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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 10-090-9031
Timber Creek Rehab and Healthcare Center

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at the Timber Creek Rehab and Healthcare Center. The complaints alleged the following:

1. A hearing aid was broken by staff and the provider is denying responsibility.
2. The facility provides inadequate care including the resident's room not being cleaned, resident's bedside toilet was not cleaned, resident was left on the toilet for twenty minutes without assistance, and resident's diabetic diet was not followed by staff.
3. The facility staff do not protect the resident's dignity. Examples include, a staff person being verbally rude to a resident and staff using words like diapers.
4. The family was not being made aware of all costs by the nursing home or what products were being used by the nursing home.

If found substantiated, the allegations would violate the Nursing Home Care Act (210 ILCS 45), the Skilled Nursing and Intermediate Care Facilities regulations (77 Illinois Administrative Code 300), and federal Medicare/Medicaid mandates (42 C.F.R. 483.10) with regards to patient personal property, patient treatment and facility contracts.

Timber Creek Rehab and Healthcare Center is a 150-bed facility that serves the Pekin, Peoria, Morton, and Tremont area, as well as other areas of Illinois, Indiana, and Iowa. Timber Creek has between 115 and 120 people on staff with Certified Nursing Assistants (CNAs) and Registered Nurses (RN) who work 1st, 2nd, and 3rd shifts. They also have a housekeeping and janitorial staff on site. Timber Creek is licensed with the Department of Public Health and has a Veteran's Administration contract.

According to reviewed medical records and the Timber Creek Administrator, the resident in this complaint was an elderly woman with a diagnosis that includes dementia, glaucoma, hypothyroidism, diabetes, and hearing loss. The resident was admitted to Timber Creek on 3/10/2010 and was discharged to home and hospice services on 6/10/2010. The patient passed away at home on 6/15/2010.

The HRA met and interviewed Timber Creek's Administrator and reviewed documents such as grievances, diet plans, and property policies. All records were reviewed with the written consent of the agent identified in the resident's Power of Attorney.

COMPLAINT STATEMENT

The complaint alleges that the staff took the patient into the bathroom where the staff member took out the patient's hearing aid and broke it. The complainant states that a family member took the hearing aid to a hearing aid specialist who said the aid looked like it was "stepped on or run over." Allegedly, Timber Creek stated that they are not responsible for the hearing aid and will not replace it. The complaint also states that the patient's bedside commode was not cleaned and it looked as though the room had not been cleaned in a week. The complaint also alleges that the patient was assisted onto a bedside commode and, when she was finished using the commode, she turned her light on and waited 20 minutes for a staff member before she was taken off the commode by a family member. The complaint also alleges a CNA was verbally rude with the patient when the patient asked the CNA to use the restroom and the resident was turned in for the behavior. The complainant was reportedly told by an administrator that, since there was no witness, and it was the patient's word against the CNA's, there was nothing that could be done. The complaint also alleges that, upon admittance, the facility was informed of the patient's diabetic diet, but then it was discovered that she was given 6 glazed donuts in one day. After the complainant brought the incident to the staff's attention, the staff reviewed the patient's records and realized that she was on a diabetic diet. Since then, the staff have followed the diabetic diet. The complaint also alleges that the patient's family was told that the patient had to start wearing incontinence protection and that the protection items would be furnished by the nursing home, but the family was not informed that they had to pay for the incontinence protection. The family was also not informed of the type of incontinence protection that was used. The complaint also alleges that the staff use the term "diapers" and the complainant feels that the term is demeaning towards the patients.

FINDINGS

Interview with Administrator

The HRA began its investigation by interviewing Timber Creek's Administrator. The Administrator verified that the hearing aid had been broken by a Timber Creek staff member. He stated that the staff member and the resident were in the shower area and the hearing aid was sitting on a ledge. He said the staff member went to pick up the hearing aid, dropped it, and then accidentally stepped on the hearing aid. The Administrator said that the staff member reported the incident to the Administrator. The Administrator contacted the resident's family members regarding the incident and told them that, even though Timber Creek is not obligated to pay for the hearing aid, as stated in their facility contract with the family members, they would be willing to discuss replacing the aid if they were provided a quote for the hearing aid. The administrator said that even though the facility is not liable for the broken items, they take situations like these on a case-by-case basis and often they will replace the item. The Administrator stated that he repeatedly asked for the quote from the family but did not receive a

quote until after the resident was deceased. The family members told the Administrator that they would still like the money for the hearing aid or possibly replacement hearing aids for them. The Administrator also stated that he was unsure as to whether or not the resident had a replacement hearing aid during the time the aid was broken and her death, which was the period of a month.

When asked about the personal property policy, the Administrator stated that the facility does not take responsibility for personal property and it is not policy to make an inventory list for the family to sign. The Administrator stated that property is sometimes inventoried but they leave the responsibility of marking the property to the family members. The Administrator stated that when the property is inventoried, he is unsure as to how accurate the inventory is because families bring items into the facility without telling anyone. He said that when a resident is coming from home, the property is inventoried more than if someone is coming from a hospital. The Administrator stated that when a resident comes from a hospital, the family slowly brings in items and they do not usually get inventoried. The Administrator also stated that they encourage the residents to not have expensive personal property within the facility because of the temptation of theft. The Administrator did state that the facility has two safes in which residents can put personal property in. The Administrator also stated that they do have an etcher that can mark items like hearing aids but he was unsure as to whether the resident's hearing aid was marked.

The Administrator also stated that the facility does have an inventory sheet that can be filled out but it is not policy for the facility to keep a list of the resident's property. The administrator also stated that if there are lost, broken, or stolen items, the residents complete a grievance form regarding the items and the facility will investigate the grievance.

In response to the complaint regarding inadequate care of the resident, the Administrator explained that Timber Creek has a full-time cleaning crew on staff that covers the facility 24 hours a day, 7 days a week. He stated that when a patient has a bedside commode; it is the job of the CNA to clean the commode after its use. He said that he did not know of an instance regarding the commode not being cleaned and he could not think of any situation where the bowl should not be cleaned right away. The Administrator said he is a stickler for cleaning within the facility and the rooms are cleaned everyday. The Administrator went on to say that he did not know of a situation where there was a grievance regarding that particular resident's commode being left unclean. With regard to the call light, the Administrator stated that he explained to the resident's family that the CNAs could have been assisting with dinner at that time which could have been the cause for the slow response time. The Administrator stated that he spoke with the CNA Supervisor regarding the incident and they ran 4 audits on the call light response time and the response time was very good. The Administrator also stated that, knowing the resident, she would not be sitting in one spot for 20 minutes at a time and she would have gotten off the commode by herself if it would have taken 20 minutes. The Administrator also stated that he did not know of a grievance where the resident was left on the commode, only one where she needed to use the commode.

In regard to the patient's diabetic diet not being followed, the Administrator stated that they knew that the patient was diabetic when she was admitted. He stated that the complaint that he received did not deal with donuts but rather the resident receiving pie. The Administrator

went on to explain that each resident is put into a specific diet category and this specific resident was placed into limited concentrated sweets diet category which is where they would place the diabetic patients. This diet gets smaller portions of sugar and sweets. He stated that this categorized diet plan, and the menu for the facility, is approved by a registered dietician and a dietary manager. He also stated that after the family brought up the complaint regarding the pie, they put the resident on a no sweets diet and only served fruit as a desert. He reported that he did not know of a situation where the resident got 6 donuts in a day but did mention that a church group did bring in donuts weekly and there is a possibility that she could have obtained donuts from the church group.

The Administrator went on to say that that all CNAs attend a mandatory in-service once a month, on the first pay day of the month, as well as a state mandated in-service on the 25th of the month. He also reported that there is a monthly optional in-service for the staff members. He indicated that the CNAs at the facility have been around, on average, for 2 ½ to 3 years.

In regard to the complaint about the staff being rude to patients and using terms like "diapers" to describe incontinence products, the Administrator stated that they did receive a grievance from the resident regarding a staff member telling her that she would need to wait to use the restroom. The Administrator did an internal investigation regarding the matter as well as reporting the incident to the Illinois Department of Public Health. The Administrator stated that no evidence was found to substantiate the resident's story but they did re-educate the staff during an in-service. The Administrator also said that he received a grievance regarding the use of the term "diaper" from the resident's family. He asked if they knew specifically who used the term and the family could not provide a name. The Administrator stated that he brought the issue up to the CNA supervisor who stated that she shadowed the CNAs in walking rounds to see if any were using the term and would also bring up the issue at the next in-service with the staff. During the in-service, the staff were to be told to use the terms "Incontinent Products" to describe the garments.

In regard to the complaint that Timber Creek did not make the family aware that they would have to pay for incontinence products for the resident, the Administrator stated that incontinence products are supplied by the nursing home and this fact is in the facility contract. The Administrator did state that the nursing home only supplies incontinence products that use tape but the family wanted the pull-up brand products. The Administrator informed them that if they wanted the resident to use the pull-up style of incontinence product, then they would have to buy them and bring them to the facility because they only provide the one style of product. The Administrator also stated that if there was a specific reason that they needed to provide that style of product for the resident, then they would accommodate but, in this case, the reason was only personal preference. The Administrator explained that what the facility covers is in the facility contract that is signed by the resident or family member when being admitted into the facility. The Administrator also stated that the Social Service Director believes to have had a partial conversation with the family upon admission regarding the incontinent products being provided.

The Administrator also stated that the facility has a grievance policy that covers any complaints regarding loss of property. He indicated that anyone can make a complaint, then that complaint will be passed along to the Administrator or Social Services. The Administrator or

Social Services will complete a grievance form and begin an investigation. When the investigation is completed, the findings are verbally communicated to the complainant. He went on to say that the grievance policy and rights are given to the patient upon admission on a form that they must sign.

Tour of the facility

The Administrator took the HRA on a tour of the facility. He stated that there are separate halls that form a U-shape. While touring one of the halls, the HRA and the Administrator walked into the dining room area where a church group was handing out donuts to the residents. While the donuts were being handed out, there were staff members within the group of residents but the church group members were handing out the donuts. The Administrator took the HRA down the hall and into a resident's room. The hallways and rooms appeared clean. The Administrator also showed the HRA where the separate diet cards were kept in the facility's kitchen. He went on to explain that each resident had a separate card with his/her diet plan and any specific dietary needs.

Record and Policies Review

With consent, the HRA reviewed documents pertaining to the complaints voiced in this case. In regard to the complaint that the staff person broke the patient's hearing aid, the HRA reviewed the facility's policy regarding personal property, the documented complaint, a quote for repairing the hearing aid, and personal notes taken by the facility's administrator. The document titled "Contract Between Resident and Timber Creek Rehab and Health Care" states, in a section titled "Resident Personal Property" that "The Facility shall provide a means of safeguarding small items of value for the Resident and the Resident may have daily access to such items. Any Resident who wishes to have a small item of value safeguarded by the facility must deliver the item to the Administrator. However, except for small items of value physically delivered to the Administrator for safeguarding, the Facility shall not be responsible for the loss, theft or destruction of any Resident's personal property." The form titled "Petersen Health Care Grievance/Complaint Report" (Dated 5/11/10) reads in the "Describe Details of Grievance or Complaint" section that "Hearing aid broken while in shower room. Aid slipped off shelf and broke." The "Method of Correction or Disposition of Complaint" reads "Notified daughter [daughter's name] - she will pick-up hearing aid today - take it to be fixed. CNA Coordinator will ask CNAs to leave hearing aid in resident room instead of shower room." The HRA was also given a photocopy of the envelope that contained an estimate for repairing the hearing aid which was postmarked 6/18/2010. The HRA also reviewed a note written on 6/21/2010 by the Administrator, which was 6 days after the patient's death on 6/15/2010 that states "[Agent of Power of Attorney's Name] wanted hearing aids to still be replaced even though the resident had been deceased. Said she would like the money or maybe she could use the hearing aid herself. Told her I was unsure, but that I would check with my boss and get back with her." In summation, the estimate for the hearing aid was received by Timber Creek one month and seven days after the aid was broken and three days after the resident's death.

The HRA also reviewed a masked copy of a resident's inventory sheet as well as a blank inventory sheet. The sheets have a section for the inventory of articles, items of a specific value,

items stored in facility/community safe, and items acquired after original entry. There are areas that could be signed and dated by a resident or responsible party and the staff member who completed the inventory.

In regard to the complaint that the facility provides inadequate care, the HRA reviewed the facility's diet plan and menus for the date of 5/10/2010. The meals are broken into 7 different categories which are Regular/NAS, Pureed, Mechanical Soft, Finger Food, Limited Concentrated Sweets, High Calorie/High Protein, and Pureed High Calorie/High Protein. This dietary menu is approved by a dietary manager. The Limited Concentrated Sweets diet is the plan that the resident was on with an addendum that she get no sweets per the family. The HRA also reviewed a housekeeping daily duties checklist that is to be signed and dated by the individual who cleaned the rooms. The rooms are labeled on the sheet by type of room (ex. Front Office, Public Restrooms) and then by room number (ex. 101, 102, 103). The HRA also reviewed an internal grievance form that reads "[Resident's Daughter] came up to me started yelling at me about that she got a piece of pie the other day. That she is not to have any sweets whats so ever [sic]." Also on the grievance sheet it reads "Administrator contacted daughter. Explained that LCS residents get smaller portions, but she demanded no sweets. She agreed to the Diet Supervisor putting 'Fruit for dessert/no sweets' on card." The HRA also reviewed the resident's "Physician's Orders" which state, under the "Diet Orders" section of the document, that the resident is to be on the "LCS" diet.

The HRA also reviewed a grievance complaint form regarding the resident turning on a call light to use the restroom and waiting for 20 minutes before a staff person arrived. The "Method of Correction or Disposition of Complaint" states that "Administrator spoke with CNA Supervisor [Supervisor's Name]. Both of them did random audits on each hall to test call light response time. Call light response time was very good from all CNAs. Will continue to stress importance during in-services with CNAs." The call light response audit sheet states that in room 401, they called at 12:35PM and a CNA responded at 12:37PM, in room C208, they called at 12:32PM and a CNA responded at 12:34PM, in room B209, they called at 12:15PM and the CNA responded at 12:18PM, and in room B305 they called at 11:40AM and a CNA responded at 11:42AM.

The HRA also reviewed the general structure of the Grievance/Complaint form. Each form has specific sections that state "Describe Details of Grievance or Complaint," "Method of Correction or Disposition of Complaint," and "Comments." The form also has areas for the resident's name, date of complaint, who received the complaint and a date when the Administrator received the complaint. There is also a section at the bottom of the page stating "Communication to Complainant" and the date. On all reviewed grievances, the "Communication to Complainant" date matches the date at the top of the page when the complaint was logged. Also, on each document, the grievance process is handwritten into the blanks on each section. The HRA also reviewed a document titled "Resident Grievances/Complaints" that was provided by Timber Creek. The document lays out the grievance process of the facility and the document begins by stating "It is the policy of Petersen Health Care to actively encourage residents and their representatives to voice grievances and complaints on behalf of themselves or others without discrimination or reprisal." Also, the sixth step of the grievance process states "The Investigator shall notify the Resident and document the

results of the investigation and notification on the grievance/complaint form. The Social Service Director is responsible to notify the family and resident representative of the resolution."

Regarding the complaint that the Timber Creek staff does not protect the resident's dignity, the HRA reviewed an in-house investigation regarding the resident being told that she had to wait to go to the bathroom. The resident stated that a red-headed woman had told her that she would have to wait to use the restroom. The report states that they informed the Administrator who asked that they fill out a grievance report and then continue to look into the situation. The report then states that the resident said that it was a male nurse who told her she would have to wait. The writer of the report goes on to interview staff members about the possible incident and also calls the resident's family members regarding the incident. No staff member stated that they had an incident with the resident regarding the bathroom. The writer tested the resident's hearing to see if she could have possibly misheard the situation and reports that the patient does have a hard time hearing conversation at various decibels. The investigation did not have a statement regarding any substantiated or unsubstantiated complaints.

The HRA also reviewed an internal grievance regarding the staff using the term "diapers" to describe incontinence products. The grievance states that "family stated they were mad that a CNA was calling incontinence products diapers. Administrator asked who this person was, but family was unaware of the first name and could not give a description. Administrator apologized and informed them that using that term was not common in the facility … Ask if family had heard it but no - resident had told them." In the "Method of Correction or Disposition of Complaint" section it reads "[CNA Supervisor] instructed to do weekly rounds with CNAs on the floor and address at next CNA in-service."

In regard to the complaint that states the facility does not make the resident's/family aware of expenses, the HRA reviewed the "Contract Between Resident and Timber Creek Rehab & Health Care." The form does not specifically state that the facility provides or does not provide incontinence products but, upon questioning the administrator via email, it was pointed out that the there is a section titled "Basic Services and Costs" that gives the patient's base rate and goes on to read "This base rate shall include the following items and services." The items and services on the list are: room, food, nursing care - 24 hrs./day, social service, activity programs, housekeeping, laundry, pharmaceutical consultation, dietetics consultation, medical consultation, and other." The Administrator stated that incontinence products would fall under the category of "nursing care - 24hrs/day."

The HRA also reviewed the resident's physician's orders, which has written, under the "Diet Orders" heading, LCS which is an acronym for the Limited Concentrated Sweets diet that she was on while in the facility.

MANDATES

The HRA researched state and federal mandates in accordance with the complaints raised within this report. In regard to the complaint concerning the staff breaking the resident's hearing aid, the Skilled Nursing and Intermediate Care Facilities Code states "The facility shall provide a means of safeguarding small items of value for its residents in their rooms or in any other part of

the facility so long as the residents have daily access to such valuables" (77 Il. Admin. Code 300.3210 e) and that "The facility shall make reasonable efforts to prevent loss and theft of the residents' property. Those efforts shall be appropriate to the particular facility and may, for example, include, but are not limited to, staff training and monitoring, labeling property, and frequent property inventories" (77 Il. Admin. Code 300.3210 f). The Code also states that "The facility shall develop procedures for investigating complaints concerning theft of residents' property and shall promptly investigate all such complaints" (77 Il. Admin. Code 300.3210 g).

The HRA also reviewed the Nursing Home Care Act regarding policies, procedures, and grievances. The Act states "A facility shall establish written policies and procedures to implement the responsibilities and rights provided in this Article. The policies shall include the procedure for the investigation and resolution of resident complaints as set forth under Section 3-702. The policies and procedures shall be clear and unambiguous and shall be available for inspection by any person. A summary of the policies and procedures, printed in not less than 12 point type, shall be distributed to each resident and representative" (210 ILCS 45/2-210).

In regard to the complaint that the client received inadequate care including the room not being cleaned, the commode not being cleaned, the client being left on the toilet for twenty minutes, the resident's diabetic diet not being followed, and the staff being rude to the resident and using the term "diapers," the HRA reviewed the Nursing Home Care Act which states "An owner, licensee, administrator, employee or agent of the facility shall not abuse or neglect a resident. It is the duty of any facility employee or agent who becomes aware of such abuse or neglect to report it as provided in 'The Abused and Neglected Long Term Care Facility Residents Reporting Act'" (210 ILCS 45/2-107). The Skilled Nursing and Intermediate Care Facilities Code also states "The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident" (77 Il. Admin. Code 300.1210 a). The Code also states "All treatments and procedures shall be administered as ordered by the physician" (77 Il. Admin. Code 300.1210 1) and "Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered" (77 Il. Admin. Code 300.2040). The Code also states "Every facility shall have an effective plan for housekeeping including sufficient staff, appropriate equipment, and adequate supplies. Each facility shall: Keep the building in a clean, safe, and orderly condition. This includes all rooms, corridors, attics, basements, and storage areas" (77 Il. Admin. Code 300.2220).

In regard to the complaint that the family was not made aware of all costs by the nursing home, the HRA reviewed the Skilled Nursing and Intermediate Care Facilities Code which states "Before a person is admitted to a faculty, or at the expiration of the period of previous contract, or when the source of the payment for the resident's care changes from private to public funds or from public to private funds, a written contract shall be executed between a licensee and the following in order of priority" and also that "The contract shall specify the services to be provided under the contract and the charges for the services. A paragraph shall itemize the services and products to be provided by the facility and express the costs of the itemized services and products to be provided either in terms of a daily, weekly, monthly or yearly rate, or in terms

of a single fee" (77 Il. Admin. Code 300.630 m). Also, the Medicare/Medicaid requirements state that a facility must "(i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of-- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services" (42 C.F.R. § 483.10 i A B).

CONCLUSION

Complaint #1: Hearing aid was broken by staff and the provider is denying responsibility.

The complaint states that a resident's hearing aid was broken by a staff member and the provider is denying responsibility for breaking the hearing aid. In our interview with the Administrator, it was stated that Timber Creek does accept responsibility for breaking the hearing aid but are not obligated to pay for the aid (which is documented in their contract with the resident). The Administrator did state that they asked for a quote for the hearing aid. The Administrator did not receive the quote until the resident was deceased. The HRA did not find any requirements stating that a nursing home facility is liable for damages to a resident's personal property. The Administrator of the nursing home also stated that personal property brought into the nursing home is not always inventoried and that they discourage resident's from bringing in expensive items for fear of theft (although they do still bring in expensive items at times). The Administrator also states that they ask the family members to label any property that is brought into the facility. The Skilled Nursing and Intermediate Care Facilities Code states that "A resident shall be permitted to retain and use or wear his personal property in his immediate living quarters, unless deemed medically inappropriate by a physician and so documented in the resident's clinical record" (77 Il. Admin. Code 300.3210 b) and that "The facility shall provide a means of safeguarding small items of value for its residents in their rooms or in any other part of the facility so long as the residents have daily access to such valuables" (77 Il. Admin. Code 300.3210 e). The Code also states that "The facility shall make reasonable efforts to prevent loss and theft of residents' property. Those efforts shall be appropriate to the particular facility and may, for example, include, but are not limited to, staff training and monitoring, labeling property, and frequent property inventories" (77 Il. Admin. Code 300.3210 f). The HRA finds the complaint that the hearing aid was broken by the staff and the provider is denying responsibility **unsubstantiated** due to the fact that the facility has admitted to breaking the hearing aid and has documented that they asked for a quote to replace the aid, which was not a violation of the resident's rights. However, the resident passed away prior to the reception of the quote and the regulations do not specify reimbursement.

Although the HRA does not substantiate the hearing aid complaint, it does identify a violation with regard to the Code's requirement that "the facility shall make reasonable efforts to prevent loss...." Family members are required to mark clothing and the facility does not consistently utilize an inventory system. There does not seem to be a clear and consistent means of preventing loss, only a means to file a grievance after a loss has occurred. The HRA strongly makes the following **suggestions**:

- The facility has chosen to implement an inventory system as a means of preventing loss and theft of a residents' property but is not diligent in the use of their chosen system. The HRA suggests that the facility utilize and update this system to include **each resident in the facility** as a means to safeguard and prevent loss of the resident's personal property.
- Although it is not a violation to discourage residents to have expensive personal property in the facility, the HRA feels it is important to communicate to each resident and their guardian/family that it is their final decision on what property is brought into the facility. The HRA suggests that there is documentation created to ensure that each resident and family member are educated and aware of these facts.

Complaint #2: The facility provides inadequate care including the resident's room not being cleaned, resident's bedside toilet was not cleaned, resident was left on toilet for twenty minutes without assistance, and resident's diabetic diet was not followed by staff.

The complaint states that the resident was receiving inadequate care at the facility and examples provided were the resident's room not being cleaned, the resident's bedside toilet was not cleaned, the resident was left on the toilet for twenty minutes after alerting the CNAs by turning on the call light, and that the resident was seen eating donuts, which does not follow the resident's diabetic diet. The Administrator stated that they have a full-time cleaning crew and the HRA toured the facility and saw that there were no cleanliness issues at the time of the HRA's visit. Also the facility reportedly ran audits regarding response time to call lights and each response was within 2 to 3 minutes. The HRA also reviewed the diet menu and the patient's physician's orders which stated that she was to be on the LCS diet at the facility. The HRA finds the complaint that the resident received inadequate care to be **unsubstantiated** due to the fact that no evidence was found substantiating the complaints, but offers the following **suggestion**:

- During the tour of the facility, the church group that the Administer spoke about in the interview was giving donuts to the resident's and, although there were staff present, due to the amount of resident's and the fact that members of the church group were handing the donuts to the residents rather than the staff, the HRA could see how the resident in the complaint could get a donut; either inadvertently from a church group member or from another resident. The HRA suggests that measures be taken to ensure that there is some form of monitoring with regard to visiting group bringing in the food.
- Periodically check call light response times as part of quality assurance activities.

Complaint #3: The facility staff do not protect the resident's dignity. Examples include, a staff person being verbally rude to a resident and staff using words like diapers.

The complaint suggests that the Timber Creek staff do not protect the resident's dignity and examples include a staff member telling a resident that they have to wait to use the restroom as well as staff members using the term "diaper" to describe incontinence products. The HRA reviewed an investigation involving the resident telling the patient to wait to use the restroom and interviewed the Administrator regarding both complaints. The Administrator stated that he never saw evidence of either situation happening but had reeducation on the matters added to the in-services. The investigation document itself did not declare a resolution to the matter but

documented evidence suggesting that the event did not happen. The HRA finds the complaint **unsubstantiated** based on a lack of evidence**,** but does offer the following **suggestions**:

- The investigation report completed by the facility does not seem to follow any formal structure and does not have a resolution or recommendation regarding the findings. The HRA suggests adding a formalized structure to the report writing process that ends in a resolution/recommendation regarding the complaint.
- The "Grievance/Complaint" forms are all handwritten and there is no indication that a document of the form is given to the resident or family member who made the complaint. The HRA would suggest typing the grievance form and, upon resolution of the complaint, giving a physical copy to the complainant for their records. This would also clear up any misunderstandings that may come from hearing a verbalization of the complaint's resolution.

Complaint #4: The family was not made aware of all costs by the nursing home or what products were being used by the nursing home.

The complaint states that the family was not made aware by the facility that they had to pay for incontinence products for the resident. The Administrator stated that the facility does pay for incontinence products but uses the tape style products rather than the pull-up style products. The HRA reviewed the contract (which was signed by the resident's Agent for Power of Attorney when admitted) which has a section that defines the list of "Base Rates" items that are paid for by the facility and, although incontinence products and other products of that nature were not listed, the HRA was told that these products would fall under the "Nursing Care - 24hours/day" category of the Base Rate breakdown. The Skilled Nursing Home and Intermediate Care Facilities Code states that "The contract [between facility and resident] shall specify the services to be provided under the contract and the charges for the services. A paragraph shall itemize the services and products to be provided by the facility and express the costs of the itemized services and products to be provided either in terms of a daily, weekly, monthly or yearly rate, or in terms of a single fee" (77 Il. Admin. Code 300.630 m). The Code also states that "A paragraph shall itemize all services and products offered by the facility or related institutions which are not covered by the rate or fee established in subsection (m) of this Section" (77 Il. Admin Code 300.630 1). Also, the Medicare/Medicaid requirements state that the facility must "(i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of-- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services" (42 C.F.R. § 483.10 i A B)." The HRA finds the complaint that the family was not made aware of all costs by the nursing home **substantiated** for not following the regulations in The Skilled Nursing Home and Intermediate Care Facilities Code, and makes the following **recommendation:**

- Adjust the current contract into an itemized pricing structure that is consistent with the Skilled Nursing Home and Intermediate Care Facilities Code section 300.630 and the Medicare/Medicaid requirements. This itemized pricing structure could address any confusion for the residents or their family members of the residents.