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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 12-090-9004
El Paso Healthcare and Rehab Center

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at El Paso Healthcare and Rehab Center, a nursing home. The complaint alleged the following:

1. **Inadequate discharge procedures, including lack of discharge plan for patients.**

If found substantiated, the allegation would violate the Nursing Home Care Act (210 ILCS 45) and Illinois Administrative Code (77 Il. Admin. Code 300).

El Paso Healthcare is a statewide nursing home for individuals in need of mental health services. It is licensed for skilled nursing care and is a long term care facility. El Paso Healthcare employs 68 staff members that consist of RNs, LPNs, CNAs, Housekeepers and Activity Directors. The facility is licensed for 128 beds and offers physical therapy, occupational therapy, restorative programs, psychosocial rehabilitation, and skills training among other programs.

To investigate the allegation, HRA team members met and interviewed staff and reviewed documents pertinent to the case, including resident records with guardian consent.

COMPLAINT STATEMENT

The complaint alleges that a patient is capable of living outside of the nursing home but staff will not provide a discharge plan for her to move into the community. The complaint alleges that facility staff have said that they will start discharge planning but have not. The complaint states that staff has also said they will help an individual find a place to live outside of the facility but have done nothing.

FINDINGS

Interview with Staff (October 24th, 2011)

The HRA began the investigation process by interviewing El Paso Healthcare staff. The staff explained that the patient never verbalized to the nursing staff that she wanted to be discharged. The patient was working on aspects of the discharge in secret without the knowledge of the staff. The social services staff discovered that the patient was working on her discharge. The staff explained that currently there are no immediate plans from a physician to discharge the individual. The patient was admitted to the facility under a court order, for 90 days, but the order was dismissed. The facility felt that the patient was not cognitively ready for discharge after the court order was dismissed. The facility explained that they do not work on discharge until the patient discusses the discharge with a physician. The staff stated that the patient never discussed the discharge with a physician. The patient contacted an outside agency for assistance in finding a place to live. The patient had previously signed up for housing through the agency. When the agency called with an apartment opening, she could not accept because she was at the facility under the court order for 90 days. The staff said that the agency will call three times, so the patient still has two more opportunities for an apartment. The staff explained that the patient wanted subsidized housing and that the housing agency she contacted would call her personally. The staff explained that patients need to have adequate housing and medications ready before they are discharged. The facility wants them to be successful. The staff stated that policy allows residents to leave against medical advice (AMA), but staff usually still try to locate a place for the resident to stay. When patients leave AMA they also contact the local police to let them know what is occurring. If staff would have known, then they would have put the resident on the housing list because they have people to contact. They said if someone has taken this step, then they need to talk to her about the process. Staff stated that they have talked about discharge planning with the patient since it was discovered that she was arranging housing. She has been a resident of the facility since June of 2010.

The staff explained that the patient has a care plan but not a plan for discharge. At admission, each patient receives a packet containing discharge policy and other documents that are signed and reviewed. The resident can express his or her interest in discharge during the initial care plan process. The patients can also have daily contact with social services. At the time of the HRA interview, staff claimed that the patient had not requested discharge from either the physician with whom she has met at the facility or any other facility staff member. The patient has never tried to leave against AMA. The staff previously believed that the patient was homeless before she entered the facility, but discovered that she had lived with her mother at one point. The patient received care from a hospital before moving to the nursing home.

The staff explained that they will usually tell a resident that he/she can leave if he/she asks. Staff will discuss staying at the facility with the patient but will not hold them against their will. The patient never stated she wanted to leave or even got upset with the facility staff about being there. The patient did get upset with the Community Reintegration Program because, according to the facility, they have quit offering services to people who are mentally ill. According to the staff, the program did not give the patient accurate information and said they would not provide her services. The staff also said the program has not been following through with anything. They stated that the service is the only community placement avenue for patients with mental illness in long term care.

The staff explained that, to be discharged, the patient has to discuss discharge with to the physician and the physician has to write orders. Then, the psychiatrist will come and meet with the patient, a nurse, and a caseworker. If they decide to start the discharge process, staff starts looking at resources. The social work department helps the patient with reintegration, which can take months. The staff explained that the patient named in this complaint is not currently in discharge planning. The patient did not go to the last care plan meeting, which the staff indicated was an opportunity for her to request discharge. Her diagnoses are schizophrenic, traumatic brain disorder and personality disorder. The staff saw nothing in her physician orders stating that she was ready for discharge. The staff explained that if the patient requests a discharge, the physician would meet with her; otherwise, the physician meets with the patient every 90 days.

Record and Policy Review

The HRA reviewed the facility's "Contract Between Resident and El Paso Health Care Center," which indicated that "prior notice is generally required to terminate this Contract" (page 1). In addition, the Voluntary Discharge policy states that "the Resident may be voluntarily discharged from the Facility at any time immediately after the Resident or Responsible Party gives the Nursing Home Administrator, a physician, or a nurse of the Facility thirty (30) days written notice of the Resident's desire to be discharged" (page 6). The resident's signature appears on the contract dated 06/28/2010.

The Annual Social Services Review and Update signed by the resident and dated 08/16/2011 indicates that the resident "was informed of and reviewed" the facility's policies. The form does not indicate, however, that the individual was reminded of the voluntary discharge policy. The form also reads, "My right to be involved in my care through participation in care plan conferences. I understand that I and/or my legal representative and/or my guardian and/or my family member are encouraged to attend these conferences." The resident is listed as her own legal contact.

Staff stated in the interview of 10/24/2011 that the resident was secretive and did not bring up her desire for discharge to anyone. According to the facility's Social Service Intervention Notes and Social Service Monthly Reviews, she discussed discharge on the following dates:

- 08/10/2010: "Resident is concerned about her court dates, and getting an apartment in [City]." (Resident Concerns, Social Service Monthly Review)
- 09/01/2010: "Residents' main concern is her court hearings and when she can be discharged." (Resident Concerns, Social Service Monthly Review)
- 12/31/2010: "Wants to leave. Very confused about where she is." (Resident Concerns, Social Service Monthly Review)
- 01/31/2011: "Discharge to independent living." (Resident Concerns, Social Service Monthly Review)
- 03/31/2011: "Resident feels she is ready for discharge." (Resident Concerns, Social Service Monthly Review)

- 04/11/2011: "Resident is interested in discharge but has no place to go. Resident in the past contacted [Housing Service Provider] but did not hear from them. Counseled on having a plan for a successful discharge. Contacted [Housing Service Provider] and left a message for them to call back so that [Resident] would be assessed." (Social Service Intervention Notes)
- 04/12/2011: "Received call from her mother…Explained that we have no plan for discharge at this time." (Social Service Intervention Notes)
- 06/06/2011: "Concerned about discharge." (Resident Concerns, Social Service Monthly Review)
- 06/09/2011: "Resident told her mom she is going home. We have no discharge orders at this time." (Social Service Intervention Notes)
- 07/26/2011: "Assisted resident with finding numbers for mental health #'s that would possibly assist her with follow up services once she is discharged. Discussed the community reintegration program and what services they are currently offering. Resident requested state representatives' # which we will give her later." (Social Service Intervention Notes)
- 07/26/2011: "Wants to be discharged but has no current plan for follow up care." (Staff Concerns, Social Service Monthly Review)
- 08/03/2011: "Spoke with resident about the MMSE, discharge, what she has done so far to suk [sic] housing." (Social Service Intervention Notes)

Staff stated that the resident was admitted to the facility under a court order that was subsequently dismissed. The HRA reviewed a court order dated 09/09/2010 that sentenced the individual to six months of probation, which expired 03/09/2011. The probation order also includes a provision that, after scheduling an evaluation for mental health at a State-licensed facility, the individual must "complete all recommendations for treatment by 02/09/2011." The HRA found no reference to this date or a treatment plan goal included with the resident's care plans. At the time of the expiration of the court-ordered probation, the individual was a resident at the facility in question (she was admitted 06/28/2010) and continued under its care. Documentation provided to the HRA by the facility indicates that the individual continued to express her interest in discharge after the expiration of her probation, during which time she was not obligated to remain at the facility. The court order reviewed by the HRA was not a court order for involuntary commitment.

Care Plan Conference Invitations to the resident for care plan conferences dated 12/30/?, 03/31/2011, 06/30/2011, and 09/29/2011 were discovered. Quarterly Notes indicated that the resident attended the conference of 10/07/2010, but did not attend on 12/30/2010, 03/23/2011, and 06/30/2011. No records were found for 09/29/2011.

The care plans that the HRA reviewed contained basic descriptions of the resident, a single goal, and interventions to assist the resident in achieving the goal. The documents were originally dated 07/01/2010, 07/06/2010, 07/09/2010, 08/17/2010, 10/07/2010, and 11/01/2010. These were the most recent plans provided to the HRA. Each of the above-mentioned documents were subsequently initialed and dated at three-month intervals, corresponding with the dates of the individual's care plan conferences listed above. Contrary to the Nursing Home Care Act, the documents did not enumerate measurable goals set against a timeline for

completion, nor did they reflect changes in the resident's behavior over the many months that they covered. The Nursing Home Care Act mandates that "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 measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial 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" (210 ILCS 45/3-202.2a). The care plans also provided no discharge plan or any mention at all of discharging the individual.

MANDATES

The HRA reviewed pertinent regulations regarding the complaint in this report. The Nursing Home Care Act states that "A resident may be discharged from a facility after he gives the administrator, a physician, or a nurse of the facility 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 Skilled Nursing and Intermediate Care Facilities Code states that "A facility shall not refuse to discharge or transfer a resident when requested to do so by the resident or, if the resident is incompetent, by the resident's guardian…If a resident insists on being discharged and is discharged against medical advice, the facts involved in the situation shall be fully documented in the resident's clinical record" (77 Ill. Adm. Code 300.620).

Regarding comprehensive care plans, the Nursing Home Care Act provides that "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 measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial 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" (210 ILCS 45/3-202.2a). The Skilled Nursing and Intermediate Care Facilities Code also states that "As part of the ITP [Individual Treatment Plan], a discharge plan shall be considered by the interdisciplinary team as a component of the individual's comprehensive program plan. This plan shall address the reduction of symptoms and the acquisition of behaviors and prioritized skill deficits that inhibit the individual from moving to a more independent environment" (77 Ill. Adm. Code 300.4060).

CONCLUSION

Complaint #1 - Inadequate discharge procedures, including lack of discharge plan for patients.

The complaint states that an individual is capable of living outside of the nursing home

but staff will not provide a discharge plan for her to move into the community. The complaint alleges that staff has said that they will start discharge planning but has not. The complaint also alleges that staff would assist an individual in finding a place to live outside of the facility, but nothing has been done. The HRA toured the facility, interviewed staff members, and reviewed relevant documents, including resident records and facility policies. The individual signed a contract which described the procedure for voluntary discharge, indicating that the resident may be "voluntarily discharged from the Facility immediately after the Resident or Responsible Party gives the Nursing Home Administrator, a physician, or a nurse of the Facility thirty (30) days written notice of the Resident's desire to be discharged" (Contract Between Resident and El Paso Health Care Center). This policy is also supported by the Nursing Home Care Act: "A resident may be discharged from a facility after he gives the administrator, a physician, or a nurse of the facility written notice of his desire to be discharged" (210 ILCS 45/2-111). When the HRA interviewed staff members during the site visit, however, staff claimed that they had not yet begun discharge planning because the resident had not discussed her discharge with a physician, nor had she discussed discharge with any other staff member. According to Social Service reviews and notes, the individual expressed her interest in discharge multiple times during the last year, even attempting to make independent arrangements with outside service providers. The Illinois Administrative Code also dictates that "A facility shall not refuse to discharge or transfer a resident when requested to do so by the resident or, if the resident is incompetent, by the resident's guardian" (77 Il. Admin. Code 300.620).

In addition, the patient's records do not contain a clear care plan with "measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs" (210 ILCS 45/3-202.2a). The resident's care plans that were reviewed by the HRA do not provide measurable objectives and timetables, nor are they updated with every care plan conference. In addition, they do not include any discharge planning whatsoever. The Skilled Nursing and Intermediate Care Facilities Code states that "As part of the ITP [Individual Treatment Plan], a discharge plan shall be considered by the interdisciplinary team as a component of the individual's comprehensive program plan. This plan shall address the reduction of symptoms and the acquisition of behaviors and prioritized skill deficits that inhibit the individual from moving to a more independent environment" (77 Il. Admin. Code 300.4060a).

Because the facility failed to comply with regulations and provide discharge planning within the care plans and because facility staff members did not comply with their own policies, the HRA contends that the facility does not have an adequate discharge procedure. The HRA finds the complaint **substantiated** and makes the following **recommendations:**

- If still in the facility, schedule a care plan meeting with the resident in this case to develop a care plan with measurable goals that will facilitate her desire to be discharged. Provide the HRA with evidence of the revised care plan and discharge plan.
- Develop a policy for constructing clear, effective discharge plans within the care plans in accordance with the Illinois Administrative Code 77 Il. Admin. Code 300.4060 which states that a facility must "provide for discharge planning to the least restrictive setting based on the resident's care needs."

- Educate staff members in the directives of the Nursing Home Care Act (210 ILCS 45) and the Skilled Nursing and Intermediate Care Facilities Code (77 Il. Admin. Code 300), particularly sections 210 ILCS 45/3-202.2a, 210 ILCS 45/2-111, 77 Il. Admin. Code 300.620, and 77 Il. Admin. Code 300.4060a which address care plans and discharge procedures. Provide evidence to the HRA of this education.
- In the interview, staff stated that a patient must discuss discharge with a physician and that the facility needs a physician's order to begin discharge; however, this is not accurate in accordance with regulations and with the facility's own policy. Educate staff members in facility policy, which is compliant with the above-mentioned directives, and provide evidence of education to the HRA. This is particularly pertinent given the frequency with which the individual's desire for discharge was recorded in the staff notes.

The HRA also makes the following **suggestions**:

- The HRA saw that there were multiple times that the patient had requested to be discharged from the facility and, at times, there were no actions being taken by the staff. Although the regulations do not specifically state that the staff must remind the patients of the needed actions to be discharged from the facility, that also does not mean that the staff has no responsibility in patient care and assisting the patients in their desires. The HRA suggests that in the future, when a patient asks to be discharged, the staff remind them of the policy and even assist them in taking the needed action in achieving that desire.
- Ensure that staff is encouraging in their approach.
- In reviewing the care plans for the patient, the HRA was alarmed in the fact that there seemed to be no goals being tracked within the plans. The HRA asks that the facility develop a policy for constructing clear, effective care plans in compliance with the Nursing Home Care Act 210 ILCS 45/3-202.2a that includes a means of tracking/documenting progress toward meeting goals.
- Review the policy of alerting local police officers to the presence of a person with mental illness in the community recognizing the confidentiality and discharge rights of the individual. Consider policy contact only when necessary to protect a documented health or safety risk to the individual or others.