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Egyptian Regional Human Rights Authority
Report of Findings
09-110-9025
Metropolis Nursing and Rehabilitation Center
November 9, 2009

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed it investigation concerning Metropolis Nursing and Rehabilitation Center, a 103 bed Skilled Nursing Home located in Metropolis. The specific allegations are as follows:

1. Two residents were inappropriately discharged from Metropolis Nursing and Rehabilitation Center.

2. A resident was not allowed to visit with other residents for several days.

3. A resident was denied privacy in written communication including the right to promptly receive unopened mail.

Statutes

If substantiated, the allegations would be violations of the Nursing Home Care Act (210 ILCS 45/2-108 and 210 ILCS 45/3-401).

According to 210 ILCS 45/2-108, "Every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or visitation. (a) The administrator shall ensure that correspondence is conveniently received and mailed, and that telephones are reasonable accessible. (b) The administrator shall ensure that residents may have private visits at any reasonable hour unless such visits are not medically advisable for the resident as documented in the resident's clinical record by the resident's physician. (c) The administrator shall ensure that space for visits is available and that facility personnel knock, except in an emergency, before entering any resident's room. (d) Unimpeded, private and uncensored communication by mail, public telephone and visitation may be reasonably restricted by a physician only in order to protect the resident or others from harm, harassment or intimidation, 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. However, all letters addressed by the resident to the Governor, members of the General Assembly, Attorney General, judges, state's attorneys, officers of the department, or licensed attorneys at law shall be forwarded at once to the persons to whom they are addressed

without examination by facility personnel. Letters in reply from the official and attorneys mentioned above shall be delivered to the recipient without examination by facility personnel."

Section 45/3-401 states, "A facility may involuntarily transfer or discharge a resident only for one or more of the following reasons: (a) for medical reasons; (b) for the resident's physical safety; (c) for the physical safety of other residents, the facility staff or facility visitors; or (d) for either late payment or nonpayment for the resident's stay, except as prohibited by Titles XVIII and XIX of the federal Social Security Act. The purposes of this Section, 'late payment' means non-receipt of payment after submission of a bill. If payment is not received within 45 days after submission of a bill, a facility may send a notice to the resident and responsible party requesting payment within 30 days. If payment is not received within such 30 days, the facility may thereupon institute transfer or discharge to the resident and responsible party by registered or certified mail. The notice shall state, in addition to the requirements of Section 3-403 of this Act, that the responsible party has the right to pay the amount of the bill in full up to the date the transfer or discharge is to be made and then the resident shall have the right to remain in the facility. Such payment shall terminate the transfer or discharge proceedings. This subsection does not apply to those residents whose care is provided for under the Illinois Public Aid Code. The Department shall adopt rules setting forth the criteria and procedures to be applied in cases of involuntary transfer or discharge permitted under this Section."

Complaint Information

According to the complaint, two residents, a man and his wife, were inappropriately discharged from the facility. Information in the complaint indicated that the female had been diagnosed with cancer and was very ill at the time of discharge.

Investigation Information

Allegation 1: Two residents were inappropriately discharged from Metropolis Nursing and Rehabilitation Center. To investigate the allegation, the HRA Coordinator (Coordinator) spoke with one of the residents (Resident I) and attempted to speak with the second resident (Resident II) who rights were alleged to have been violated. During a site visit at the facility, the HRA Investigation Team (Team), consisting of one member and the Coordinator, spoke with the Administrator and the Director of Nursing (DON). With written authorization, the Authority reviewed information from each individual's chart. Additional information provided by one of the residents and facility Policies pertinent to the allegation were also examined. An Illinois Department of Public Health (IDPH) Complaint Determination Findings (Findings) and information from the IDPH website were also reviewed.

Investigation Information

I…Interviews:

A…Resident I:

The Coordinator conducted a visit to the facility where the couple was transferred to after their discharge from Metropolis Nursing and Rehabilitation Center. During the visit, the Coordinator spoke with Resident I and attempted to speak with Resident II. However, Resident II was physically unable to be interviewed.

According to Resident I, he and his wife (Resident II) were inappropriately discharged from the facility at a time that his wife's health was very fragile. He stated that she is terminally ill due to a cancer diagnosis and was receiving hospice services at the time of the interview. The resident stated that while at Metropolis Nursing and Rehabilitation Center he expressed many concerns about patient care and privacy issues and believed that as a result he and his wife were asked to leave the facility.

Resident I, who has Power of Attorney for his wife's medical needs, provided written authorization for review of her clinical chart, as well his own records.

B…Administrator:

During the site visit to the facility, the Administrator informed the Team that Resident I was more appropriate for an Assisted Living Arrangement. However he chose to live at a nursing home in order to be with his wife who required skilled nursing care. The Administrator stated that Resident I had many complaints involving the nursing home and there had been numerous attempts to resolve those issues. She stated that an endeavor to reach a resolution of the resident's concerns, at the facility's request, was to contact a representative from the Ombudsman program who met with Resident I and facility staff. The Administrator related that during the meeting, the Ombudsman asked Resident I if he wanted to remain at the facility. According to the Administrator, Resident I stated that he wanted to move to another nursing home that would also admit Resident II. The Administrator informed the Team that when an area nursing home agreed to accept both residents, plans were made for the transfer. According to the Administrator, a van from the transferring facility came to the nursing home to pick up the couple and to transport them and their belongings to the new site. The Administrator stated that the transfer was implemented at the request of Resident I, and neither Resident I nor Resident II was involuntarily discharged.

C…Director of Nursing (DON)

According to the DON, the couple had been residents at the facility for approximately two years. The DON stated that Resident II required skilled nursing care due to a diagnosis of terminal cancer. However, Resident I, who has diabetes and other health issues, did not require the same level of care but preferred to remain at the nursing home to be near his wife.

The DON informed the Team that Resident I had expressed dissatisfaction with various issues at the nursing home, which included needs not being met, unsatisfactory food, noisy staff, etc. The DON informed the Team that Resident I's complaints would vary from day-to-day, and when resolutions were proposed, he would not accept the proposals. Due to lack of resolution and Resident I's belief that the entire staff was against him, the facility contacted an Ombudsman representative with the expectation that an outside entity could mediate and his issues of concern

could be solved. According to the DON, when the Ombudsman came to the facility for a meeting options and mediations to improve the problems were proposed; however, Resident I continued to voice concerns. When the Ombudsman asked Resident I if he wanted to remain at the facility, he stated that he did not want to maintain the residence. Conversely, he stated that he did not want to be transferred without his wife. According to the DON, when Resident II was asked what she wanted to do, she stated that she wanted to abide by the decisions made by her husband.

The DON stated that the transfer was implemented at Resident I's request and with Resident II's approval, rather than the couple being involuntarily discharged from the facility.

II…Record Review:

A…Resident I… Care Plan (Plan):

According to a 01/22/2008 Plan, Resident I's diagnoses were listed as follows: Intestinal Obstruction NOS (Not Otherwise Specified); Rectal Anal Hemorrhage; Anxiety State NOS; Diabetes Mellitus I; Alzheimer Disease, AC (Acute) Renal Failure; Coronary Artery Anomaly; Chest Pain NOS; Myasthenia Gravis WO AC EXAC (Without Acute Exacerbation); Intermediate Coronary Syndrome: Hypertension NOS, Gout NOS; and Difficulty Walking.

Goals listed in the Plan were as follows: 1) to maintain activities of daily living; 2) to have a soft formed stool every 1-3 days; 3) to have no injury related falls; 4) will understand and state the consequences of non-compliance with dietary restrictions; 5) skin tissues will be pink and healthy with no open areas and skin breakdown; 6) will have a therapeutic benefit of medication for depression at the lowest possible dosage level; 7) will not have complication of Diabetes; 8) will have a decrease in complaints of pain due to pain management.

Documentation in the Plan indicated that staff consistently attempted to educate the resident of the importance of following his diet and possible adverse effects of diabetes if he did not follow the diet. However, he continued to be non-compliant.

A 04/30/09 entry to the Plan indicated that the resident was unhappy at the facility and frequently stated that he and his spouse were moving elsewhere. The record indicated that social services at the facility had assisted the resident and his efforts to find alternate placement; however when placement was located he made a decision to stay at the facility. A goal for the resident to accept the need for care at the facility without further attempt to relocate was added to the Plan.

Documentation indicated that on 04/30/09, the resident had an angry outburst toward staff when it was necessary to reschedule an appointment. A goal was incorporated into the Plan for the resident to voice an understanding on the occasion it is necessary to reschedule an appointment and not to become angry when this occurs. The record indicated when cancellation and rescheduling of an appointment was necessary a staff member would promptly inform the resident of the cancellation, rescheduling date, and why the rescheduling was necessary. Staff

will also remind the resident of his appointment dates and times and arrange transportation for the appointments.

On 04/11/08, a behavior goal was added to the Plan due to the resident's screaming and yelling at staff. Documentation indicated that the resident used his wife's illness as an excuse for his aggression toward staff members. A goal was added to the Plan that specified that the resident should have 0 incidents of verbal outbursts and loud screaming by the next Care Plan review on 07/11/08.

A 04/30/09 entry to the Plan indicated that the resident had persistent anger toward staff which was exhibited by his yelling, cursing and making threats toward nursing staff. Additional documentation indicated that the resident interfered with his spouse's, as well as his own, care. A goal was added to the plan for the resident to allow staff to care for him and his spouse without getting angry.

B…Resident II…Care Plan (Plan):

In a 02/24/08 Plan for Resident II, documentation indicated that the resident was admitted to the facility on 02/13/08 with the following diagnoses: Bone Cartilage Disorder NOS; Anxiety State NOS; Diabetes Mellitus, Type II; Dementia with Behavior Disturbance; Iatrogen Hypothyroid; Scoliosis; Occluded Carotid Artery Without Infarction; Spondylosis; Difficulty in Walking; Alzheimer Disease; Senile Dementia; Backache NOS; Lumbago; Senile Delirium; Chronic Heart Failure NOS; Coronary Artery Anomaly; Esophageal Reflux, and Allergy, Unspecified. The diagnosis of Possible Metastatic Cancer Involving Sacral Vertebra was added on 05/06/08 and Hospice Care was commenced.

The 02/24/08 Plan contained goals to address the following problem areas: 1) Alteration in ADLs; 2) constipation; 3) risk for falls; 4) risk for weight loss and fluid imbalance; 5) risk for pressure ulcers; 6) risk for side effects caused by use of psychotropic medication; 7) Hospice/terminal care needs; 8) Diagnosis of cancer; 9) Pain Management; 10) Delirium; 11) Mental impairment for making consistent and reasonable decisions for everyday wants/needs and 12) verbal expressions of feeling helpless and worthless.

C…Social Service Progress Notes: (Note)…Resident I

Documentation in a 04/11/08 Note indicated that within the previous thirty days Resident I had yelled at staff and called them "idiots" on numerous occasions. According to the recording, "Resident I often gets upset if he or his wife were not attended to before other residents. Additionally, he becomes angry if appointments are not scheduled several months in advance."

According to a 05/13/08 Note, Resident I yelled and screamed at social service staff because he believed that he had missed an appointment. However, the appointment was scheduled for the following day. Documentation indicated that the social service director called the Office of the Ombudsman to request a conference to include Resident I, the Ombudsman and facility staff in an attempt to resolve some of the Resident I's concerns.

In a 05/15/08 Note, documentation indicated that the Ombudsman came to the facility to meet with Resident I and facility staff. The social worker recorded that Resident I was provided with the option to remain at the facility or to transfer to another facility, and he chose to transfer if his wife could accompany him. The record indicated that a skilled nursing facility in a nearby town agreed to accept both residents and both of the residents were transferred.

Documentation in a 05/16/08 Note indicated that the resident and his wife were discharged, and staff from the transferring facility came to pick up the residents and the majority of their belongings. The record indicated that all of the residents' belongings could not be placed in the van when the residents were discharged necessitating an additional trip to relocate all of their possessions.

III…Resident Involuntary Discharge Policy (Policy I)

According to Policy Statement, "It is the policy of this facility to only initiate involuntary discharge proceedings when the below-listed situations exist. The facility's primary concern is for the health and safety of the affected resident and for the health and safety of other residents, visitors and staff members."

Criteria listed for involuntary discharge were listed as follows: 1) The discharge is necessary to meet the resident's welfare and that welfare cannot be met in the facility; 2) The discharge is appropriate because the resident's health has improved so that he/she no longer needs the services; 3) The safety of individuals in the facility would be endangered;. 4) The health of individuals would be endangered; 5) The resident has failed after reasonable and appropriate notice to pay for a stay at the facility. (Any resident cannot be discharged for non payment if he or she has submitted all of the necessary paperwork to a third part payer. Discharge cannot proceed unless the third party payer, including Medicare and Medicaid, denies the claim and the resident refuses to pay for the stay.); 6) The facility ceases to operate. The justification for discharge when the facility is unable to meet the resident's welfare, he/she has sufficient health improvement or health issues that endanger others should be recorded in the resident's record by a physician. When the resident is a danger to others, the details must be documented in the resident's record.

According to Policy I, prior to discharge the resident, family members, surrogate or legal representatives must be notified of the reason for discharge. The Notice must be provided at least 30 days in advance and include the following: 1) the reason for discharge; 2) the effective date of discharge; 3) the location to which the resident is being discharged; 4) the resident's right to appeal the discharge with the State, and the telephone number and address of the appropriate office; 5) the name, telephone numbers and address of the State Long Term Care Ombudsman; 6) the names, telephone numbers and addresses of Agencies responsible for advocating for developmentally disabled or mentally ill individuals if the resident is developmentally disabled or mentally ill; 7) orientation materials for discharge including information for the resident and family on safe transportation to the new location and the material necessary to provide continuity of care at the new location, including discharge plans of care; and 8) The notice will be given a language and wording that is understandable to the resident and his/her facility in a 12-point type.

Documentation in Policy I indicated that a 30 day advance notice is not required under the following circumstances: 1) when the resident is an endangerment to the health and safety of others in the facility; 2) the resident's health has improved to allow a more immediate transfer or discharge; 3) when the resident's urgent medical needs require a more immediate transfer or discharge. 4) when the resident has not resided in the facility for 30 days; 5) If the above circumstances are present, the notice must be provided as soon as practicable before the transfer, but must be given before the resident leaves. The notice must contain the same information that is given in a 30-day notice, which is provided to the resident, resident's guardian, or durable power of attorney prior to the discharge.

IV…Documentation from Community Ombudsman (Ombudsman)

According to an 11/03/08 letter from an Ombudsman addressed "To Whom It May Concern", the Ombudsman documented that Resident I had numerous complaints regarding care, resident rights and dignity at the facility. The Ombudsman stated that she attended a meeting at the facility to discuss an issue involving interception of the resident's mail. When no clear answers were obtained regarding the issue, Resident I decided to transfer to another facility provided the transferring facility met certain expectations for him and his wife. The Ombudsman documented that when the meeting was over, she met with Resident I in his room at his request. At that time, Resident I stated that he had decided that he and his wife wanted to remain at the facility. The Ombudsman recorded that she spoke to the Administrator prior to leaving the facility to inform her that the Resident had changed his decision and wanted to remain at the facility. According to the Ombudsman, approximately a week later she learned that Resident I and Resident II? had been transferred to another skilled nursing facility.

Additional documentation indicated that efforts to solve concerns between Resident I and the facility was an ongoing problem and often ended without a resolution. The Ombudsman recorded that Resident I would not accept the facility's explanation to his issues of concern, and the facility would not accept responsibility; therefore, no solutions were reached.

V…IDPH Complaint Determination Findings (IDPH Findings) :

When the HRA reviewed a 07/15/09 IDPH Findings pertinent to the allegation, the record indicated that the residents discharge and transfer to another long-term care facility was not involuntary, but chosen by the residents. Documentation indicated that the Administrator, Director of Nursing, physician, several nursing staff, and the Ombudsman were interviewed during the investigation process. When the IDPH surveyor spoke with the Ombudsman about the allegation, the Ombudsman stated that it was possible that after she left the facility that Resident I could have once more changed his decision about the move. According to documentation in the findings, Resident I was "alert, generally oriented, but forgetful from time to time."

VI…IDPH Website:

When the Coordinator reviewed the IDPH Website, documentation indicated that there were no substantiated findings pertinent to the allegation.

Summary

According to the complaint, two residents were involuntarily discharged from Metropolis Nursing and Rehabilitation Center. When the Coordinator spoke with Resident I, he stated that he and his wife were discharged from the facility and transferred to another skilled nursing home against their will. During a site visit, the Administrator and the DON informed the Team that Resident I frequently complained about issues at the facility. According to the Administrator and documentation in Resident I's clinical chart, when those issues could not be resolved, the Administrator contacted the Ombudsman to mediate. When the Ombudsman met with facility staff and Resident I at the facility on 05/115/08, the record indicated that a resolution could not be reached. Documentation in Resident I's clinical chart, and interviews with the Administrator and DON indicated that Resident I informed those present at the meeting that he did not believe that the facility could meet his needs. He stated that he wanted to be transferred to another facility that would accept his wife (Resident II). The record indicated that when staff spoke with Resident II she stated that she wanted to do whatever her husband wanted. Documentation completed by the Ombudsman indicated that during the 05/11/08 meeting, Resident I decided to move from the facility to another nursing home that would also accept his wife. However, when she spoke with Resident I after the meeting, he said he had changed his decision about the move. The Ombudsman recorded that she spoke to the Administrator about Resident I's change in his decision. The IDPH investigation pertinent to the allegation concluded that the residents were not involuntarily discharged, but chose to be transferred to another facility. The record indicated that when the IDPH investigator spoke with the Ombudsman, she stated that Resident I could have once more changed his decision about the transfer.

Conclusion

Based on the information obtained, the allegation that two residents were involuntarily discharged from the facility is unsubstantiated. No recommendations are issued.

Allegation 2….A resident was not allowed to visit with other residents for several days. To investigate the allegation, the Coordinator spoke with Resident I at his current residence. During the site visit to the facility, the Team spoke with the Administrator and the DON. The Authority reviewed information from Resident I's clinical chart.

Investigation Information

I…Interviews:

A…Resident I:

According to Resident I, the Administrator and other staff members at Metropolis Nursing and Rehabilitation Center restricted him from visiting with other residents for several days. The resident could not remember the exact dates of the restriction; however, he stated that he had not any behaviors that would warrant the restriction.

B…Administrator:

The Administrator informed the Team that Resident I had not been restricted from visiting with any of the residents. However, after some of the residents reported that he had insisted that they sign a petition, he was counseled regarding the matter. The Administrator stated that she and another staff member attempted to explain to Resident I that his actions were confusing and upsetting the other residents. According to the Administrator, Resident I denied bothering the other residents and began to yell and scream at staff members. When Resident I's behaviors continued to accelerate, the local police and Resident I's physician were called. The Administrator stated that the event occurred after the Resident had made the decision to be discharged to another facility.

II…Record Review:

During review of Resident I's clinical chart, the Authority did not observe any documentation that indicated that Resident I had any restriction pertinent to visitation with his peers at the facility. There were no physicians' orders, Restriction of Rights Notices or other documentation in the progress notes that specified any of Resident I's rights had been restricted.

Documentation in the Administrator's 05/15/08 Progress Note written at 4:30 PM indicated that the resident "had been going up to other residents asking them to sign his petition. Resident [INITIALS] came to DON and said '[NAME] is making me sign some papers'". The record indicated that the resident was visibly upset and confused regarding Resident I's request. As a result of the report the Administrator recorded that she and the Director of Operations attempted to talk with the resident regarding him upsetting other residents by demanding that they sign his petition. Documentation indicated that when Resident was confronted about the problem, he began yelling, stating "I'm not bothering anyone" and quickly rolled Resident II down the hall of the facility in her wheelchair. The Administrator documented that she made additional attempts to speak with Resident I about his actions and attempted to calm him; however, the behaviors continued to accelerate. The record indicated that when staff failed to decelerate Resident I's behaviors, it was necessary to contact the local police and Resident I's physician.

In a 5:05 PM Note on 05/15/08 the Administrator recorded that when a local police officer came to the facility, he spoke with Resident I about the rights of the other residents and his need to remain calm. The Administrator documented that she explained to the police officer that Resident I had requested to be discharged to another facility and that the transfer was taking place the following morning. The record indicated that the police officer was able to calm Resident I and 15-minute observations were implemented, per physician's orders, in order to monitor Resident I's behaviors.

Documentation indicated that at 8:15 PM on 05/15/08, Resident I slammed the door in a Certified Nurse's face; however, there was no other documentation regarding behavioral issues. According to the record, Resident I and Resident II were transferred to another nursing facility on 05/16/08.

Summary

According to Resident I, he was restricted from speaking with other residents for several days. When the Team spoke with the Administrator, she stated that no restrictions were implemented pertinent to the allegation. However, she and another staff member had requested that the resident cease his actions of attempting to force other residents to sign "his petition". Documentation in Resident I's clinical chart indicated that the when staff members spoke with him about the other residents' concerns; he began to yell, scream and threaten staff. After several attempts to calm the resident, staff contacted the local police. The record indicated that the police officer was able to decelerate the situation, and Resident I was placed on 15-minute observations for self protection and the protection of others.

Conclusion

Due to the information obtained during the course of the investigation, the allegation that a resident was not allowed to visit with other residents for several days is unsubstantiated. No recommendations are issued.

Allegation 3: A resident was denied privacy in written communication including the right to promptly receive unopened mail. To investigate the allegation, the Coordinator spoke with Resident I. During the site visit at the facility, the Team spoke with the Administrator and the DON. The Authority reviewed copies of information from Resident I's clinical chart, and a facility policy relevant to the allegation. An IDPH Complaint Findings pertinent to the allegation was also reviewed.

Investigation Information

I…Interviews:

A…Resident I:

According to Resident I a package, which was sent to him at the facility from the Veteran's Administration, was intercepted. He stated that he did not know if the medications that were in the package were destroyed or returned to the sender. Resident I informed the Coordinator that when he was admitted to the facility, he documented on a form provided by the facility that he did not want anyone at the facility opening his mail. He stated that the facility admitted to taking the package; however, the contents of the package have not been returned to him.

B…Administrator:

The Administrator informed the Team that Resident I had ordered medications from the Veteran's Administration pharmacy without staff members' knowledge. The Administrator informed the Team that it is the facility's policy when medications come to the facility they are sent to the nurse to "check in". The Administrator stated that the resident was getting the same medications prescribed by the facility physician and given at the facility that he had ordered from

the Veteran's Administration. Due to the duplication, the DON contacted the Veteran's Administration pharmacy to inform pharmacy personnel that the medications would be returned. She stated that prior to returning the medication, Resident I was informed that he could keep the medication in a locked box in his room for later use; however, he refused the offer. The Administrator stated that she and the DON tried to explain the problem with duplication of medication; however, Resident I was not accepting of the explanation.

C…DON:

The DON informed the Team that Resident I received a package from the Veteran's Administration hospital pharmacy at the end of April 2008. The DON stated that anytime mail arrives that appears to be medications or other medical supplies the package is taken to her office for screening. The DON stated that when the package was received, she opened it and found that it contained medications that Resident I was already taking. After examining the package, the DON related that she called the Veteran's Administration hospital pharmacy to let them know that the medications would be returned and sent them through the mail.

The DON affirmed that she had discussed with Resident I on multiple occasions that when new medications were prescribed by a physician at the Veteran's Administration hospital, the prescription could be brought back to the nursing home, approved by the facility physician and ordered though the facility provider. It was explained that this process would prevent duplication problems.

The DON stated that when Resident I was informed that the medication had been returned, he became very angry and accused staff of stealing his medications.

II…Record Review:

As a part of the investigation process for allegation 3, information obtained while investigating the previous two allegations was reviewed.

Admission Agreement (Agreement)…Resident 1:

Documentation indicated that the purpose of the Agreement was listed as follows: "This Agreement is for care and services to be provided to the Resident by the Facility. The Resident hereby authorizes the Facility, his or her attending physician and other providers of medical treatment at the Facility to provide medical care to the Resident as necessary." The facility's policies regarding non-discrimination, authorized representatives, compliance with agency regulations, resident's personal property, restraint-free care, involuntary transfer and discharge policy, release of records, physician and professional services, other medical services, pharmacy services, resident grievance procedure, acknowledgement of resident's rights and responsibilities, advanced directives, mandatory disclosure-identified offender, resident planned absences from the facility, medical emergency or death of resident, notices, mail, and miscellaneous information are outlined in the Agreement.

An area below each policy allows for the signature of the resident or the resident's authorized representative to signify that the individual has read the information and made selections when appropriate. Documentation indicated that the Resident I had read all areas and signed the Agreement on 03/27/06.

Documentation indicated the resident had selected the facility's preferred pharmacy to provide all of his required pharmaceutical services.

In the authorization to have mail opened section of the Agreement, residents are informed of the right to send and promptly receive mail unopened. However, if a resident wishes to have his incoming mail to be opened and (if needed) read to him/her by facility staff, the facility will do so. The resident has the right to revoke authorization to have his/her mail opened at any time upon written notice to the facility. Documentation indicated that Resident indicated by his mark and signature that he did not want the facility to open his mail.

III…Checking in of Medications Policy…(Policy II):

According to Policy II, "When medications are received daily to the facility a licensed nurse must check them in. The nurse will match the ordered medication on the medication administration record (MAR) to the medication received. The nurse will check for the proper drug in the proper dosage. The nurse will also review all new orders to ensure accuracy. Match the telephone doctor's order to the new medication. Any discrepancies must be reported to the Director of Nursing and to the pharmacy. No medications will be stored for administration unless they have been properly checked by the licensed nurse. The licensed nurse will sign off on the accuracy of the medications received daily."

IV…IDPH Complaint Determination Findings (IDPH Findings)

Documentation indicated that when the complaint was investigated on 07/15/08, IDPH cited the facility for failure to deliver unopened mail to one of three residents in the sample of residents interviewed. According to the IDPH Findings, the DON opened a package from a local hospital without the resident's permission and not in his presence. According to the resident's Admission Agreement, he had stated, "I do not want the facility to open my mail."

Summary

According to Resident I, a facility staff member confiscated a package that was sent through the mail after he had informed the facility that he did not want anyone opening his mail. According to the Administrator and the DON, the package was sent to Resident I from a Veteran's Administration hospital pharmacy. When the package was received, it was opened by the DON in order that the medications might be "checked in", in accordance with facility policy. When the DON discovered that the medications were a duplication of the medications that Resident I was receiving at the facility pharmacy, she repacked the medications, and sent them back to the hospital pharmacy. Resident I informed facility staff when he signed the Admission Agreement that he did not want staff to open his mail. Documentation in an IDPH Complaint

Determination Findings indicated that the facility was cited for restricting Resident I's rights to privacy in written communication.

Conclusion

Based on information obtained, the allegation that the resident was denied privacy in written communication including the right to promptly receive unopened mail is substantiated.

Comments and Recommendations:

Although the HRA understands the facility's concern regarding the duplication of medications and the problems associated with a resident having medication in his/her room, the HRA reminds the facility that the Nursing Home Care Act allows for restrictions provided steps are followed in accordance with the Act's requirements. However, the facility failed to follow those requirements. Therefore, the allegation that a resident was denied privacy in written communication including the right to promptly receive unopened mail is substantiated

The following recommendations are issued:

1. Residents should be permitted unimpeded communication by mail. Facility staff should cease opening residents' mail.

2. When restriction of a resident's unimpeded, private and uncensored communication by mail, telephone or visitation is necessary to protect the resident or others from harm, harassment or intimidation, the restriction should be ordered by the facility physician.

3. The reason for the restriction should be documented in the resident's clinical chart.

4. A Restriction of Rights Notice should be given to the resident and/or the resident's authorized representative.

5. Facility staff should review documentation in the Admission Agreement to determine if the resident has requested that his/her be opened by facility staff.

6. All facility policies should be in accordance with the Nursing Home Care Act's pertinent to resident's communication.

The following suggestion is issued:

The facility should consider asking a resident to open a received package in the presence of staff if the facility is concerned about the contents of the package.