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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 11-090-9031
Wesley Village

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations at the Wesley Village. The complaints alleged the following:

1. Resident was moved to acute Alzheimer's unit to make room for other patients even though the resident did not have the disease.
2. Resident was not allowed to be in the same room with his wife while at the facility.
3. Power of Attorney and resident were charged extra for not providing seven days notice for changing facilities even though Power of Attorney did not see a contract stating they had to give notice and resident did not have the capacity to sign and understand a contract.
4. Individual fell and broke hip while visiting his wife at facility and ambulance was not called to take individual to the hospital. Individual was not admitted to the facility when this incident occurred.
5. Requests for additional therapy by Power of Attorney were denied.
6. Facility only used Medicare for five days, rather than exhausting coverage.

If found substantiated, the allegations would violate the Nursing Home Care Act (210 ILCS 45), Skilled Nursing Facility and Intermediate Care Facility regulations (77 Il Admin Code 300) and Federal mandates (42 CFR 483).

The facility has 73 beds in healthcare and intermediate departments, 200 including independent living. They have 125 on staff (60 in nursing and support staff). The Wesley Village programs include independent living, home nursing, intermediate care, skilled nursing, and home services.

COMPLAINT STATEMENT

The complaint states that a patient was moved into the acute Alzheimer's unit to make room for two other patients. The patient did not have Alzheimer's Disease and was admitted into the rehab part of the unit. The complaint states that the patient was improperly placed in an Alzheimer's Unit not for the patient's benefit, but to maximize profits of the nursing home by

creating a room for additional patients. The complaint also alleges that the agent named in a Power of Attorney (POA) requested that the patient be put in a room with his wife (who was also admitted to the nursing home) but it was denied by social services. The complaint states the patient also made this request. The complaint also states that, prior to his facility admission, the patient fell and broke his hip while visiting his wife at the facility and the facility called a neighbor to transport the patient to the hospital rather than using the facility car. The complaint also states that when the POA agent moved the patient to a different nursing home, they were charged for seven extra days because seven days notice was not given to Wesley Village. The complaint states that a contract was never signed regarding notice. The complaint explains that, if there was a contract signed by the patient, he did not have the capacity to understand the contract he signed. The complaint also alleges that the facility denied the POA agent's requests for additional physical rehabilitation of the patient. An additional complaint alleges that the patient's funds were depleted without the agent's knowledge and that the patient was eligible for Medicare services after hospitalization. The complaint alleges that Wesley Village only used five days of Medicare during the patient's stay and the rest was paid out-of-pocket by the patient.

FINDINGS

Interview with staff (5/11/2011)

The HRA started the investigation of the complaints by interviewing Wesley Village staff members regarding the complaints. The Wesley Village staff discussed that the resident had some confusion even before he was admitted to the facility. He would come to visit his wife daily so the staff got to know him. He would even spend the night. He was not diagnosed with dementia but he was very confused and seemed to be in the early stages of dementia. Staff even noted that on the individual's hospital transfer they said he was confused. The resident was injured while visiting his wife and was admitted into the rehabilitation unit at Wesley Village. The staff has a side rail assessment that also states the individual was confused.

The HRA reviewed the first complaint and second complaint in succession because they are closely related. The staff stated that when the individual was admitted into the facility, they only had the one bed open which he received. The individual was in the facility from January 24th until February 8th. The staff needed to readmit two other residents of the facility, and the rehab unit was full, so they brainstormed and decided to move the patient into the Memory Care wing. The other two patients were residents of Wesley Village, and if you are a resident, the facility policy states that you be given priority in receiving a bed in the rehabilitation unit. The individual could not move into his wife's unit because she was private pay and he was required to be in a Medicare bed so, after the patient was moved into the Memory Care unit, the facility was then going to move the individual and his wife to the Medicare rehab unit within 48 hours so the couple could share a room. The other two patients would be discharged by that time. Before the facility could move the couple into the same room, the POA agent moved the couple out of the Wesley Village. The staff stated that they would have moved the couple into the same room sooner but they did not have the room. The staff also thought that, because the patient had issues with confusion, he would fit into the Memory Care wing. The nurse's station is the only divider between the two units. The staff explained the individual was only going to be in the Memory Care area for 3 days, and the couple still spent time together. The staff explained that they were not deprived of each other's company. The individual was in the facility for 16 days; 15 in

rehabilitation and 1 in the Memory Care unit. When they were transferred, neither patient wanted to leave and they were both crying on the day of the transfer. The facility did not know that the couple was being transferred. The POA agent decided to move them. The agent had another facility review and assess the couple for a referral. The Wesley Village staff unsuccessfully attempted to discuss the situation with the POA agent.

Regarding the second complaint, the staff explained that they were working towards placing the couple into a room they could share, and it would have happened within 48 hours but they were moved from the facility. The patient was admitted on the 24th and had to remain in the facility because of his condition. As stated previously, the patient could not move into the area with his wife because she was in a private pay room and he was in the Medicare area. The POA agent was told of the plan. When the couple moved, it was very emotional for the couple and the staff.

The Memory Wing that the patient was moved into is still located in the Rehabilitation section of the facility, the patient was just moved from one side of the facility to the other. The patient was never moved out of skilled care. The patient's waking time was spent with his wife and he still had his regular routine of spending time together, much like before he was admitted at the facility. When he was moved he was still receiving the same care and had the same staff. The staff explained that no regression was caused by the move.

The Wesley Village staff explained that the patient was not charged for seven days notice and did not sign a contract with the facility because Medicare automatically pays for services. The patient had 16 days paid for by Medicare. Also, regarding the complaint that the patient was only on Medicare for 5 days and then was charged out-of-pocket, the staff stated again the Medicare paid for all 16 days that the patient was at the facility.

The staff reiterated the individual involved in the complaint was not a patient at the facility during the timeframe of the fourth complaint; he was only at the facility visiting his wife. The staff explained that the individual's wife was in the nursing home for a year and the individual visited her daily. When the individual fell, the couple were outside in the lobby and there were no witnesses. The staff attempted to help him but he kept expressing that he wanted to go home. They tried to persuade him to allow them to call an ambulance but he would not allow it. Finally the staff decided to call his wife's POA agent. The agent arrived at the hospital and convinced him to allow her to take him to the hospital. The patient's confusion made it hard to convince him to go to the hospital after he fell. The staff said that they did fill out an incident report about the situation.

The facility policy regarding when individuals are hurt while visiting the facility states that if an individual needs first aid, they will receive first aid. If the individual who was injured refuses to go to the hospital, the staff cannot make them. It was not documented that he refused, on the report. The staff marked "yes" that he went to the hospital because he eventually did go. If they needed to, they would have taken him to the hospital had he agreed. The facility would use a van or have called 911. If an injury happens in the facility that can not be treated by first aid, then they have to call 911. The staff stated that there is no written documentation of this policy.

The staff said that visitor injury at the facility is uncommon. They stated in the past a woman fell and hit her head and they called an ambulance. That was the only other situation such as this that the staff could recall. They said that the individual was confused and had a determined personality and decided that he did not want to go to the hospital. He was living alone and took care of himself and so he wanted to go home.

The Wesley Village staff explained that the Memory Care unit is not advertised as an Alzheimer's unit. The patients on the unit do not need to be diagnosed with Alzheimer's to stay on the unit. The unit is more secure than other units but not restricted. The staff also explained that the patient approved the move.

The staff stated that they where unclear about the complaint that additional therapy requested by the POA agent was denied. The staff claimed that no one ever asked for additional physical therapy. The facility explained that the physical therapy was actually what made the patient eligible for Medicare and he was receiving physical therapy every day. The therapy was not denied and no extra therapy could have been done.

Second Conversation

The HRA spoke with the facility a second time to discuss the complaints in the case. The Wesley Village staff stated that Medicare covers the Memory Care unit. They stated that the unit is not an Alzhiemer's Special Care unit and it is not regulated as one. The unit is just a unit in the facility for patients with memory and confusion related issues. The unit is Medicare certified and skilled nursing licensed.

The staff member also stated that the patients who live on campus receive priority in the rehabilitation unit and this is written into their contract but there is no written policy about priority. The staff also said there is no written policy explaining what to do when visitors are injured at the facility. The staff reiterated that the rehabilitation unit was filled the entire time that the resident was there and the day that the resident was moved out was the day that the couple could have moved into a room together.

Record Review

The HRA began the record review by evaluating documents that deal with the first complaint allegation regarding the resident being moved into the Alzheimer's unit. As stated above, the facility explained that they needed to make room for two other residents of the facility because residents are given priority in receiving a bed in the rehabilitation unit. The facility staff also explained that the unit is not "advertised" as a unit for residents with Alzheimer's Disease and you do not need a diagnosis of the disease to stay on the unit. The HRA reviewed the Wesley Village website and read a web page titled "Memory Care." The website reads that "Wesley Village provides a memory care wing for individuals with dementia or related diseases. This wing is low stimulus and addresses the needs of individuals with memory issues through specialized activities and meal planning." The web page proceeds to explain more aspects of the unit and does not mention Alzheimer's disease within the page.

The HRA looked at the daily census for the rehabilitation center on the dates of 2/7/11 and 2/8/11. On 2/7/11, the individual was in room 35-2A, and the census was 24 individuals, with an opening in room 38-2 and 43-2 (both were doubles with other occupants). On 2/8/11, the resident was moved to 43-2 and the census in the rehabilitation wing was 26, indicating that two people had moved in. In reviewing the facility information on the Illinois Department of Public Health website, the facility has 26 Medicare/Medicaid beds and 47 Medicaid beds which equals to the 73 total capacity in the healthcare and intermediate departments. In accordance to the census of the rehabilitation wing, there are 26 total beds, which equal the number of Medicare/Medicaid beds for which the facility is licensed. The resident was moved from one bed in the 26 bed rehabilitation wing, to another bed in the rehabilitation wing. The facility stated that two new patients were moving into the rehabilitation wing, and the number of patients on the census moved up by two from one day to the next, which does indicate that two individuals were moved in on the 8th. All the beds that residents were moved to, including the two new patients and the patient involved in this case, were beds in the rehabilitation wing which are part of the 26 licensed Medicare/Medicaid beds. The resident was technically not removed from a Medicare bed.

The HRA also reviewed documents that stated the individual had confusion, for example, in the resident's care plan, there is a document titled "Fall Comprehensive Care Plan," dated 1/31/11, states that the resident has a "Cognitive impairment/poor ability to learn safety measures d/t confusion." The form also states the resident has "Poor judgement re: safety d/t confusion." As stated by the staff in the interview, the resident's siderail assessment (dated 1/25/11) categorizes the resident's cognition as "confused," "forgetful," but "alert." An elopement risk assessment dated 2/6/11 states that the resident is cognitively impaired with poor decision making skills and an explanation stating the resident is confused. On the patient transfer form, from a local hospital to Wesley Village, dated 1/24/11 by a physician, it states that his mental status is "alert," "forgetful," and "confused" and it is written on the form that the patient is "very very confused and forgetful …" The nurse's notes from Wesley Village also references the resident's confusion and states the resident is "very confused at times" (2/4/11) and "Resident having episode of increased confusion" (2/7/11). The HRA did not review a diagnosis of dementia nor did they view any documentation regarding the decision to move the patient into the memory care unit.

The HRA also reviewed a sample membership agreement for Wesley Village. The agreement reads "Should MEMBER need to be admitted to a hospital for treatment of acute illness, the MEMBER will be returned and admitted to WESLEY VILLAGE'S HEALTH CARE CENTER as soon as the MEMBER'S attending physician, the Administrator, and the Director of Nursing Services of WESLEY VILLAGE have determined that MEMBER has recovered sufficiently to be cared for in WESLEY VILLAGE HEALTH CARE CENTER or in MEMBER's own Apartment."

Another section of the agreement states that the facility operates a Health Care Center which is regulated by the Illinois Department of Public Health (IDPH) and that one of the requirements of the IDPH is that there is a contract between the intermediate care or skilled care

facility and the resident of the facility. This indicates that the membership agreement is not the contract that is required by the IDPH.

The HRA reviewed records dealing with the second allegation which is that the resident was not allowed to live in the same room with his wife while at the facility. The HRA reviewed the facility policy regarding the complaint which reads "The resident has the right to share a room with a spouse when they are married residents that are living in the same facility while both agree to the arrangement." The policy also reads "Married residents have the right to share a room; however, it does not force the facility or the other resident to relocate to a different room to accommodate one of the spouses. This means that when a room is available for a married couple to share the facility must allow them to share the room if they agree to do so." The policy also reads "If a spouse is not on the same payment source regarding care units at the facility they are not able to share a room due to licensure (unless one of the spouses elects to pay for his or her care in a different unit)."

The HRA also reviewed nursing notes, dated 2/8/11 at 1300, which read "family here, informed that we need to transfer resident to room 43-2 to make accommodation for female resident, family upset due to his wife not in room with him. Encouraged to talk to social services." Notes on the same date at 1345 state that the facility received a new order to transfer the resident from Wesley Village.

The HRA also reviewed a rehabilitation unit census for the entire month of January and February. According to the census, which did not appear to the HRA to be an official signed document, the patient was admitted on January 24th and, on that day the census for the rehab unit equaled 25 individuals and stayed at 25 until the end of the month. On the first of February, the census dropped to 24 individuals and maintained until the 8th when it increased to 26 individuals. On the 9th, which was the day that the facility stated they would move the couple into the same room, the census dropped to 24 individuals.

In a written response to the complaints in the HRA case, the facility writes that "[individual's name] POA requested that [couple] be placed in the same room after [wife's] return from the hospital on February 3rd. At that time the facility had committed to a couple of admissions from the hospital and did not have two beds available in the same room in the Rehab unit."

The HRA also reviewed a sample membership agreement between the facility and individuals living in the facility. The membership agreement states that Wesley Village is a "Not-For-Profit Illinois corporation with no stockholders and a non-salaried Board of Directors, hereinafter called WESLEY VILLAGE, which is the owner of a retirement community in Macomb, Illinois." In reviewing the Illinois Department of Public website the facility is also listed as a non-profit corporation.

Regarding the third complaint and the sixth complaint, which both deal with Medicare payment services, the HRA reviewed documents related to the facility's billing. The third complaint alleges that the resident was charged extra for not providing seven days notice and the sixth complaint stated that the facility only used Medicare for 5 days rather than exhausting

coverage. The HRA reviewed the resident admission information document, which is dated 1/25/11 but states the resident was admitted on 1/24/11, and this form states that Medicare is the resident's primary pay source and lists the patient's Medicare number. In reviewing a billing statement, each date range of billing has the Medicare number provided by the date range. The ranges are from 1/24/11 until 2/9/11. The billing statement also has a "paid date" of 3/11/11 for the first date range and 3/25/11. The HRA also reviewed another set of itemized bills, one covering the date range of 1/24/11 through 1/31/11 and one covering the range from 2/01/11 through 2/9/11. Both forms have the Medicare identification number on the form and both state they were paid, one on 2/16/11 and the other on 3/11/11. The HRA did not see any additional charges for an extra 7 days on either billing form. The HRA also did not see a contract signed by the resident, which corroborates the statement made by the facility that the resident did not sign a contract with the explanation that Medicare was covering his stay.

In the Wesley Village contract, it reads, under the Right to Terminate Membership During Lifetime, section that "At any time MEMBER shall have the right to terminate this Agreement by submitting to the Administrator of WESLEY VILLAGE a written notice of MEMBER'S intention to terminate. This notice shall be delivered at least thirty (30) days prior to the effective termination date."

The HRA also reviewed documentation dealing with the fourth complaint which is that an individual was injured in the facility while visiting but an ambulance was not called. The HRA reviewed the incident/accident report. As stated in the interview, there is no statement from the facility regarding the resident saying that he did not want an ambulance called or transportation to the hospital. It does state that an individual was notified but it is not clear as to whether this person transported the individual or any details on transportation from the facility to the hospital. There is also a section on the incident report form which states "additional comments and/or steps taken to prevent reoccurrence" which was completely left blank.

In regard to the fifth complaint, which states that the facility denied the additional therapy requested by the POA agent, the HRA began by reviewing physician orders. There is a written physician telephone order stating the resident should receive skilled physical therapy 5 times a week for 4 weeks and occupational therapy three times a week for 4 weeks. The chart copy of the physician's orders lists the admission date as 2/8/10 and the document states that the charting is for 2/1/11 - 3/31/11. The physical therapy progress notes state that the resident had physical therapy on 1/25, 1/26, 1/27, 1/28, 1/31, 2/1, 2/3, 2/4, 2/7 and 2/8. The notes for 2/1 state "weekly note" and has no data on what was done for the day. The HRA also reviewed occupational therapy daily notes for 1/26, 1/27, 2/2, 2/4, 2/7, 2/8. There were also two notes that were not dated, one between 1/27 and 2/2, and one between 2/4 and 2/7. In the weekly therapy progress note, dated 2/1/11 with service dates of 1/25/11 to 1/31/11, the treatment interventions provided section reads "Pt seen for skilled PT 5x/week …" The physician telephone orders are dated 1/26/11. In reviewing the documents, the HRA saw no evidence that additional physical therapy was requested.

MANDATES

The HRA reviewed mandates and regulations related to the complaints in this report.

The Skilled Nursing and Intermediate Care Facilities regulations regarding admission criteria for Alzheimer Special care units of centers providing Alzheimer or dementia care state that "b) All unit residents shall have a diagnosis of Alzheimer's disease or other types of dementia" (77 Il Admin Code 300.7010).

The HRA reviewed the federal mandates for long term care facilities, which reads "(m) Married couples. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement" (42 CFR 483.10). The Nursing Home Care Act reads "h) The facility administrator shall ensure that married residents residing in the same facility be allowed to reside in the same room within the facility unless there is no room available in the facility or it is deemed medically inadvisable by the residents' attending physician and so documented in the residents' medical records. (Section 2-108(e) of the Act)" (210 ILCS 45/2-108). This is also mirrored in the Illinois Administrative Code (77 Ill. Adm. Code 300.3210). The HRA also reviewed a State Operations Manual on the Center for Medicare/Medicaid Services website titled "Guidance to Surveyors for Long Term Care Facilities" which has interpretive guidelines for the federal regulations on married couples and states "The right of residents who are married to each other to share a room does not give a resident the right, or the facility the responsibility, to compel another resident to relocate to accommodate a spouse. The requirement means that when a room is available for a married couple to share, the facility must permit them to share it if they choose. If a married resident's spouse is admitted to the facility later and the couple want to share a room, the facility must provide a shared room as quickly as possible. However, a couple is not able to share a room if one of the spouses has a different payment source for which the facility is not certified (if the room is in a distinct part, unless one of the spouses elects to pay for his or her care)."

The Nursing Home Care Act states that "Every resident shall be permitted to participate in the planning of his total care and medical treatment to the extent that his condition permits . . . (b) All medical treatment and procedures shall be administered as ordered by a physician." (210 ILCS 45/2-104).

The Skilled and Long Term Care Regulations state "s) *The contract shall provide that if the resident is compelled by a change in physical or mental health to leave the facility, the contract and all obligations under it shall terminate on seven days notice. No prior notice of termination of the contract shall be required, however, in the case of a resident's death. The contract shall also provide that in all other situations, a resident may terminate the contract and all obligations under it with 30 days notice*" (77 Ill. Adm. Code 300.630).

The Nursing Home Care Act reads that "(a) 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: (1) the person, or if the person is a minor, his parent or guardian; or (2) the person's guardian, if any, or agent, if any, as defined in Section 2-3 of the Illinois Power of Attorney Act; or (3) a member of the person's immediate family" (210 ILCS 45/2-202). The Skilled Nursing and Intermediate Care Code mirrors the mandate in the Nursing Home Care Act (77 Ill. Adm. Code 300.630).

The HRA found no mandates or regulations relating to individuals being injured in facilities while visiting.

The HRA reviewed the handbook "Medicare & You" taken from the Centers for Medicare and Medicaid Services website. In the "Part A-Covered Services" it states, under the Skilled Nursing Facility Care byline, that "Medicare covers semi-private rooms, meals, skilled nursing and rehabilitative services, and other services and supplies that are medically necessary after a **3-day minimum medically-necessary inpatient hospital stay** for a related illness or injury." The passage proceeds to state that "You pay nothing for the first 20 days each benefit period."

The HRA found no evidence in mandates and regulations that refer to individuals already contracted with facilities being allowed priority over those who are not previously contracted with the facility.

FINDINGS

Complaint #1 - Resident was moved to acute Alzheimer's unit to make room for other patients even though the resident did not have the disease.

The complaint states that a resident was moved into an acute Alzheimer's unit to make room for other patients even though the resident was not diagnosed with the disease. The complaint alleges that this was an improper use of money and the action was taken not for the patient's benefit but rather to maximize profits of the nursing home by creating room for additional residents. The staff needed to admit two other residents of the facility, and they were full, so they brainstormed and decided to move the individual into the Memory Care wing. The other two patients were residents of Wesley Village, and if you are a resident, the facility policy states that you be given priority in receiving a bed in the rehabilitation unit. Also, the unit that the resident was moved to was still Medicare certified. The staff explained that the move was made because of the resident having some confusion and also to make room for the other residents who were being readmitted. The facility also explained that the unit is not a certified Alzheimer's unit but rather a unit that is set aside for individuals with memory/dementia issues. The documentation that was reviewed by the HRA indicated that the patient did have problems with confusion while staying in the facility. In reviewing the documentation, the facility is accredited for 26 Medicare beds, and upon review of the daily census of the 26 Medicare beds, the resident was moved from one Medicare bed to another. Also, on the day prior to the resident being moved, the census stated that there were 24 residents in the unit, therefore there was room for the two individuals. Because the resident was essentially being moved to another Medicare bed within the same unit, and the Memory Care unit is not a liscensed Alzhiemer's unit, and also because of the lack of regulation concerning the prioritization of individuals already living on campus, the HRA finds this complaint **unsubstantiated.**

Complaint #2 - Resident was not allowed to be in the same room with his wife while at the facility.

The complaint states that a resident was not allowed in the same room with his wife while at the facility and that this request was made to social services who denied the request. The staff stated that they were working towards placing the couple in a room that they could share and it would have happened within 48 hours but the patient and wife were moved out of the facility. The staff stated that the patient could not move into the area with his wife because she was private pay and he was Medicare and they had planned to move her into the Medicare area before the POA agent transferred the patient. The staff said that they would have moved her sooner but they did not have room. The staff stated that the Medicare unit was previously full so they could not have moved her then. In reviewing the census, there seemed to be an open bed in the rehab unit during January and then two open in February, but the facility knew that two campus members needed the beds in January. The written response to the complaints in this report stated that the POA agent did not request to have the couple together until February 3rd and the nursing notes state that the patient's family was upset about the couple not being together on February 8th. In a State Operations Manual provided by the Medicare/Medicaid Services website, it states that the couple are not able to share a room if one of the spouses has a different payment source for which the facility is not certified. The facility did state that the patient could not move into the patient's wife room because she was private pay and that they were trying to move the patient's wife into the Medicare bed, which according to the Operations Manual, is not an action that the facility is required to take due to the differences in payment method. The HRA also did not find evidence of the patient requesting to move into the same room with his wife. Because the facility is not required to move the couple into the same room when payment methods differ, the HRA finds this complaint **unsubstantiated** but offers the following **suggestions:**

- The mandates quoted in this report regarding married couples do not specifically state that the couples have to request to live together in the same room, yet the facility states that it was not requested of them until February 3rd. The HRA suggests that the facility adopt a more proactive approach with living situations of couples in the facility and develop procedure where it is discussed with family/guardian/POA agent and patients themselves when it is discovered that the couple are married, even if the two cannot live in the same room due to circumstances illustrated in the mandates.
- Although the facility stated there was not room in the Medicare unit to move the wife because two campus members were moving in, there did seem to be room in January to move the wife into the husband's room. Although the facility did not have to do this because of differing payment methods, they did decide to accommodate the arrangement later in the couple's stay. Although the HRA recognizes that the facility is doing the couple a favor by even stating that they would accommodate the situation, the HRA also feels as though there was a possibility that this accommodation could have been made sooner in the patient's stay. The HRA suggests that if the facility is going to make it a practice to accommodate situations such as this, they make the accommodation as soon as possible rather than waiting until later in the patient's stay.

Complaint #3 - Power of Attorney and resident were charged extra for not providing seven days notice for changing facilities even though Power of Attorney did not see a contract stating they had to give the time and resident did not have the capacity to sign and understand a contract & Complaint #6 - Facility only used Medicare for five days, rather than exhausting coverage.

The complaint states that when the resident was moved to a different nursing home, there was a charge for an additional seven days because the seven days notice was not given to Wesley Village. The complaint also alleges that there was never a contract signed by the resident's POA agent stating that there needed to be seven days notice, and that the resident did not have the capacity to sign a contract if that occurred. This complaint also closely aligns with complaint #6 which alleges that the patient's funds were depleted without the knowledge of the POA agent and that the resident was eligible for Medicare services but the facility only used 5 days of Medicare for the patient's stay and the patient paid the rest out of pocket. The facility stated that the resident was not charged for 7 days and did not sign a contract with the facility because Medicare automatically pays for services. The facility staff also stated that the patient had 16 days paid for by Medicare. In reviewing billing documentation, the HRA discovered that Medicare did pay for the resident's 16 day stay and the HRA saw no evidence of seven extra days being charged to the patient, and due to this, the HRA finds the complaint **unsubstantiated** but offers the following **suggestion:**

- The Nursing Home Care Act reads that "(a) Before a person is admitted to a facility, 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 …" (210 ILCS 45/2-202). The HRA saw no evidence that a contract did not need signed because of Medicare payments and, because of this, the HRA suggests the facility comply with the Nursing Home Care Act mandate stated above and contract with all future residents regardless of payment source.
- In reviewing the documents provided by the facility, the HRA noticed that some documents, such as consents for treatment, were signed by the POA agent, while two documents, the Do-Not-Resuscitate document and the Siderail Assessment and Consent form were signed by the actual resident. Because of the evidence found that the resident was confused during his stay at the facility, the HRA questions the resident's ability to sign documentation such as this. The HRA suggests that in the future, when a patient has issues with confusion and possibly dementia affecting decisional capacity, that all documentation be signed by the POA agent.

Complaint #4 - Individual fell and broke hip while visiting his wife at facility and ambulance was not called to take individual to the hospital. Individual was not admitted to the facility when this incident occurred.

The complaint states that a resident fell and broke his hip while visiting the facility and the facility called a neighbor to pick up the patient, rather than 911, to take the resident to the hospital. The resident was not actually a resident at that point; he was only visiting the hospital. The Wesley Village staff stated that the individual did not want to go to the hospital and did not want 911 called; he just wanted to go home. Eventually they did contact his wife's POA agent who convinced him to go to the hospital. The HRA reviewed the incident report and, the report read that the individual would not allow 911 to be called and did not want to go to the hospital, the individual was not a resident of the facility yet, and staff had to abide by his wishes

concerning his medical care, and because of this the HRA finds the complaint **unsubstantiated** but offers the following **suggestion:**

- The Steps or Comments to Prevent an Occurrence section on the incident report was left blank by the staff member who completed the form. The HRA recognizes that individuals being injured while visiting the facility is an uncommon experience but, when it occurs, there is still an opportunity to make suggestions so that the incident does not happen again. The HRA suggests that the facility revisit the incident and add suggestions to prevent further occurrences and educate staff to always complete that section for future incidents regardless of how infrequent the occurrence.

Complaint #5 - Requests for additional therapy by Power of Attorney were denied.

The complaint states that the POA agent's requests for additional physical rehabilitation of the patient was denied. During the interview, the Wesley Village staff stated that they were unclear about the complaint and that no one ever requested additional physical therapy of the patient. In reviewing documents, the HRA did not see any evidence of the agent requesting extra physical therapy. The HRA did find that the resident was receiving physical therapy and that there were physician's phone orders from that hospital stating that the patient needed rehabilitation daily and then later, there were physician's phone orders stating that the patient should receive physical therapy 5x a week, which in accordance with the dates for physical therapy, occurred. Due to the fact that there were physician's orders for a certain amount of physical therapy which was complied with, and because there is no indication that additional therapy was requested, the HRA finds this complaint **unsubstantiated.** The HRA would also like to state that a POA agent/guardian can partake in the treatment plan of the individual for whom they are caring, can have input into the treatment, and can contact the physician regarding treatment issues, questions or request but the physician has ultimate responsibility for clinical decisions.

From reviewing the documentation and speaking with the facility regarding these complaints, the overwhelming theme behind the complaints seems to be a miscommunication between the facility and parties involved with the residents. Although the HRA does not feel as though the facility is completely at fault regarding the communication breakdown, the HRA did not see much evidence in the form of communication with parties involved in the complaint, and the HRA would still like to suggest that the facility work with guardians, POA agents, and residents to ensure communication over residents care and general stay at its facility and perhaps take a more proactive role in describing fees for services and actions taken by the facility for patients in the future.

The HRA would like to thank the facility staff for its cooperation and participation in this investigation.