FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
GLENWOOD HEALTHCARE AND REHABILITATION —– 12-040-9008
HUMAN RIGHTS AUTHORITY—– South Suburban Region

[Case Summary—– The Authority did not substantiate the complaint as presented; the public record on this case is recorded below. The agency did not provide a response to the report.]

INTRODUCTION

The Human Rights Authority (HRA) has completed its investigation into an allegation regarding Glenwood Healthcare and Rehabilitation. This investigation was opened in November 2011. The complaint alleged that the facility failed to provide a resident with adequate care and assessments in regard to a swallowing evaluation. If substantiated, this allegation would violate the Nursing Home Care Act (NHCA) (210 ILCS 45/2 et seq.), the Illinois Administrative Code for Skilled Nursing and Intermediate Care Facilities (77 Ill. Admin. Code Part 300), the Centers for Medicare and Medicaid Services, Department of Health and Human Services' (CMS) Requirements for Long Term Care Facilities (42 C.F.R. 483) and the Illinois Probate Act (755 ILCS 5/11a-23).

Glenwood Healthcare and Rehabilitation provides 24-hour skilled nursing care and offers a range of programs. The 184-bed facility is located in Glenwood.

METHODOLOGY

To pursue the investigation, the complaint was discussed with the Facility Administrator, the Director of Nursing and a social worker many times during closed sessions at the South Suburban Regional public meetings. The complaint was discussed with the resident's court appointed guardian. A site visit was done at which time the resident was observed by the investigation team. Sections of the resident's record were reviewed with written consent. Relevant facility policies were also reviewed.

COMPLAINT STATEMENT

The complaint stated that the facility failed to have a swallowing evaluation done to determine whether the resident could be weaned from her feeding tube as allegedly recommended by the hospital's physician who had inserted the tube. It was reported that the Director of Nursing told the resident's family member that an assessment would be done if requested by the verbally impaired resident. Another staff person allegedly told the guardian that

the cost of the assessment would have to be taken out of the resident's trust fund or that her family member should pay for the evaluation if she wanted it done.

FINDINGS

According to the record, the resident was transferred to the facility from a community hospital in 2010. She is dependent in all areas of activities in daily living. Her diagnoses include Profound Mental Retardation, Blindness, Cerebral Palsy and multiple physical problems. A gastrostomy tube (g-tube) had been inserted in her abdominal area while she was hospitalized. This is a feeding tube used to provide nutrition to a person who cannot obtain nutrition by swallowing. There were many nursing notes documenting that the resident's feeding tube was checked and flushed as ordered by the assigned facility physician. They were also notes reflecting that the resident's lips were often moisturized because the resident's family member usually expressed concerns about them being too dry.

The HRA found no written indication during the record review that the physician who had followed the resident in the hospital had recommended a swallowing evaluation as the complaint alleged. However, an order dated June 3rd, 2011 written by the facility physician stated that a swallowing evaluation would be done as requested by the resident's family. We note that the family member is not the resident's legal guardian. The next entry concerning the evaluation was written on October 18th, 2011. According to the nursing note, the guardian's supervisor said that the assessment was not clinically warranted and that the resident's family member should pay for the evaluation if she wanted it done. On November 18th, 2011, the physician wrote that a swallowing evaluation was not clinically warranted based on the resident's physical condition.

When the complaint was discussed with the facility's administration, the Director of Nursing said that resident was eating and drinking by mouth before she had aspirated while swallowing. This occurs when solids or liquids that should be swallowed into the stomach are breathed into the respiratory system. She reportedly has been on "nothing by mouth" status since 2010 and maintains her weight. She does not show signs of wanting to eat or drink by mouth or biting down during oral care. According to the Director of Nursing, the physician is at the facility every week. She said that the physician had previously ordered an evaluation based on the resident's family member's request, but the clinician was unaware that the individual's condition did not warrant an assessment when she wrote the order.

The Director of Nursing explained that a swallowing assessment is done by a speech therapist and that the resident would have to consume liquids and different consistencies of food such as apple sauce during the procedure. She said that Medicaid will not pay for any kind of therapy such as a swallowing assessment. The guardian reportedly told her that the resident's personal funds could not be used to pay for the assessment and had refused to give consent because of possible risks such as aspiration associated with the procedure. The guardian told the HRA that there was nothing to authorize. The staff further reported that the assigned physician had met with the resident's family member in January 2012 concerning her request for an evaluation and explained that the procedure was contraindicated in the eligible person's care. And, the staff reportedly told her what signs would suggest that a swallowing evaluation was

needed. We note that the resident appeared to have been sleeping in a wheelchair when the investigation team observed her at the facility.

According to Glenwood Healthcare and Rehabilitation "Admission Policy," no resident who is determined by professional evaluation to be in need of services not readily available in the facility, or through arrangement with a qualified outside source, shall be admitted or kept in the facility.

The facility's "Resident Assessment Instrument" policy provides guidelines for identifying each resident's care needs, strengths, and assisting the individual to attain the highest practical level of mental and physical functioning and well-being as possible. It states that a comprehensive assessment will be completed on every resident within 14 days of admission, with each significant change, annually and as needed. A quarterly assessment will then be done unless the resident's condition warrants a full comprehensive assessment.

According to the facility's "Oral Assessment" policy, all residents will have an oral assessment completed upon admission and quarterly thereafter. It states that appropriate treatment and follow up will be initiated when issues are identified.

The facility's "Grievance/Complaint" policy states that all residents have the right to voice concerns or complaints which affect their lives at the facility without fear of discrimination or reprisal. A complaint may be presented to any staff person who may resolve the issue immediately. The policy contains procedures if unable to resolve immediately.

Section 45/1-117 of the NHCA 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. Section 45/2-107 of the Act states that an owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

According to CMS' Requirements for Long Term Care Facilities Section 483.25 and the Illinois Administrative Code 300.1210 (a),

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan care.
>
> Section 483.25 (g) furthers states that based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic

abnormalities, and nasal pharyngeal ulcers and to restore, if possible, normal eating skills.

The Illinois Probate Act (755 ILCS 5/11a-23) states,

Every health care provider and other person (reliant) has the right to rely on any decision or direction made by the guardian … that is not clearly contrary to the law…as though the decision or direction had been made or given by the ward.

Based on the physician's note dated November 18th, 2011, the complaint that the facility failed to provide a resident with adequate care and assessments in regard to a swallowing evaluation is unsubstantiated. The HRA leaves medical determinations to the assigned physician, but we question why the clinician had previously ordered a swallowing evaluation that reportedly was not warranted and possibly harmful to the resident upon her family member's request. However, the Authority finds no violations of the above statues or program policies.

SUGGESTION

1. The HRA reminds the facility that the resident's plan of care should always be based on her needs and any decision made by the guardian without undue influence of others unless so designated or unless the guardian's decisions are contrary to law.