FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
BURNHAM HEALTHCARE- 10-040-9024
HUMAN RIGHTS AUTHORITY- South Suburban Region

[Case Summary— The Authority did not substantiate the complaint as presented but found that documentation in one of resident's record did not clearly support that her progress or discharge potential were reviewed as required by law. The public record on this case is recorded below; the provider's response immediately follows the report.]

INTRODUCTION

The Human Rights Authority has completed its investigation into an allegation concerning Burnham Healthcare. According to the complaint, residents are routinely held against their will in regard to discharge. If substantiated, this allegation would violate the Nursing Home Care Act (NHCA) (210 ILCS 45/2-111), the Illinois Administrative Code for Skilled Nursing and Intermediate Care Facilities (77 Ill. Admin. Code 300.3300 [a] and 300.4020 [a]), the Centers for Medicare and Medicaid Services, Department of Health and Human Services' (CMS) Requirements for Long Term Care Facilities (42 C.F.R. 483) and the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/2-102 [a]).

The 309-bed facility located in Burnham reportedly has about 303 residents, and 163 of them have been diagnosed with a serious mental illness.

METHODOLOGY

To investigate the complaint, the Facility Administrator, the Facility Assistant Administrator, the Director of Nursing and the Director of Social Services were interviewed. Sections of resident A, B, C and D's records for 2009 and 2010 were reviewed with guardian consent, as we were unable to obtain a release from the resident named in the complaint. The complaint was discussed with the guardian. Some of the facility's residents were privately interviewed concerning the complaint. Relevant policies were also reviewed.

COMPLAINT STATEMENT

The complaint stated that residents are usually held against their will upon requests for discharge to another facility. One resident allegedly had a letter from a judge permitting her to leave the facility but was petitioned for emergency involuntary hospitalization. She reportedly was not violent or threatening as the petition alleged. It was further reported that the facility's

social services staff have been directed to delete any positive information in residents' records upon their or their significant others' requests for transfer.

FINDINGS

After reviewing all four residents' records, the Authority determined that resident A, B and C were still living at the facility when the complaint investigation was opened in 2010. Included in their records was a typed statement that discharge planning is done at the guardian's request. There were no discharge requests found in any of the records reviewed.

Resident A's record indicated that she was admitted to the facility on September 13th, 2007. She was diagnosed with Seizure Disorder, Anxiety Disorder, Renal Failure, Chronic Obstructive Pulmonary Disease and Hypertension. She attends dialysis three times a week, and she is dependent on a wheelchair. A "Discharge Potential and Assessment, Review and Plan" form stated that the resident's length of stay could not be determined and that her discharge potential was poor. All of the reasons warranting a nursing home placement on the form were checked. She was hospitalized many times during her stay at the facility. There was no written indication regarding her discharge potential for 2009. Documentation on February 23rd, 2010 stated that the resident was able to follow simple instructions but relied on the staff for total care. On May 17th, social services wrote that the guardian was aware that there were no discharge plans at the time. On August 17th, the guardian was informed that the resident's discharge potential was poor because of her medical and psychiatric condition. There was no mention of the guardian's response to this.

Resident B's record documented that he was initially admitted to the facility on March 25th, 1987 and was readmitted from a hospital on October 1st, 2008. He was diagnosed with Paranoid Schizophrenia, Seizure Disorder, Congestive Heart Failure, Hypertension, Gastritis and Hearing Impairment. According to the assessment form, the resident's length of stay at the facility could not be determined, and his discharge potential was poor. A nursing home placement was needed because of non-compliancy with mental health treatment and lack of a support system that could provide care. His potential for discharge was reassessed on December 31st, 2008, March 30th, July 1st, September 24th and December 24th, 2009, March 24th and June 24th, 2010. And, it was determined that the resident was not appropriate for discharge because of his needs. The guardian's response concerning this issue was not evident in the record.

Resident C's record indicated that he was admitted to the facility on January 13th, 2007. He was diagnosed with Schizoaffective Disorder, Osteoarthritis and Chronic Kidney Disease. It was recorded that he ambulates in a wheelchair. The resident's anticipated length of stay was longer than 90 days, and his discharge potential was poor. A nursing home placement was needed because of recurring patterns of instability characterized by frequent hospitalizations. On January 20th, April 29th, July 29th, October 21st, 2009, January 21st and April 27th 2010, documentation indicated there were no discharge plans pending because of his needs. There was no indication of the guardian's response to this.

Resident D's record documented that she was admitted to the facility on February 6th, 2009 and was readmitted many times post-hospitalization. She was diagnosed with Schizoaffective Disorder, Seizure Disorder and a Compromised Immune System. Her length of

stay at the facility could not be determined, and her discharge potential was poor. Her record included many incidents of inappropriate behaviors such as physical aggression toward others. On September 5th, the resident's guardian was informed that another living arrangement might be needed because of aggression and non-compliancy with treatment. Social services then wrote that the resident was not appropriate for discharge because of her behaviors and needs on the following month. Progress notes detailed the facility's efforts to find another placement with the guardian's involvement after an ultrasound determined that the resident was nine weeks pregnant on January 11th. On February 4th, the guardian was informed that the facility could no longer meet the resident's needs. A 30-day discharge notice was faxed to the guardian and the Illinois Department of Public Health on that same day. She was transferred to another agency on February 18th.

Burnham Healthcare administration told the HRA that residents are invited to their quarterly staffings but many of them do not attend the meeting. All deficiencies are addressed in residents' care plans, and assessments are completed by the assigned social worker. Residents are assessed for discharge through the "Discharge Readiness Form" within 14 days of intake and during quarterly care planning meetings. According to the staff and the facility's form, residents must find their apartments, develop a budget and identify personal support in the community. They must be linked with psychiatric care in the community. The facility's policy further directs the staff to provide assistance with continuity of care. The Facility Administrator added that residents do not have to complete the readiness assessment form if they can verbalize a discharge plan. He said that some residents have problems with reading and writing. According to the staff, the guardian is informed about discharge planning information. The Director of Social Services said that Resident D's guardian had requested a transfer prior to her inappropriate behaviors, but there was no facility willing to accept her.

According to the Director of Social Services, the facility has eight social workers who are responsible for overseeing the discharge planning process. Residents are directed to social services concerning discharge. The facility does not have a form that lists the documents sent to the receiving intake worker. They reported that the referral packet includes the following information: face sheet, history and physical, medical, nursing and social services notes. The staff interviewed denied that positive information is deleted from residents' records upon requests for transfer. They said that the discharge protocol that includes Leaving Against Medical Advice (AMA) is found in the "Residents' Rights." Subsequent to the site visit, a copy of the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities was provided to the HRA by the facility. The AMA discharge option is not mentioned in these rights.

According to the staff, two of the facility's residents were discharged to another agency in 2009. They said that the receiving agency usually wants to talk to the assigned psychiatrist or see the resident a couple of times before accepting the person. The HRA was informed that thirty residents were transferred to other facilities between January and April of 2010. Twenty-two residents reportedly were discharged AMA during that same timeframe. At least twenty residents were interviewed for a new community reintegration program called "The Money Follows the Person" (MFP) but only two of them were accepted. According to the staff, residents with a history of substance abuse and safety concerns related to smoking cigarettes are

not eligible for the MFP program. They said that sometimes residents are asked to submit to a urine drug screening to qualify for the new program.

Burnham Healthcare reportedly has about four residents who want to return home upon their discharge from the facility. A physician's order is needed for a successful discharge. The HRA was informed that grievances are tracked in a log book. Residents are instructed to fill out a form or the social worker will assist them in completing the form, if needed. According to the Director of Social Services, residents usually file grievances about food and property but rarely about discharge. There were no grievances found in the residents' records reviewed by the HRA.

When the complaint was discussed with the facility's residents, eight of them expressed satisfaction with living at the nursing home. One resident told the HRA that he would like to live independently but has not discussed this issue with his social worker. One resident alleged that he agreed to the nursing home placement because his physician said that his Social Security benefits would be discontinued if he did not agree. Another resident said that he was interviewed for an independent living arrangement last year, but he was not accepted by the program.

Burnham Healthcare "Discharge Planning and Resident Transfer" policy states that each resident's potential for discharge will be assessed upon admission. A discharge plan will be developed by the interdisciplinary team (IDT) as a component of the comprehensive care plan. The resident, legal guardian or family members will be involved in the discharge planning process, if appropriate. The policy documents the importance of open communication between the resident, responsible party and the health care team to ensure planning flows smoothly and services are not duplicated. According to the policy, the social service staff, as directed by the social work consultant (as appropriate) will oversee the discharge planning process. This includes making certain that all necessary assessments/evaluations are completed in a timely manner. When a resident requests to be discharged, social services will determine the reasons for transfer to another setting. If the issue can be resolved to enable the resident to remain comfortable in his or her current setting this will be pursued. If the resident still wants to be discharged, the appropriate consent forms will be requested so that information may be shared with the desired facility by email or fax. A physician's order will be requested for transfer as appropriate. The staff will help the resident to prepare for the pending transfer that will be arranged within reasonable time lines depending on the response from the receiving facility.

According to the facility's grievance policy, its administration will make every effort to promptly resolve any complaint, concern or grievance brought to the staff's attention. A grievance or complaint may be given to any staff member. If the grievance is not resolved to the complainant's satisfaction, it should be submitted to the facility's Social Services Department and will be given to the Administrator. All original grievances will be kept in the Administrator's office. The facility respects each person's right to file a complaint or grievance without fear, reprisal or discrimination.

CONCLUSION

According to Sections 45/2-111 of the Act and 300.3300 (a) of the Administrative Code,

> A resident may be discharged from a facility after he gives the administrator, a physician, or a nurse of the facility written notice of his desire to be discharged. If a guardian has been appointed for a resident or if the resident is a minor, the resident shall be discharged upon written consent of his guardian.

Under Section 300.4020 (a) of the Administrative Code, at least every three months, the facility shall document review of the resident's progress, assessments and treatment plans.

Section 483.20 (b) (1) (xvi) states that the facility must conduct, initially and periodically, a comprehensive assessment of each resident's functional capacity. The assessment must include discharge potential.

According to Section 5/2-102 (a) of the Mental Health and Developmental Disabilities Code,

> Services shall be provided in the least restrictive environment, pursuant to an individual services plan…. In determining whether services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided.

The Authority does not substantiate the complaint that residents are routinely held against their will in regard to discharge. Resident A, B, C and D's records lacked written indication that the guardian requested discharge. Resident D was discharged to an agency that provides services for pregnant clients with her guardian's approval. All four residents' records reviewed lacked documentation of any grievances. The facility's residents interviewed did not report any problems regarding the right to request discharge. The staff reported that fifty two residents were either transferred or had left the facility AMA in early 2010. They also denied that positive information is deleted from residents' records upon transfer requests. No violations of Sections 45/2-111 of the Act, 300.3300 (a) of the 77 Administrative Code, 5/2-102 (a) of the Code or the facility's policies were found.

The Authority finds violations of Sections 300.4020 (a) of the Illinois 77 Administrative Code and CMS' Requirements for Long Term Care Facilities 483.20 (b) (1) (xvi), only in regard to Resident A because there was no documentation that her progress or discharge potential was reviewed in 2009.

RECOMMENDATIONS

1. Follow Section 300.4020 (a) of the Illinois 77 Administrative Code and document reviews of all residents' progress at least every three months.

2. Ensure that each resident's potential for discharge is assessed pursuant to Section 483.20 (b) (1) (xvi) of CMS' Requirements for Long Term Care Facilities.

SUGGESTIONS

1. Include discharge options such as leaving AMA in the facility's Discharge Planning and Resident Transfer policy.

2. Document in the record the resident or guardian's input concerning discharge planning.

COMMENT

One resident allegedly had a letter from a judge permitting her to leave the facility but was petitioned for emergency involuntary hospitalization. She reportedly was not violent or threatening as alleged in the petition. Although the HRA did not receive a signed release to specifically investigate the complaint, the allegation must be taken seriously. While Burnham Healthcare may have been justified in seeking treatment for the resident, the Authority reminds the facility that a person’s right to self-determination and the right to move about freely absent dangerousness are to be respected, particularly for those who remain legally competent.

RESPONSE

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

BURNHAM HEALTHCARE
14500 SOUTH MANISTEE AVE
BURNHAM, ILLINOIS 60633
708-862-1260

June 23, 2011

Judith Rauls, Chariperson
Regional Human Rights Authority
West Suburban Regional Office
P.O. Box 7009
Hines, Illinois 60141-7009

Dear Ms. Rauls:

Based on the recommendations of the Human Rights Authority-South Suburban Region, Burnham Healthcare has the following response:

The interdisciplinary team will review the progress of each resident at least every three months through the care plan meeting process. Residents who have a significant change in condition will be evaluated more frequently, as needed. This review will include the resident potential for discharge.
The Social Services director will review any resident request for discharge in order to evaluate their discharge potential.
We will include all discharge options, including leaving AMA, in the facility's Discharge Planning and Resident Transfer Policy.

Sincerely,

Nancy Given, Administrator
Burnham Healthcare

BURNHAM HEALTHCARE
14500 SOUTH MANISTEE AVE
BURNHAM, ILLINOIS 60633
708-862-1260

September 22, 2011

Judith Rauls, Chairperson
Regional Human Rights Authority
West Suburban Regional Office
P.O. Box 7009
Hines, Illinois 60141-7009

Dear Ms. Rauls:

Enclosed please find the Discharge Planning and Resident Transfer policy as well as our policy on voluntary discharges. I have also enclosed the training sheet on the policy.

If you have any questions, please contact me at the above number.

Sincerely,

Nancy Given, Administrator
Burnham Healthcare