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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT #12-030-9012
California Gardens Nursing and Rehabilitation

Case summary: The HRA did not substantiate that the facility administered forced psychotropic medication absent an emergency, however it did substantiate that the facility did not follow Nursing Home Care Act requirements when it regularly ran out of a recipient's medications and when it hospitalized the recipient against her will for no adequate reason. The provider has submitted a corrective plan which has been approved by the HRA.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at California Gardens Nursing and Rehabilitation (California Gardens). It was alleged that the facility did not follow Nursing Home Care Act requirements when it regularly ran out of a recipient's medications, administered forced psychotropic medication absent an emergency, and hospitalized the recipient against her will for no adequate reason. If substantiated, this would violate the Nursing Home Care Act (210 ILCS 45) and the Mental Health and Developmental Disabilities Code (405 ILCS 5).

California Gardens is a 297- bed skilled nursing facility in Chicago which includes short term rehabilitation, specialized dementia care, and long term care. Approximately 130 of the adult residents have a diagnosis of mental illness.

To review this complaint, the HRA conducted a site visit and interviewed the Director of Nursing and spoke with the facility's General Counsel. Relevant facility policies were reviewed, and records were obtained with the consent of the recipient.

COMPLAINT SUMMARY

The complaint indicates that the recipient was on the phone with a family member who heard a nurse state that the hospital was out of the recipient's medication. The recipient stated to the nurse, "That makes three meds you are out of for me." The nurse responded, "Yes." Additionally, when the facility was out of the prescribed medication, the recipient was given medications (specifically Haldol and Adderall), which actually caused negative behaviors in the recipient or were contraindicated due to her diagnosis.

On one occasion the hospital called a family member and told her that the recipient was missing. A staff member told this family member that the recipient had been given other people's medication because there was a shortage of her medication. The family member spoke with the Nursing Supervisor who acknowledged the shortage of medication. The family member suggested that perhaps the recipient had gone to a hospital to get her proper medication and she asked for the names of nearby hospitals. That is where the family member then found the recipient, who had admitted herself into a hospital in order to receive her medication. The complaint also indicates that the recipient was repeatedly hospitalized as punishment and on one occasion was hospitalized for 11 days for no adequate reason.

FINDINGS

MEDICATIONS

The recipient was admitted into California Gardens on 9/07/11 for rehabilitation for a broken neck. She was also diagnosed with hypertension, bipolar disorder and alcohol abuse. Upon her admission the record shows that the recipient's California Gardens physician left orders to "continue all medication," meaning the medication she had been prescribed by her physician to address her medical issues and by her psychiatrist for her mental health issues. The recipient's medications on 9/07/11 are listed as:

Diltiazem, 1 cap every 24 hours for high blood pressure
Atomoxetine (Strattera) 60 mg 1 capsule every morning for hyperactivity
Folic acid 1 mg tablet daily, supplement
Metoprolol 50 mg tablet daily for high blood pressure
Multivitamin 1 tablet daily
Duloxatine (Cymbalta) 60 mg tablet daily for depression, sleep disorder or pain
Divalproex SOD DR (Depakote) 1 500 mg tablet 3 times daily for mania
Pancrelipase (Creon) 12,000 units three capsules four times daily for digestion
Enoxaparin 30 mg/0.3 ml injection every 12 hours to prevent blood clots
Lunesta 3 mg tablet at bedtime as needed for insomnia
Chlordiazepoxide (Librium) 1 25 mg capsule four times daily as needed for alcohol withdrawal symptoms
Hydrocodon/ Acetaminophin (Norco 10-325) 2 tablets every 6 hours as needed for pain
Alprazolam (Xanax) 0.5 mg tablet three times daily as needed for anxiety
Hydrocodone/ Acetaminophen 1 tablet every four hours as needed for pain.

On 9/29/11 the recipient's physician ordered Adderall (amphetamine/dextroamphetamine) 20 mg, and on 12/06/11 Ativan was added as a prn (as needed) medication. The record does not contain informed consents for the following medications: Strattera, Hydrocodone and Adderall. Medline, a service of the U.S. National Library of Medicine, indicates that Adderall may be habit-forming. There is no indication from the record that the recipient received forced, or emergency psychotropic medication during her hospitalization.

On 10/01/11 Nurse's Notes state, "Resident alert up and about resident concerned about new orders for Ambien and Adderall…Called Pharmacy spoke with… States resident's doctor needs to verify the order. Resident made aware signs of respiratory distress. Resident states she cannot sleep at night pharmacy called back gave the pharmacy staff MD's cell number.

Resident received alert... The due meds are given per orders. Good appetite for dinner Consumed 100%. Cervical collar in place… Amphetamine salts 20 mg tab given once available from pharmacy. No signs of distress or complications.

Resident at the nurse's station very upset with writer, stating she want her scheduled medication Adderall because she hasn't received it as ordered since 3 days ago, resident informed that although medication was delivered, we can't just give it anyhow, it is a scheduled medication and she'll have to wait for scheduled dose, but can receive other PRN medications, hesitantly agrees, new order for Ambien not here yet, pharmacy called and waiting for authorization from MD, resident made aware, resident is still upset, will continue to monitor behavior."

On 11/19/11 Social Service Notes may describe the recipient's elopement episode referred to in the complaint. Notes state, "Resident stepped out of the building despite effort to convince her to stay back. Nsg supervisor aware. Dr... notified. Left voice message to [recipient's sisters], social service aware. Per family request 311 non-emergency policy …report made to Chicago Police." The following day a Nurse's Note states, "Call placed to [hospital ER-the same hospital that recipient's sister had said she located her]. Resident's being evaluated in their ER at this time. Rec'd third call from resident's sister, also aware of resident being at …hospital. Per sister, resident stated she left because she was upset with different issues, felt like she was going to explode. Assured sister that resident would be followed up on." The record does not reflect that the recipient left the facility to obtain her medication, however the record confirms that she did admit herself into the hospital emergency department.

The record describes several incidents of medication being unavailable for the recipient. On 11/25/11 the recipient's Norco was unavailable. Notes state "…Writer made an attempt to explain this to resident and asked resident to be patient and pain medication would be given. Supervisor aware", on 12/07/11 notes state, "…Resident came to the nurse's station complaining of pain and told her meds are not yet in the facility...", and on 12/13/11 an entry states, "…Patient came to the nurse's station asking for prn medication, none available."

HOSPITALIZATIONS

There are no petitions for involuntary admission in this recipient's clinical record.

On 11/25/11 Social Service Notes include a Behavior Note (there is no time indicated on the entry). It states, "Resident is demanding that PRSC [Psychosocial Rehabilitation Services Coordinator] fax over a document for her. PRSC told resident she would be able to after lunch. Resident stayed outside PRSC office knocking on the door. PRSC was then notified that resident called 311 saying that she has been abused. PRSC began the process of getting resident petitioned out. PRSC notified Nursing supervisor who then followed up with the DON. The

process is in motion. There are no other concerns at this time." The resident was readmitted to the facility on 12/06/11 following this hospitalization.

Throughout the recipient's hospitalization she requested to see her medical records and received copies of them. For instance, on 12/07/11 the recipient requested her records (presumably to verify her medication regimen) and was told she would have to pay for them and this request was made again on 12/8, 12/09, and 12/10. Additionally, on 12/09/11 the recipient met with the DON and Social Service Director to discuss the issue of the records. At this time the recipient had requested that parts of her record be faxed to her doctor: "Resident has anxious concerns regarding her records being faxed to a certain doctor and facility." The record shows that the recipient was being seen by a neurosurgeon for her broken neck and may have wanted her physician to review her chart for the changes that were being made by the California Gardens physician.

On 12/11/11 Social Service Progress Notes state, "Resident is found by the staff that Resident is in possession of another resident's discharge medical records. The resident is asked by the Medical Records Director how did she manage to get hold of those records, resident stated, she just found those medical records on her bed, and that she did not know how it got there, res also stated is just a set up for her to get her in trouble. The writer, along with the Medical Records Director conducted room search, but did not found any other orange documents nor any other resident's medical records. The resident is placed on behavior monitoring in order to prevent any occurency of this behavior happens again. The resident display belligerent attitudes while staff is going through the whole process of room search; and ….. verbally aggressive voicing she going to let her lawyer about this matter. The resident is schedule to be sent for hospital for psych eval."

Another entry on the same day by the PRSC states, "PRSC was informed by staff that resident was in possession of another resident's medical records. Room search was conducted by another PRSC and medical records to obtain all records, however nothing else was found. PRSC addressed issue with resident. Resident denies taking any medical records and states she does not know how the records got in her possession. Resident believes she is being 'framed.' PRSC explained to resident that she is violating others privacy and that type of behavior is not acceptable. Resident continued to deny taking any records. Staff attempting to petition resident out due to behavior. Resident has been displaying anxious behavior regarding her records and has attempted to retrieve her records at various times. Resident has also been giving her money away to various residents stating she feels 'bad for them'. PRSC explained to resident that it is nice of her to want to help others, however other residents need to learn to be responsible with their money. PRSC encouraged resident to keep her finances to herself. Resident states she just likes to help others, especially when it comes to assisting other residents. PRSC explained to resident that she should not interfere with staff doing their jobs, and if she observes a resident who needs assistance, staff should be alerted. Resident stated she understood. PRSC will continue to monitor resident's behavior and whereabouts in the facility. There are no other concerns at this time". It is not clear from the record whether or not the recipient was hospitalized for this event.

On 12/17/11 at 4:40 pm Nurse's Notes indicate that the recipient was hospitalized: "Resident…to unit asking for her pain meds Hydrocodone/Alprazolam cause she didn't get it yet and due by 7 am and res start being verbally abusive, cursing out staff. Res was referred to supervisor for this situation and she start also …and threatening herself and staff. Supervisor called DON and DON stated to call MD to get an order. Dr… ordered to send to ER…" At 8:35 pm the recipient was transferred to a hospital ER for a psychiatric examination. The resident remained in the hospital until 12/22/11.

On 12/22/11 Social Service Progress Notes indicate that the resident returned to the facility on this day and immediately requested to leave the facility to visit her mother in the hospital. The notes state, "PRSC explained to resident that she's unable to go out on pass at this time since she just returned to the facility. Resident was also reminded of the facility's policy on readmits and her 72 hour restriction for observation purpose. As a result, resident became agitated and was uncooperative with staff, stating that she would sign out AMA [against medical advice] if she was not given a pass. PRSC provided support and counseled her on appropriate ways to help resolve her issues. After discussion with the nursing supervisor and the DON regarding her request, resident was informed that her doctor would be notified before any determination was made. …." An entry was made in the Nurse's Notes for this event and it states, "Res arrived to facility very anxious refusing assessment and was stating she had to leave her mother was sick. Writer explained to res. 72 hour policy. Res stated was going AMA. Signed AMA and left. M.D. paged and informed. M.D. stated not to let res. back to the facility. Will pass on and continue to monitor."

On 12/29/11 Nursing Notes and Social Service notes indicate that the recipient returned late from an outside pass with slurred speech, was approached about her behavior, and then became "threatening":

"Resident returned to the facility from an outside pass on this date. PRSC met with her to discuss the issue of non-compliance with pass policy as resident was suppose to return to the facility 12/28/11. Resident immediately became agitated and appeared belligerent with difficulties communicating due to occasional slurred words. PRSC informed her that due to non-compliance with pass policy, she would be placed on restriction until determined by staff. Resident became increasingly agitated and expressed that she like to leave the facility. She also made threats about leaving. Nonetheless, following continuous belligerent behavior, a drug test was carried out on her. Although, she appeared intoxicated, she tested negative for the use of controlled substance, and remained alert and oriented x 3. Nevertheless, she continues to display verbal aggression towards staff and was very difficult to redirect, as she displayed inappropriate behavior such as going into peers room and taking their belongings without their approval. After threats of signing out AMA, resident refused all directions and hospitalization per order from resident's MD." Nurse's Notes indicate the recipient stated, "I am not going to the hospital."

Social Service Notes later state, "Therefore, a peace officer was informed in order to help escort/assist resident with hospitalization. Following the arrival of the peace officers, resident then expressed and requested to leave the facility AMA. At this time, resident continue to remain verbally aggressive towards staff and was highly paranoid of others, while accusing staff of different allegations. Nonetheless, she was escorted outside the facility, but was unable to

find a place to go. Even though, she expressed a friend was coming to pick her up, staff was unable to reach any contact willing to pick up resident at this time. Resident was encouraged to stay away from the facility and a memo was placed not to allow resident back into the facility as of this date."

FACILITY REPRESENTATIVE RESPONSE

Facility representatives were interviewed about the complaint. They stated that the recipient in this case was very quiet and high functioning when she was admitted, however she became very manipulative and demanding as she remained in the facility. Staff stated that the recipient's medications were ordered immediately upon her arrival, and that she never missed her medications. The only delay in medication would be the narcotic medication, because it requires a physician's approval before the pharmacy (which is not on site) will send it out. Staff stated that the narcotic medications are in a locked area and the recipient wanted her medication off of the cart along with her other medications, which are on the floor along with all other generic medications. Medications are ordered in 30 day amounts and staff felt that the only problem might have been with the Norco because the amount of Norco was changed, which might have meant that it had run out before the end of the 30 day period. Staff stated that there is a 4-6 hour turnaround time for ordered medications to arrive at the facility from the pharmacy. Staff also said that the facility did not request Adderall, and that it was added because the recipient insisted on it. Staff also stated that the pharmacy may make "therapeutic interchanges" of medications within the same chemical category, however the substituted medication would have the same effect. Staff stated that generally recipients sign informed consents for all psychotropic medications and staff felt that the recipient had signed for her medications as well.

Facility representatives were interviewed about the use of emergency or forced medication. Staff confirmed that recipients never receive forced medication. Recipients who display dangerous behaviors are offered prn medication that has been ordered for them and if they refuse, they are then petitioned and sent to the hospital for a psychiatric evaluation. Staff did not think that the recipient in this case ever received forced medication.

Facility representatives were interviewed about the recipient's hospitalizations. Staff confirmed that there were no petitions for involuntary commitment in the clinical record. They suggested that the recipient may have removed these documents when she removed pieces of her record. Additionally, staff were asked about the number of hospitalizations that the recipient experienced and it was unclear from the record the number and dates of these events. Staff stated that the documentation may not have captured the dangerousness of the recipient's behaviors when she was hospitalized, however staff felt certain that it rose to the level of potential harm. Staff were interviewed about the final incident when the recipient was locked out of the facility. Staff felt that this was also a recording issue. Staff stated that the recipient had made a routine out of leaving the facility AMA and that this is what occurred on 12/29/11. Staff were asked why the police had been called if the recipient was leaving AMA and they stated that the recipient changed her mind once the police arrived. The HRA told staff that information obtained after the complaint was issued alleges that the recipient was forced out of the building and that police officers who saw her there without a coat offered to let her sit in their car until the matter was resolved. Staff did not recall that the recipient did not leave AMA.

Facility representatives were interviewed about the recipient's request for her records. Staff answered that the recipient had been allowed to see her record and may have even received a listing of her medications. However, she was so fixed on her records that she waited until the evening when no one was around and went into the nurse's station and grabbed papers out of the patients' charts. Staff stated that this was caught on camera and that the recipient even returned the records later in the evening. Staff were asked why the recipient suffered consequences for this behavior when it is the responsibility of the facility to secure its files. Staff stated that they realized there was a problem and competed an inservice on maintaining the security of the nurses' station.

STATUTES

The Nursing Home Care Act states that 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 "solely on account of his status as a 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 defines "Neglect" as, "A facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident" (210 ILCS 45/1-117).

The Nursing Home Care Act states "a resident shall be permitted to retain the services of his own personal physician at his own expense or under an individual or group plan or health insurance, or under any public or private assistance program providing such coverage. However, the hospital is not liable for the negligence of any such personal physician. Every resident shall be permitted to obtain from his own physician or the physician attached to the facility complete and current information concerning his medical diagnosis, treatment and prognosis in terms and language the resident can reasonably be expected to understand. Every resident shall be permitted to participate in the planning of his total care and medical treatment to the extent that his condition permits."(210 ILCS 45/2-104). The Act states, "Every resident shall be permitted to refuse medical treatment and to know the consequences of such action, unless such refusal would be harmful to the health and safety of others and such harm is documented by a physician in the resident's clinical record. The resident's refusal shall free the facility from the obligation to provide the treatment."(2-104 c). The Act also states, "Every resident, resident's guardian, or parent if the resident is a minor shall be permitted to inspect and copy all his clinical and other records concerning his care and maintenance kept by the facility or by his physician. The facility may charge a reasonable fee for duplication of a record." (2-104 d).

The Nursing Home Care Act states, "Psychotropic medication shall not be prescribed without the informed consent of the resident, the resident's guardian, or other authorized representative. 'Psychotropic medication' means medication that is used for or listed as used for

antipsychotic, antidepressant, antimanic, or antianxiety behavior modification or behavior management purposes in the latest edition of the AMA Drug Evaluations or the Physician's Desk Reference" (2-106.1a and b).

The Mental Health and Developmental Disabilities Code outlines the process whereby a person 18 years of age or older who is subject to involuntary admission and in need of immediate hospitalization may be admitted to a mental health facility (405 ILCS 5/3-600 et seq.). This process requires a detailed statement of the reason for the assertion that the recipient is in need of involuntary admission, the signs and symptoms of mental illness, and a description of any acts, threats, or behaviors supporting the assertion (405 ILCS 5/3-601).

The Nursing Home Care Act states that a facility may involuntarily transfer or discharge a resident only for one or more of the following reasons:

1. for medical reasons;
2. for the resident's physical safety;
3. for the physical safety of the other residents, staff or visitors;
4. for late payment or nonpayment for the resident's stay (210 ILCS 45/3-401).

The Nursing Home Care Act states that "Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under Section 3-408 and by a minimum written notice of 21 days except in one of the following instances: (a) When an emergency transfer or discharge is ordered by the resident's attending physician because of the resident's health care needs, (b) When the transfer or discharge is mandated for the physical safety of other residents, the facility staff, or facility visitors, as documented in the clinical record. The Department shall be notified prior to any such involuntary transfer or discharge. The Department shall immediately offer transfer, or discharge and relocation assistance to residents transferred or discharged under this paragraph (b) and the Department may place relocation teams as provided in Section 3-419 of this Act, and (c) When an identified offender is within the provisional admission period defined in Section 1-20.3…." (210 ILCS 45/3-402).

The Nursing Home Care Act requires that the Notice issued pursuant to an involuntary discharge include the reason for the proposed transfer or discharge, the effective date of the proposed transfer or discharge, and a statement of the right to appeal the transfer. It states, "You have the right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may file a request for a hearing with the Department of Public Health within 10 days after receiving this notice. If you request a hearing, it will be held not later then 10 days after your request, and you generally will not be transferred or discharged during that time…." A hearing request form, together with a postage-paid, pre-addressed envelope to the IDPH, and the name, address, and phone number of the person responsible for the transfer or discharge is to be included with the Notice (210 ILCS 45/3-403).

The Nursing Home Care Act states, "A resident may be discharged from a facility after he gives the administrator, a physician, or a nurse of the facility a written notice of his desire to be discharged… In such cases, upon the resident's discharge, the facility is relieved from any responsibility for the resident's care, safety or well-being" (210 ILCS 45/2-111).

The Nursing Home Care Act states, "Every resident shall be permitted unimpeded, private, and uncensored communication of his choice by mail, public telephone or visitation…. Unimpeded, private and uncensored communication by mail, public telephone and visitation may be reasonably restricted by a physician only in order to protect the resident or others from harm, harassment or intimidation, provided that the reason for any such restriction is placed in the resident's clinical record by the physician and that notice of such restriction shall be given to all residents upon admission" (210 ILCS 45/2-108).

FACILITY POLICY

California Gardens provided the HRA with policy and procedure regarding patient rights. Residents are given the Residents' Rights handbook prepared by the Illinois Department on Aging upon their admission into the facility. According to this policy residents must be allowed to see their medical records within 24 hours of their request, and may purchase copies of all or part of their record with two days advance notice. The residents also have the right to remain living in their facility unless they are a danger to themselves or others, for medical reasons, or because they have not paid their bill. The policy also outlines the process of written notice of transfer and the recipients' right to appeal that decision.

California Gardens provided policy related to residents leaving the facility AMA. It states that the hospital must allow residents to leave the facility AMA if they wish. It also states that "The resident will be given information to allow them to as safely as possible care for themselves in the community." The resident must sign a form requesting to leave AMA and this form becomes part of the resident's clinical record. The policy states that if a resident goes out on pass and does not return to the facility within a specified time, he will be considered AMA. Also, residents who leave AMA are not admitted back to the facility.

California Gardens provided their Behavior Management Program policy. This system is developed "to promote mature and respectful conduct enabling coherent residents to function at their highest practical level." The policy indicates that each new resident starts the program on Level 2. If a resident wants move to a higher level, he must petition to do so only after two weeks in the facility. Those newcomers who want to leave for a family visit may only do so after 72 hours after their arrival. To advance through the level system, residents are expected to follow the Basic Expectations and the additional responsibilities of the level they wish to achieve. They must then petition and secure approval and signatures from their health care team. All decisions regarding petitions are subject to the clinical judgment of the health care team.

CONCLUSION

The complaint issued in this case alleges that California Gardens did not follow Nursing Home Care Act requirements when it regularly ran out of a recipient's medications, administered forced psychotropic medication absent an emergency, and hospitalized the recipient against her will for no adequate reason. The record does not show that the recipient received forced psychotropic medication and the HRA cannot judge the appropriateness of medication substituted by the facility physician since we are not licensed to do so. However we can confirm

from the record that as late as 11/25/11 and 12/07/11 and 12/13/11 the recipient approached staff for her medication and was told that it was unavailable. Additionally, the record is missing informed consents for several medications, a requirement of the Nursing Home Care Act. And finally, the issue of her medication, its appropriateness for her symptoms, and its approval by her personal physician, may have contributed to the recipient's anxiety over viewing and copying her record, which plagued her throughout her stay at California Gardens. The HRA substantiates the complaint that California Gardens violated the resident's right to receive her medications as prescribed under the Nursing Home Care Act and the Mental Health Code requirements when it regularly ran out of a recipient's medications.

Although it is unclear from the clinical record, it appears that the recipient in this case was involuntarily hospitalized at least three times while she was a resident of California Gardens. On 11/25/11 it appears the recipient was hospitalized for calling 311, on 12/17/11 it appears she was hospitalized for having another resident's clinical records in her possession, and on 12/17/11 it appears she was hospitalized because she requested pain medication and became upset when told she could not have it. There are no petitions in the record although the recipient is repeatedly said to be "petitioned" for psychiatric hospitalization, so the clinical justifications for these hospitalizations are unknown. Without this documentation the record simply does not indicate that the recipient was a danger to herself or others and did not deserve to be denied her right to refuse treatment. In fact, it appears that on 12/29/11 the recipient was locked out of the facility because, as staff reported, she said, "I am not going to the hospital." The HRA substantiates the complaint that California Gardens hospitalized the recipient against her will for no adequate reason.

RECOMMENDATIONS

1. Develop policy and train staff in the Nursing Home Care Act law regarding medication to include: that psychotropic medication cannot be prescribed without the informed consent of the recipient, that residents are permitted to refuse medical treatment, and that all residents are permitted to inspect and copy all of their clinical and other records concerning their care and maintenance kept by the facility or by their physician.

2. Ensure that involuntary hospitalization is not used for punishment: Train staff in the Mental Health and Developmental Disabilities Code law which requires a petition for involuntary hospitalization giving a detailed statement of the reason for the assertion that the recipient is in need of involuntary admission, the signs and symptoms of mental illness, and a description of any acts, threats, or behaviors supporting the assertion.

SUGGESTIONS

1. An entry in the record on 12/10/11 states, "PRSC was notified that resident was seen and heard calling the State. PRSC will counsel resident about policies and procedures and that if she has concerns to discuss with in house staff first…." The Nursing Home Care Act states, "Every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or visitation." This right may be reasonably restricted by a physician only in order to protect the resident or others from harm, harassment or intimidation,

provided that the reason is placed in the resident's clinical record. Additionally, if a resident is abused by a staff member they should not have to report to another staff member to address the crime. Educate staff on private communication rights.

2. The HRA considered opening an additional complaint against the facility for the last entry included in the Findings, which was discovered in the record review. This entry is subject to interpretation, however the facts are that the resident's physician ordered hospitalization and the resident refused to go, stating that she would leave AMA. She was then escorted out of the building by police, the doors were locked, and a memo was distributed to refuse her entry, even after staff acknowledged that she had no place to go. The HRA suggests that the facility investigate this incident and ask staff how this situation could have been handled more humanely, keeping in mind that there are strict State laws for involuntarily discharging residents (see above), even for emergency purposes, which this was not.

3. The resident in this case was able to enter the nurse's station and remove records, and she was reprimanded for this action. The HRA suggests that the private records of the facility residents are the responsibility of the facility and must be secured by the facility. Any breach of confidential records is the fault of the facility.

4. The HRA suggests that all entries in the clinical record be signed by the writer, dated, and the time of the entry and time of the event be included.

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