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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT #11-030-9006
Lakefront Nursing and Rehabilitation

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Lakefront Nursing and Rehabilitation (Lakefront). It was alleged that the facility did not follow Nursing Home Care Act requirements when it did not give rights information to the recipient upon admission, did not have a discussion regarding the funding of the recipient's stay or offer her a contract to sign for her services upon admission, did not include the recipient in the development of a Care Plan, did not provide a washcloth to the recipient for the three months in which she had been a resident at Lakefront, and breached the recipient's confidentiality by discussing her finances in front of other residents and staff. If substantiated, this would violate the Nursing Home Care Act (210 ILCS 45 et seq.), the Illinois Administrative Code for Skilled Nursing and Intermediate Care Facilities (77 Ill. Admin. Code 300), and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/5).

Lakefront is 99- bed long term care facility in Chicago. Staff report that approximately 25% of the residents are over the age of 65- the remaining population are mental health recipients.

To review this complaint, the HRA conducted a site visit and interviewed the Administrator and the Social Service Director. The HRA obtained the recipient's record with written consent.

COMPLAINT SUMMARY

The complaint alleges that the resident did not ever receive rights information when she was admitted to the facility. Additionally, the complaint alleges that the recipient was asked to sign over her social security check before she was in the nursing home and before she was informed of what her services would be, or what her social security amount would be, making her feel that her payment was more important than her care. The complaint also alleges that the resident never received a contract for services and was not given a Care Plan or outline of what her care would entail. Also, the complaint alleges that the resident did not receive a washcloth

while she was at the facility. Additionally, the complaint alleges that the recipient's confidentiality was breached when the Administrator approached her in the dining room and discussed her lack of payment in front of her peers, threatening to discharge her for non-payment.

FINDINGS

The record shows that the recipient was admitted to Lakefront on 6/03/10. Social Service Notes state: "….Social Service Director [SSD] informed resident of the rules and regulations of the facility and resident verbally agreed to follow all the rules of the facility…." The documentation includes a copy of "Residents' Rights for People in Long Term Care Facilities". On the front of the pamphlet is the date of 6/3/10 and a statement written by the SSD that a copy was given to the resident. At the bottom of the form is a handwritten statement, "resident refused to sign" and the resident's name is written by the same writer. The record contains computerized Social Service Notes and Nursing Notes, however there is no document signed by the resident stating she received rights information or any other information in the record and there is no contract for services.

Social Service Notes from 6/08/10 state, "Resident was approached by staff to fill out social security change of address forms and resident refused to sign, saying that she had to see if she liked it here first before paying anything. Writer informed resident that they should get the paperwork done as soon as possible because it takes some time to process. Resident said that she wasn't worried because she got her checks when she needed them. Writer will try again another time and will inform administration." Notes from 6/17/10 state, "Writer approached resident this afternoon to go over the intake packet with resident. Writer waited because when he approached her before she was far too busy to go over the packet. Resident again said that she didn't have time to review the rules and the packet but she would humor writer with a couple of minutes. Writer started reviewing intake, asking resident questions when she said that she was tired and that they would finish the packet later. Writer encouraged resident to finish now so she wouldn't have to do this again but she said she was done."

On 7/7/10 Social Service Notes state, "Writer again approached resident about her intake packet and her social security change of address but she said that she wasn't signing anything because she didn't have to. Writer started reviewing rules with resident and she started talking on her cell phone. Writer again left resident and informed administration that she wouldn't sign and he said that he would speak to her." Another Note, written on 8/17/10 states, "Writer again approached resident about social security change of address and she said that she wasn't going to sign the papers. Resident complained that she never got the paperwork for the rules when she first came into the facility and said that she was calling the proper authorities. Writer and nurse both informed resident that writer approached her numerous times and she turned him away. Writer asked resident if she would review the paperwork now and she said that she didn't want to and it was already too late."

On 7/27/10 the recipient called the HRA to report that she had been told she had to sign over her social security check or she would be issued a 30-day Notice of Discharge.

On 8/18/10 the administrator's notes are entered into the record: "Writer visited resident. Resident was told upon admission that she needs to turn over her social security the first month that she is here at the beginning of the month. She had agreed to turning it over but has reneged on the agreement. Writer told that he will start today the discharge process. As soon as the facility receives the prepayment report from the state the resident will be given a bill of exactly how much she owes the facility".

Again on 8/23/10 the administrator notes state: "Writer visited resident. Resident was given a statement showing that she owes the facility every month $644.00 which she hasn't paid for the 2 months she owes. A final entry regarding the finances is entered on 9/07/10 which states, "Discussed: resident has been spoken to numerous amounts of times in regards to her obligation to turn over her social security check to the facility. This resident was evicted from her apartment and brought to …hospital. That day this writer had a long conversation with the resident. During this conversation she was told that if she wasn't to be a resident here she will have to turn over her check as soon as she comes into the building. She had agreed to this condition. She has reneged on this condition and has been shown paperwork and has been told by numerous outside organizations that this is a requirement. She has given a $400 check but has said she owes money to cover storage expenses but has been told that this isn't the responsibility of the facility."

Within the Social Service Notes there is a description of the resident's Care Plan, however there is not a separate Care Plan that is signed by the resident and there is no indication from the record that that the resident took part in her Care Plan development. The record reflects that the resident met with a psychiatrist (6/23/10), however the evaluation is not included in the record, so there is no indication of a mental health diagnosis.

The record contains numerous notes, both by the social workers and nursing, that the resident resisted taking showers. Notes indicate that staff repeatedly encouraged, and then insisted, for hygiene purposes, that she shower and clean herself.

The record shows (Nursing Notes) that on 9/27/10 the resident insisted on going to the hospital: "resident demands to go to hospital. and threatens writer that if MD will not send her out to hosp she will call 911 or send herself out." The resident was then admitted to a local hospital with a diagnosis of pneumonia. She did not return to Lakefront.

FACILITY REPRESENTATIVE RESPONSE

Facility representatives were interviewed regarding the complaints. They stated that the resident had been evicted from her apartment and was in a hospital emergency room when she was recommended for transfer to Lakefront. They stated that she had an advocate assigned to her from another agency and this advocate had informed them that the resident had a history of non-payment of her bills and for this reason it was made very clear to the resident that she would have to immediately sign over her social security check to the agency to cover her expenses. Staff stated, "Before she got here I told her she would have to sign over her check. I went to her room too, and told her she had to sign over her social security. She refused." Staff were asked about the resident's rights information and they stated that she was given the brochure but that

she refused to sign that she had received it. They were also asked why this refusal was not noted in the progress notes and they thought that noting it on the cover was sufficient.

Facility representatives were asked about the contract for services and the list of services for which the resident would be charged and they stated that it was included in the record. The HRA asked for, but did not receive this documentation. Additionally, the HRA asked about the resident's Care Plan. They stated that they had worked with the resident to develop the plan and that she had been "very involved" in its development. The HRA asked for but did not receive a copy of the Care Plan with the resident's signature on it or any documentation showing that the resident had input into the Plan. The facility staff were asked about the psychiatrist's evaluation and they stated that it was part of the record, however the HRA has not received a copy of this document as of this writing.

Facility representatives were interviewed about the availability of washcloths for the resident. Staff stated that the resident was very resistant to showering and that this became a serious hygiene issue for the resident and others. HRA staff stated that the resident had reported that she wanted to shower at night because she did not want to be seen by others and that she did not want staff to be in the shower with her. Facility staff stated that residents are able to take showers at any time. They noted that they had wanted their Restorative staff person to do a body assessment of the resident when she arrived, and this person is only available from 7 a.m. until 5:30 p.m. approximately, so it would have been a one-time event that the staff would accompany her. The administrator recalled that at one time the resident was observed going to the shower and she had a regular washcloth with her. Because of the resident's size (resident was morbidly obese), the staff commented to the resident that the size of the washcloth would not be useful, and a towel was torn into pieces and given to the resident to use as a wash cloth. Generally speaking, staff reported that washcloths and towels are always available for the residents.

Facility staff were interviewed about the discussion of the resident's finances in the dining room. The facility administrator stated that it was actually the resident who confronted him in the dining room. He stated, "She tried to egg me on and I said we could talk about it later. She said she was calling the State." Staff reported that they generally had discussions about the resident's finances in her room, as was noted in the record.

STATUTORY BASIS

The Nursing Home Care Act states, "No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States soley on account of his status as resident of a facility" (210 ILCS 45/2-101). The Act also states that, "Each resident and resident's guardian or other person acting for the resident shall be given a written explanation, prepared by the Office of the State Long Term Care Ombudsman, of all the rights enumerated in Part 1 of this article and Part 4 of Article III" (45/2-211).

The Nursing Home Care Act states, "To protect the residents' funds, the facility: 1) Shall at the time of admission provide, in order of priority, each resident, or the resident's guardian, if any, or the resident's representative, if any, or the resident's immediate family member, if any.….

The resident's rights regarding personal funds and listing the services for which the resident will be charged. The facility shall obtain a signed acknowledgment from each resident or the resident's guardian if any, or the resident's representative, if any, or the resident's immediate family member , if any, that such person has received the statement" (45/2-201).

The Nursing Home Care Act states, "Before a person is admitted to a facility, or at the expiration of the period of previous contract, or when the source of 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: the person, or if the person is a minor, his parent or guardian, the person's guardian, if any, or agent, if any…or a member of the person's immediate family. An adult person shall be presumed to have the capacity to contract for admission to a long term care facility unless he has been adjudicated a 'disabled person' within the meaning of Section 11a-2 of the Probate Act of 1975, or unless a petition for such an adjudication is pending in a circuit court of Illinois" (45/2-202 a 3). Also, "At the time of the resident's admission to the facility, a copy of the contract shall be given to the resident, his guardian, if any, and any other person who executed the contract."

The Nursing Home Care Act allows a facility to involuntarily discharge a resident for either late payment or nonpayment for the resident's stay. "Late payment' is defined as "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 proceedings by sending a notice of transfer or discharge to the resident and responsible party by registered or certified mail" (210 ILCS 45/3-401).

The Nursing Home Care Act states, "All persons age 18 or older seeking admission to a nursing facility must be screened to determine the need for nursing facility services prior to being admitted, regardless of income, assets, or funding source (210 ILCS 45/2-201.5a). In addition, in Subsection a-1 it states, "Any screening performed pursuant to subsection (a) of this section shall include a determination of whether any person is being considered for admission to a nursing facility due to a need for mental health services. For a person who needs mental health services, the screening shall also include an evaluation of whether there is permanent supportive housing, or an array of community mental health services, including but not limited to supported housing, assertive community treatment, and peer support services, that would enable the person to live in the community…. Prescreening for persons with a serious mental illness shall be performed by a psychiatrist, a psychologist, a registered nurse certified in psychiatric nursing, a licensed clinical social worker, who is competent to (i) perform a clinical assessment of the individual, (ii) certify a diagnosis, (iii) make a determination about the individual's current need for treatment, and recommend specific treatment, and (iv) determine whether a facility or a community-based program is able to meet the needs of the individual. For any person entering a nursing facility, the pre-screening agent shall make specific recommendations about what care and services the individual needs to receive, beginning at admission, to attain or maintain the individual's highest level of independent functioning and to live in the most integrated setting appropriate for his or her physical and personal care and development and mental health needs. These recommendations shall be revised as appropriate by the pre-screening or re-screening

agent based on the results of resident review and in response to changes in the resident's wishes, needs, and interest in transition."

The Nursing Home Care Act mandates that every resident be permitted to participate in the planning of his care and medical treatment (210 ILCS 45/2-104). Section 3-202.2a of the Act states, "A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measureable objectives and timetables to meet the resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable."

The Nursing Home Care Act states that the Illinois Department of Public Health shall set standards which regulate the "Equipment essential to the health and welfare of the residents" (210 ILCS 45/3-201). The Illinois Administrative Code (Section 300.2420) states that "There shall be a sufficient supply of clean linen and bedding in good condition to provide proper care and comfort to the residents".

The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/5) states that all records and communications shall be confidential and shall not be disclosed without written release. The Nursing Home Care Act states that, "A resident shall be permitted respect and privacy in his medical and personal care program. Every resident's case discussion, consultation, examination and treatment shall be confidential and shall be conducted discreetly, and those persons not directly involved in the resident's care must have his permission to be present" (45/2-105).

HOSPITAL POLICY

Lakefront provided the Residents' Rights for People in Long term Care Facilities prepared by the Illinois Department on Aging Ombudsman Program, which is given to all residents upon admission to a long term care facility. This document provides the basic rights of residents developed around 8 categories. Some, but not all of these, are:

1. Residents' rights to safety and good care. These include the provision of services for physical and mental health, a clean environment, freedom from abuse, freedom from physical restraints, and psychotropic medication only when permitted by the resident and as part of an overall treatment plan.
2. Residents' rights to participate in their own care. These include a written Care Plan developed with the input of the resident and family or friends, the choice of personal doctor, the names of all doctors who treat the resident, the right to be in charge of taking their own medication, and to be able to refuse medical treatment or experimental medical treatment, to develop a Living Will, freedom to view their clinical record, freedom from being required to work and freedom to move out of the facility.

3. Residents' rights to privacy. These include privacy in medical and personal care and in person space, privacy of information regarding care, privacy in visitation, phone calls, and mail, and the right to a room with their spouse.
4. Residents' rights regarding money. These include the residents' right to manage their own money and that the facility may not become the residents' money manager or Social Security representative payee without written permission, that residents may ask the facility to manage their personal money for them, that if the facility manages their money and they receive Medicaid, the facility must tell the residents if their savings come within $200 of the amount Medicaid allows them to keep, and that if the residents die, the family must be given a final accounting of all money left in any account that was managed by the facility within 30 days, and that residents may see their financial record at any time.
5. Residents' personal property rights. These include the right of residents' to wear their own clothes, to keep and use their own property, to expect the facility to have a safe place to keep small valuables, to expect the facility to keep residents' property from being lost or stolen and to aid in its recovery if stolen.
6. Residents' rights in paying for care and getting Medicare and Medicaid. These rights include the right to a written contract that states all of the services provided by the facility and how much they cost as well as what expenses are not part of the regular rate, that the right of residents who cannot pay their bill themselves to have only a court appointed guardian or someone else appointed by the residents to handle their money for them and not be required by the facility to have someone else agree to pay their bill, the right to information about how to apply for Medicare and Medicaid and rules about spousal impoverishment and the right to apply for Medicare and Medicaid, and if they receive Medicaid, the right to a written list of what items and services for which Medicaid pays and items and services for which residents will be charged.
7. Residents' rights to remain in the facility. These include the right to remain in the facility unless they are a danger to themselves or others, if their medical needs cannot be met in the facility, or for non-payment, the right to a written notice within 21 days if the facility requests them to move from the facility, the right to appeal a transfer or discharge from the facility, preparation before a transfer or discharge, and the right to return to the facility after hospitalization.
8. Residents' rights as a citizen and a facility resident. These include the right to see all facility inspections by the Illinois Department of Public Health from the last 5 years and the most recent survey, the same rights as any citizen of Illinois and the United Sates, the right to have their legal guardian or Power of Attorney exercise their rights for them, the right of freedom of religion, the right to vote, the right to participate in social and community activities, the right to participate with other residents in the Resident Council, the right to meet with the Long Term Care Ombudsman, and the right to file grievances to the facility, to outside organizations and advocates such as the Long Term Care Ombudsman, Equip for Equality, or the Illinois Department of Public Health.

CONCLUSION

Lakefront was requested to provide, but did not, any documentation with the resident's signature on it. Thus we will have to assume (because the staff wrote "pt. refused to sign") that they provided the resident with her rights information, although it is not documented in the Progress Notes that she received it, only that she was given "rules and regulations" which she verbally agreed to. The HRA does not substantiate that the resident did not ever receive rights information when she was admitted to the facility.

The record does show that hospital staff approached the resident and demanded that she sign over her Social Security check both before admission and upon admission (as stated in the record "as soon as she comes into the building") because they had heard that she had a history of non-payment. The Nursing Home Care Act is clear in that, "Before a person is admitted to the facility… a written contract shall be executed between a licensee and …the person…", and a copy of this contract must be given to the resident and any other person who executed the contract. As a guarantee that residents' funds are protected, the Act mandates that residents, at the time of admission, are given their rights regarding personal funds and a listing of the services for which they will be charged. The facility must also obtain a signed acknowledgement that the resident received this information, and to date the facility has not provided the HRA with this information. Additionally, the HRA reminds the facility that the Nursing Home Care Act defines "late payment" as "non-receipt of payment after submission of a bill." The Act clearly lays out the process for notification of late payment and discharge and the facility in this case appears to have initiated this process preemptively in order to guarantee their payment. The HRA substantiates the complaint that the facility did not have a discussion regarding the funding of the resident's stay or offer her a contract for services upon admission.

A description of the elements of the resident's Care Plan are listed in the Social Service Progress Notes. The facility did not provide a separate Care Plan with input from the resident or her signature. Additionally, although the Progress Notes indicate that the resident received a visit by a psychiatrist, a comprehensive assessment, as mandated by the Nursing Home Care Act, was not included in the record. This analysis is the diagnostic foundation for the Care Plan and if completed, has specific clinical directives for mental health recipients. The facility was unable to provide any of these documents for the HRA. The HRA substantiates the complaint that the facility did not include the resident in the development of the Care Plan.

The complaint alleges that the resident did not receive a washcloth for the three months that she was a resident at Lakeshore. Although hospital representatives reported that they always have sufficient washcloths for residents, the scenario presented by the administrator regarding the use of a torn towel for a resident because she was too large for a regular washcloth is both demeaning and disrespectful, and could certainly have precipitated the issue with the resident's refusal to bathe. The HRA substantiates the complaint that the resident did not receive a washcloth in the three months that she was a resident at Lakeshore.

The record shows that the resident was approached numerous times regarding non-payment. The complaint indicates that one of these conversations took place in the dining area in front of other residents. The administrator states that the resident actually approached him in the dining hall, and that he did all he could to redirect her to another more private location, however she "egged" him on. It is not clear why the administrator could not have walked away

and discontinued the conversation if he felt he was being provoked. The HRA substantiates the complaint that the recipient's confidentiality was breached when the Administrator approached her in the dining room and discussed her lack of payment in front of her peers, threatening to discharge her for non-payment.

RECOMMENDATIONS

1. Develop policy and train staff to adhere to the Nursing Home Care Act which mandates that before a person is admitted to a facility the resident's rights regarding personal funding and a listing of all services for which the resident will be charged is given to the resident. Ensure that a written contract is developed which outlines these requirements and that a signed copy is given to the resident and placed in the clinical record.

2. Develop policy and train staff that the Care Plan be developed with the input of the Interdisciplinary team as well as the resident to the extent possible, and that the Plan is signed and becomes part of the clinical record. If the resident is unable or unwilling to sign, note this on the document and in the Progress Notes.

3. Ensure that there is "a sufficient supply of clean linen in good condition to provide proper care and comfort to the residents".

4. Develop policy and train staff that all records and communication must be confidential and cannot be released without written release.

SUGGESTIONS

1. Although it was not part of the stated complaint, the HRA notes that the resident's psychiatric assessment for mental health diagnosis and treatment was not included in the record. This provides the clinical underpinning for the Care Plan and directs specific requirements if the resident has a mental health diagnosis. Ensure that this document is completed and is used to formulate the care and services for the resident's treatment.

2. Ensure that residents are given their right to participate with other residents in the Resident Council, the right to meet with the Long Term Care Ombudsman, and the right to file grievances to the facility, to outside organizations and advocates such as the Long Term Care Ombudsman, Equip for Equality, or the Illinois Department of Public Health.