department, 2) Complete the request form, 3) A copy of the signed form will be placed in the resident's chart and a copy will be filed in the Social Services Department, 4) The resident's old face sheets should be removed from his/her chart and replace with new ones, and, 5) The updated information will also be reflected on the outside of the resident's chart.

Further documentation indicated that the resident's care plan was updated on November 1st. The resident reportedly had no complaints concerning services when the Administrator met with her on November 12th. On December 1st, the resident did not attend her appointment with her personal psychiatrist because her friend reportedly "fired the doctor." The resident told the investigation team that she still wanted to receive care from her personal psychiatrist, and the facility's administration agreed to follow up with the physician of the resident's choice.

Hillcrest Healthcare Center care planning policy states that all residents will have a comprehensive assessment including an individualized plan of care to assist them in achieving and maintaining their optimal status. The Interdisciplinary Team (IDT) will consist of but is not limited to the attending physician, the licensed nurse responsible for the resident's care, other appropriate staff in disciplines determined by the resident's need, the resident, a family member or legal representative to the extent practicable. A minimum of five goals is usually considered appropriate for each plan of care. These goals should consist of at least two physiological, one psychological and one sociological and one other. All IDT departments are responsible for charting that includes progress or lack of progress toward the problems, needs and/or strengths identified in the resident's care plan.

CONCLUSION

Section 45/2-104 (a) of the NHCA states that,

> A resident shall be permitted to retain the services of his own personal physician at his own expense or under an individual or group plan of health, or under any public or private assistance program providing such coverage.

Pursuant to Section 45/2-108 (d) of the NHCA,

> Unimpeded, private and uncensored communication by mail, public telephone or visitation may be reasonably restricted by a physician only in order to protect the resident or others from harm … provided that the reason for any such restriction is placed in the resident's clinical record by the physician and that notice of such restriction shall be given to all residents upon admission.

CMS' Requirements for Long Term Care Facilities Section 483.10 guarantees a resident the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside of the facility.

CMS' Requirements for Long Term Care Facilities Section 483.25 and the Illinois Administrative Code 300.1210 (a) states that,

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan care.

This case revealed the problems that can arise when two psychiatrists are providing care to the same resident. Although the complaint alleged that the facility was not working therapeutically with a resident's choice of physician, there was no documentation regarding a phone restriction in the resident's record. Furthermore, the resident's private clinician reported that calling the facility was not a problem, and the facility's administrative staff said that no such restriction occurred. The HRA acknowledges that the resident reported that a nurse refused to call her private psychiatrist, but there was no evidence in the record of her request.

The record contained documentation that the resident's goals were being implemented. The resident's private psychiatrist reported that the facility's psychiatrist restarted Clozaril without consulting him although he has been providing care since March 2007. Some copies of the resident's face sheet completed at intake lacked information regarding those physicians involved in her care, and psychotropic medications were ordered by the facility's psychiatrist upon her admission. According to medication records, the recipient's informed consent was not secured before the intake medications were administered.

Whether the resident was asked about her preference of physicians during the intake process is unclear to the HRA— this may be confusing based on the resident's face sheets found in the record. It was also unclear whether the resident informed the facility about her personal psychiatrist upon her admission. What is clear, the resident signed a change of physician form on October 10th, 2007, but all copies of the resident's old face sheet were not removed from her chart in accordance with the facility's policy. An updated copy of the intake form was provided during the investigation by the facility.

Based on the record, the Authority does not substantiate that the resident cannot receive phone calls and messages from her private psychiatrist. The HRA finds no violations of the NHCA 45/2-108 (d) and CMS' Section 483.10.

The complaint that the staff refuses to call the resident's private psychiatrist regarding her care is unsubstantiated. No violations of the NHCA Section 45/2-104 (a) were found.

Additionally, the Authority does not substantiate that the resident's chart lacks adequate documentation regarding her psychiatric goals and progress. No violations of CMS' Section 483.25 and the Illinois Administrative Code 300.1210 (a) were found. However, the HRA finds a violation of facility policy with regard to the documentation of the psychiatrist overseeing the resident's care.

RECOMMENDATION

1. Hillcrest Healthcare Center must follow its procedures for changing physician/psychiatrist and remove all copies of the resident's old face sheets from the record.

SUGGESTIONS

1. The facility should document in the resident's record when physicians are notified about laboratory reports.

2. To ensure continuity of services, the facility should make reasonable efforts to secure documentation from outside physicians involved in a resident's care.

3. Review Residents' Rights for People in Long Term Care Facilities with the appropriate staff members.

COMMENT

A psychotropic medication consent form indicated that the benefits, risks and side effects were orally explained to the resident. However, the form was dated July 24th, 2007, and the facility started administering medication on July 20th, 2007. According to Section 45/2-106.1 (b) of the NHCA, psychotropic medication shall not be prescribed without the informed consent of the resident, the resident's guardian, or other authorized representative. Hillcrest Healthcare Center violated this Section. The HRA urges that the facility obtain residents' informed consents prior to prescribing psychotropic medications in non-emergent situations pursuant to the Section.

Complaint # 4: The complaint alleged that residents on the 3rd floor do not have reasonable access to communication because the pay phones were broken. Residents on this floor are reportedly not allowed to make calls on the staffs' phones.

Information from interviews and program policies

Hillcrest Healthcare Center Administrator said that the facility's 3rd floor had only one public pay phone that was removed by the telephone company in July 2007. She stated that the facility was not allowed to keep the phone after the contract had expired because the telephone company is discontinuing this kind of service. The Administrator said that finding another company willing to install a pay phone was not easy, but she provided the HRA with a letter dated November 29th, 2007 confirming that the phone would be replaced soon.

According to the Administrator, residents on the 3rd floor still had access to communication after the pay phone was removed. She explained that the 3rd floor consists mainly of residents with psychiatric diagnoses, and she has not received any grievances from any resident regarding this issue. She said that residents can make local calls at designated times on the facility's phone located in the "group room," which is also used for therapy groups. She reported that the facility's Psychiatric Counselor's phones are available when needed and some residents have cellular phones. The Administrator said that residents can use the public pay phone on the 1st and 2nd floor anytime. She reported that the facility's two remaining pay phones are owned by the same telephone company that removed the 3rd floor pay phone, but the phones were not removed because they were on a separate contract.

The HRA inspected the facility's two public pay phones, and they appeared to be working. Four residents on the 3rd floor said that they had adequate access to phones. The residents interviewed said that they could use the counselor's phones and the phone in the group room at designated times. One of them reported that the phone in the group room was broken, and this occurred a few days before the HRA's visit. Upon questioning, the Administrator said that she was not aware that the phone may be broken, but she would replace the phone if needed. While touring the facility, the investigation team noticed that a resident on the 3rd floor asked the Administrator if he could make a long distance call. She reportedly took him to her office on the 1st floor to make the call.

Subsequent to the site visit, a staff person reported that the public pay phone on the 3rd floor was reinstalled on January 2008.

Hillcrest Healthcare Center reportedly does not have a policy regarding residents' rights to communication, but the facility's procedure is to follow the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities.

CONCLUSION

According to the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities and Section 45/2-108 (a) of the Nursing Home Care Act, every administrator shall ensure that correspondence is conveniently received and mailed, and that telephones are reasonably accessible.

The complaint alleged that residents on the 3rd floor do not have reasonable access to communication because the pay phones were broken. These residents are reportedly not allowed to make calls on the staff's phones. The investigation revealed that the facility had no choice regarding the telephone company's decision to remove the only public pay phone on the 3rd floor in July 2007. The Administrator said that the staffs' phones are available to residents when needed. They can use the pay phone on the 1st and 2nd floor anytime. She reported that some residents have cellular phones. Four residents reported no difficulties in making calls on the facility's phones. The 3rd floor pay phone was reportedly reinstalled on January 2008.

The HRA does not substantiate the complaint. The Authority finds no violations of the Sections.

SUGGESTIONS

1. When using the staff's phone, the facility should ensure that residents are provided with privacy as clinically indicated.
2. The facility should consider policy development concerning telephone communication for residents.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

HILLCREST HEALTHCARE CENTER
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May 7, 2008

Theresa Buell, Chairperson
Regional Human Rights Authority
P.O. Box 7009
Hines, Illinois 60141-7009

RE: HRA No. 08-040-9005

Dear Theresa Buell:

Please accept this letter as the written response of Hillcrest Healthcare Center to your report of HRA No. 08-040-9005 investigation. Facility staff were in-serviced to follow our procedures for changing physicians/psychiatrist and remove all copies of resident's old face sheets, in a response to your recommendation.

Hillcrest Healthcare Center's current laboratory policy states all diagnostic reports are filed in the residents charts and the physician is to be notified of the results. All nurses have been in-serviced to document in the residents record when the physician is notified regarding laboratory results. The facility continues to provide a staff member, as needed, to accompany residents to doctors appointments, diagnostic tests, etc. in order to collect all documentation from the appointment and for the safety of the resident. If a family member transports the resident, staff will call the physician for any missing progress notes after the resident has returned. All nurses have been in-serviced on the need to secure documentation from outside physicians involving resident care. All staff will be re-inserviced on resident rights. Hillcrest Healthcare Center will also review resident rights with residents at the resident council meeting.

The facility has done the following regarding the need for residents, guardians or other representatives signing a consent form for all psychotropic medications: the nurse assigned to this task was re-inserviced on the procedure to obtain residents informed consents prior to administering the psychotropic medication in non-emergent situations.

A policy concerning telephone communication already exists as a current policy at Hillcrest Healthcare Center. Please see the attached document as this was a suggestion made for the facility to consider.

The facility will continue to review these policies with staff and follow all procedures under the Nursing Home Care Act. We appreciate the opportunity to provide a written response to the investigation report. Hillcrest Healthcare Center continues to be dedicated toward improving and protecting the quality of life, emotional well-being, dignity, and rights of all our residents.

Sincerely,

Amy Walko; LNHA
Administrator