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REPORT OF FINDINGS
IMPERIAL OF HAZEL CREST- 10-040-9001
HUMAN RIGHTS AUTHORITY- South Suburban Region

[Case Summary: The Authority substantiated that the recipient was not seen by a physician as required under the law and made corrective recommendations that were accepted by the service provider. The HRA's public record on this case is recorded below; the provider's response is not included in the public record.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA) has completed its investigation into allegations concerning Imperial of Hazel Crest. The 199-bed skilled nursing facility is located in Hazel Crest. According to the complaint, a resident was not routinely seen by the facility's physician. The complaint also stated that the staff opened the resident's mail without his consent. If substantiated, these allegations would be violations of the Illinois Administrative Code (77 Ill. Admin. Code 300.1010), the Centers for Medicare and Medicaid Services, Department of Health and Human Services' (CMS) Requirements for Long Term Care Facilities (42 C.F.R. Part 483) and the Nursing Home Care Act (NHCA) (210 ILCS 45/2- 108 [a]).

METHODOLGY

To investigate the complaint, the Facility Administrator, the Facility Medical Director who is the Attending Physician and the Clinical Director were interviewed. The complaint was discussed with the adult resident who maintains his legal rights. Sections of the resident's record were reviewed with his written consent. Some of the facility's residents were privately interviewed concerning the complaint involving mail. Relevant facility policies were also reviewed.

COMPLAINT STATEMENT

The complaint alleged that the facility's medical physician saw the resident one time, but he billed for more visits. He was subsequently seen by another physician in the community after having a second stroke and told that he should have been taking medication for high cholesterol. But, the facility's physician never prescribed the medication. Additionally, it was reported that the staff opened the resident's medical bills without his consent.

FINDINGS

According to the record, the resident was admitted to the facility on July 18th, 2008 for restorative services. He was transferred from a local hospital after having a major stroke. He was described as alert and did not complain of any pain at intake. His diagnoses included Depression, Cerebral Vascular Hemiplegia, Hypertension, Arthritis and Dysphagia. Aspirin 325 mg daily and as needed (PRN) medications were ordered. He was prescribed a regular diet (no fried food, cheese, gravy, liver or added salt) and skim milk.

An "Authorization to Inspect and Open Official Correspondence" form was signed by the resident on the admission day. The form includes a statement that the resident understands the right to receive personal mail that is unopened. But to avoid lost or misplaced mail, the resident authorizes the facility to inspect, open and remove the contents of the following, and that the person will be informed of issues deemed necessary: Social Security, Pension and Veteran's Administration Checks, Correspondences from the Illinois Department of Human Services and the Illinois Department of Healthcare and Family Services, the Social Security Administration, Medicare and medical bills.

On July 20th, the House Rules, Residents' Rights, and the facility's pass policy were explained to the resident. He was encouraged to attend assigned groups and activities and to discuss all medical concerns with the nursing staff. His grooming and hygiene skills were described as good. According to assessments, on July 21st, the resident told the Physical Therapist that he could perform activities of daily living without assistance. He was able to independently ambulate with a cane but believed that he needed to make more gains in this area. He had received acute inpatient rehabilitation services prior to his intake and had probably reached his maximum potential with skilled services. It was agreed that the resident could continue with certain parts of physical and occupational therapy to maintain his present gains. On July 22nd, a determination was made that speech therapy was not needed.

Documentation indicated that the facility's medical physician named in the complaint provided care to the resident during his stay. His care was also monitored by the facility's psychiatrist and the dietician. According to a nursing note written on July 24th, the resident requested a hot compress and pain medication after a restorative session. His physician was notified, and orders were given. On that next day a physical examination form documented that the resident's blood pressure was 130/70 when examined by the physician. On August 6th, a nursing note stated that the physician was in the building to see the resident. A corresponding physician's note referenced that the resident's blood pressure was very high. On that same day medication records indicated that Hydrochlorothiazide 12.5 mg daily and Lisinopril 20 mg for hypertension were ordered.

A psychiatric evaluation, completed on August 12th, stated that the resident's depression had improved and that he was sleeping better. A form documented that the resident's mother gave consent for Zoloft, a psychotropic medication on the admission day. But, there was no Durable Power of Attorney for Health Care form found in his record. According to physicians' notes, the resident was seen by the medical physician and the psychiatrist on September 2nd and the 23rd respectively. On the 2nd, the medical physician wrote that the resident's vital signs were stable. For September, nursing entries indicated that the medical physician agreed that the

resident could use his personal weight bar as requested. Another note stated the physician did not give any new orders concerning the resident's sore throat. The dietician referenced that the He weighed 173 pounds on August 8th and 183 pounds on September 8th. The dietary note stated that he could continue receiving double food portions at meals. The resident had a 5.8% weight gain in 30 days.

According to progress notes, on October 3rd and November 10th, the medical physician recorded that the resident did not have any new complaints and that his vital signs were stable. On the 10th, the resident's care plan was also explained when he was seen by the physician. On November 19th, the medical physician was informed about the resident's laboratory results, but there were no new orders given. A dietary note stated that the resident weighed 186 pounds in October and that double portions would be limited to breakfast and dinner. His weight was recorded as 194 pounds in November, and the dietician recommended that double food portions should be discontinued at dinner. The medical physician was informed about the resident's nutritional recommendations.

On November 25th, "A Final Incident Report" stated that the facility's Administrator was informed by the Illinois Department of Public Health (IDPH) that the medical physician allegedly had never seen the resident. According to the report, the allegation had been appropriately addressed during the surveyor's visit, but the resident was not satisfied with the outcome. It stated that the physician denied the allegation. The Charge Nurse witnessed the physician accompanying the resident to his room where the August visit took place. Five residents, who had been seen by the physician at least twice, reported no problems with his services. The report documented that the resident was informed that the facility found no evidence to support the allegation. And, he was offered a new medical physician to oversee his care.

Documentation on November 26th stated that the resident requested to review his record and refused the chart when offered on that same day. The resident told the nurse that he would "wait for [the] surveyor." On that same day a care plan meeting was held, and the resident reportedly agreed with his plan. On December 31st, a nurse wrote that the medical physician saw the resident, but there was no corresponding physician's note found in the record.

According to progress notes for 2009, the resident agreed to discontinue excessive snacking because he weighed 200 pounds on January 16th. Three days later, the medical physician was notified that the resident's laboratory results were within the normal limits. Nursing entries documented that the resident did not complain of any pain and went on therapeutic home visits. In March, the resident was seen by the psychiatrist. On April 28th, the facility's administrative staff met with the resident concerning his outstanding balance for his care. He was issued a discharge notice because of non-payment and verbalized an understanding of his rights. A physical examination form, completed on April 29th, indicated that the resident was seen by a new medical physician at the facility. A note indicated that the physician previously assigned was informed that the resident's laboratory results did not show any critical values on that next month.

On June 5th, the resident told the nurse that he was going on a weekend pass. He was reminded that an upper endoscopy exam was scheduled on that next Monday and that the test required prior preparation. He said that he would try to return to the facility on Saturday evening. The next day, the facility received a call from a hospital downstate, and the nurse was informed that the resident was unresponsive. There was no other information concerning the resident's condition found in the record, but the complaint alleged that he had a stroke. On June 9th, the resident's vital signs were within the normal limits upon his return to the facility. Two days later, the resident was strongly encouraged to follow his prescribed diet by the dietician. Physicians' notes indicated that the resident was seen on June 27th, July 5th and August 4th. On June 27th, Simvastatin 20 mg twice daily for cholesterol was ordered. In June, he was also seen by the psychiatrist.

In response to the first complaint, the Administrator said that the resident was referred to the facility for physical therapy. The resident made some progress concerning his mobility and wanted to stay after completing therapy. The staff explained that the medical physician involved in the complaint usually sees residents in their rooms. When the physician started seeing residents at the facility, he was able to see all assigned on the same day because his case load was small. He then started seeing residents on certain days as his case load grew. The physician presently provides care to about 40 residents at the facility, but he does not see them on designated days. The Clinical Director reportedly was not aware that the resident had a stroke during a family visit. The staff said that the resident had unsupervised passes in the community and traveled a great deal with his family.

On questioning, the medical physician reported that he has been practicing for 15 years and never had a complaint. Residents are seen in their rooms or his office. The physician or nurse practitioner always completes a progress note after each visit. He said that caring for patients involves clinical decisions such as what kind of medication is needed. They are not billed according to how much time he spends with them. According to the physician, the resident involved in the complaint did not want to talk to the clinician and changed physicians without notification.

In response to the second complaint, the facility's staff explained that the authorization form to open and inspect official correspondences is reviewed with the resident during the admission process. The facility reportedly has received requests to limit the items on the form, but residents have not rescinded their consents. Some residents have agreed to allow the facility to serves as representative payee, but they want to sign their checks. The facility's clerical staff sorts the mail delivered by the United States Postal Service. Residents can pick up their mail at the front desk or mail will be brought to them. The facility usually does not receive many medical bills because most of the residents' expenses are paid by Medicare and Medicaid.

The Facility Administrator reportedly has not received any complaints from residents about staff opening their mail. The facility's residents interviewed said that censoring of mail is not a problem. The Administrator further explained that one resident was expecting mail but never received it. The resident involved in the complaint showed her a physician's bill and said that he was not going to pay it because the physician only saw him briefly. The HRA was informed that the resident was responsible for paying a portion of his care under Medicaid

eligibility rules because his monthly income consisted of about $300.00 to $700.00 from the Illinois Department of Employment Security. The resident paid maybe a couple of hundred dollars toward his care. He later refused to pay the facility because he allegedly had not been seen by a physician. According to the staff, the complaint was investigated by the Illinois Department of Public Health (IDPH). On September 4th, 2009, the resident was discharged because of non-payment after a hearing with the IDPH.

Imperial of Hazel Crest policy states that the assigned physician shall oversee the resident's total plan of care. The physician is also responsible for conducting required routine visits, delegating and supervising follow up visits from the Nurse Practitioners or Physicians Assistants, etc., to ensure that the resident receives quality care and medical treatments. Physician's visits, frequency of visits, emergent care of residents, etc., are provided in accordance with current federal regulations and the facility's policy. The Administrator told the HRA that although this was not part of the policy, residents must be seen by a physician every 90 days.

According to the facility's resident rights statement # 19, the staff shall not open or read residents' mail. It states that mail will be delivered to residents daily, Monday through Saturday, except on holidays.

CONCLUSION

According to the Illinois Administrative Code Section 300.1010 requirements for skilled and intermediate nursing facilities,

> (c) Every resident shall be under the care of a physician.
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> (d) All residents, or their guardians, shall be permitted their choice of a physician.
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> (e) All residents shall be seen by their physician as often as necessary to assure adequate health care (Medicare and Medicare requires certification visits).

According to CMS' Requirements for Long Term Care Facilities Section 483.40,

> (b) (1) The physician must review the resident's total program of care, including medications and treatment, at each visit required by paragraph (c) of this section.
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> (c) (1) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

According to the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities and Section 45/2-108 (a) of the NHCA, every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or

visitation. The Administrator shall ensure that correspondence is conveniently received and mailed.

Section 483.10 (i) (1) of CMS' Requirements for Long Term Care Facilities guarantees residents the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.

The Authority cannot substantiate that a resident was not routinely seen by the facility's physician involved in the complaint. The resident's record contained progress notes indicating that he was seen monthly by the physician from July through November 2009. A nursing note indicated that the physician saw the resident in December, but there was no corresponding physician note. The physician told the HRA that he always completes a progress note after each visit. An incident report stated that the resident was offered a new medical physician in November because he was not satisfied with his assigned physician. The record does not clearly reflect when the resident chose this option. But, he was seen by a new medical physician in April 2009 and then monthly from June through August. By documentation, the resident was not seen by a medical physician from December 2009 through March 2010. This does not meet the requirements of CMS' Section 483.40 (c) (1).

The complaint that the staff opened the resident's mail without his consent is unsubstantiated. A form documented that the resident gave written consent during the intake process for official correspondences addressed to him to be opened by the staff. Some of the facility's residents told the HRA that privacy in written communications is not a problem at the facility. The Authority finds no violations of the facility's resident rights statement # 19, Residents' Rights for People in Long Term Care Facilities, Section 45/2-108 (a) of the NHCA or CMS' Requirements for Long Term Care Facilities 483.10 (i) (1).

RECOMMENDATION

1. Imperial of Hazel Crest shall follow Section 483.40 (c) (1) of CMS' Requirements for Long Term Care Facilities.

SUGGESTION

1. The facility should document in the residents' records their responses concerning changing physician/psychiatrist.

COMMENT

A form indicated that the resident's mother gave consent for Zoloft, a psychotropic medication. A copy of a Durable Power of Attorney for Health Care form was not found in the record. 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. Imperial of Hazel Crest must obtain residents' informed consents prior to prescribing psychotropic medications in non-emergent situations pursuant to the Section.