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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 13-090-9004
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 treatment, including staff ignoring residents, punishing residents, and acting in a rude manner towards residents. Also, a resident was not examined by a physician until 30 days after the resident was admitted. And, the facility ignored a resident's complaints regarding pain.**
2. **Communication violation including a resident was not allowed stamps or told about phone calls.**
3. **Inadequate inventory process.**
4. **Facility not following physician's orders by not providing resident prescribed medication.**
5. **Inadequate safety of residents and inadequate staff supervision, including violence between two residents not being prevented by staff.**
6. **Inadequate communication between facility and resident.**
7. **Inadequate treatment planning.**

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

A subsidiary of Petersen Healthcare, the El Paso Healthcare Center is a nursing home the primarily services individuals with mental health needs. It is a licensed, skilled nursing long term care facility. El Paso Healthcare employs 68 staff members that consist of Registered Nurses (RNs), Licensed Practical Nurses (LPNs), certified nursing assistants (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 interviewed staff and reviewed documents pertinent to the case, including a resident's records, with guardian consent.

COMPLAINT STATEMENT

The complaint states that staff ignored a resident who needed Insulin, ignored a resident requesting nurses, punished a patient for having a bowel movement by not providing her water or toilet paper, and did not clean that resident afterwards. Also, a resident did not see a physician for 30 days after being admitted to the facility and there was no examination or physical of any kind within 24 hours of being admitted. When the resident did see the physician, the resident's kidney history was not discussed. The complaint also alleges a dietary worker rudely shoved a food tray at a resident. Additionally a resident had pain that the facility did not examine. A family member of the resident in pain transported the resident to an emergency room and it was discovered that the resident had a urinary tract infection (UTI). The facility was said to have ignored her complaints and only provided the patient Tylenol, and the resident stated that she was in pain on 6 different occasions.

The complaint alleges that a resident was not told about phone calls and was not allowed stamps to send letters. The allegations also state that a resident's clothes were not marked or inventoried upon admission and the clothes were stolen and worn by other residents in the facility.

The allegations state that a nurse did not give a resident Geodon for 3 nights. The nurse made excuses each time such as that the facility could not find the medication or that the facility did not have the medication. The resident also did not receive medication for a home visit.

The allegations also state that a resident's roommate was physically threatening. The resident's roommate told the resident that she would kill her if she did not stay away from her boyfriend. A resident also believed her roommate had a weapon that was provided by another patient after a separate altercation. Other residents were physically abusive and made gestures like they were going to hit the resident. Other residents were actually hit.

The complaint also states that nursing home staff transported a resident to a police station for fingerprints but did not explain to the resident why the fingerprints were taken. While there, the resident was also made to sign documents that she did not understand.

The complaint alleges that the resident did not discuss future plans of rehabilitation with the resident. The resident was to go to community college and the facility did not discuss it with the patient. The facility also did not discuss discharge with the resident and did not realize that the resident had been there 30 days.

Interview with Staff (November 14th, 2012)

The staff stated that they follow their abuse and neglect policy if complaints like this were to occur, but the staff stated that they were not aware of any inadequate treatment. The staff explained that the resident was very delusional upon admission. Staff explained that the

resident has a history of telling caretakers that she was sick or has thrown up, then when the caretakers would respond, there was nothing indicating that the resident had vomited. Caretakers could not respond if they saw no evidence that the resident was sick and then the resident would get upset. The staff stated that they believe the resident may have overheard conversation and thought someone else in the facility did not recieve medication. Staff explained that the resident had delusions and after overhearing conversations, thought they involved her.

Staff stated that at the time of the HRA site visit, the resident was no longer at the facility and had left after one month. Staff stated that the resident was committed for treatment for 90 days. Staff stated that a family member took the resident on a home visit and the resident never returned.

Staff denied most of the allegations, stating that the delusions could be the reason why the resident thought the allegations occurred. The staff said that upon reviewing the record, there is a pain assessment sheet stating the resident was not in pain and, in fact, denied pain. Staff said that on 6/25 the resident complained of a headache and Tylenol was ordered. Staff explained that they had never heard a complaint regarding bowel movements, toilet paper not being provided to residents and staff not cleaning residents. Staff stated that the resident was not diabetic. Staff explained that they had no records of fights or violence involving the resident and that this could have been a result of her delusions as well. They explained that the resident's roommate was very loud and talked very quickly and there was a chance that something she said could have been misconstrued as being directed at the resident. Staff explained that if violence is reported they follow the abuse policy. If there is an allegation and staff considers the resident to be harmful, that resident receives checks every 15 minutes or a one-on-one aide. Staff said that staff members meet weekly for behavior teams and recieve yearly Crisis Prevention Institute (CPI) training. Staff explained that there are also quarterly trainings and two in-service trainings per month in which abuse is discussed. Staff said they did not have knowledge of the resident mentioning a kidney problem.

The facility stated that they have an ample supply of stamps for sale. If a resident does not have money for stamps the facility will provide them with one. Staff explained that the patient was always aware of recieving telephone calls. When residents recieve a call, the staff member contacts the nurse on the resident's wing who informs the resident of the call. Staff said that the resident did not use the phone often. Staff said that the only time the resident brought up her relatives was in regard to money being stolen from her and staff had no information about the relationship between the resident and family.

The staff also explained that the resident was transferred to the facility from a hospital where she was seen by a physician and, because of this, the facility had 30 days before the resident had to see a physician. Staff explained that the resident was admitted on 6/21 and was then examined by a physician. The facility staff explained that admissions are usually transferred from other facilities and are rarely admitted under other terms. Staff said that if a resident is not a transfer, a local physician will see the resident when admitted. Staff explained there is also a physician's assistant that visits the facility weekly.

Staff stated that they were unaware of a complaint about not following physician's orders. Staff explained that there was nothing in the resident's record about a history of kidney issues. Staff said that the resident had a history of gastroesophageal reflux disease (GERD), hypothyroidism, shizoeffective disorder, and anxiety. Staff said they had no knowledge of the resident mentioning a kidney problem. Staff stated that if there were complaints they would have been investigated immediately. The facility administrator is the abuse coordinator. If a complaint of abuse is brought to staff or staff witnesses abuse, then it is reported to the administrator. The facility reports the abuse to the Illinois Department of Public Health within 24 hours. If the alleged assault is by facility staff, they are immediately suspended pending an investigation. If the abuse is substantiated, the staff member is terminated. Upon admission staff review a copy of the resident grievance process with the resident and the resident signs the policy. Residents receive rights information which are also posted in the facility.

Staff said that this resident did not have clothes stolen, and if she had, the facility would have investigated the situation. Staff did not think that the resident even had many personal items. When property is brought into the facility during admission, staff review the items with the resident, and the items are inventoried. If other items are brought to the facility after the resident is admitted, they are added to the inventory list. Staff said they have records of an inventory that was completed for the resident which the resident signed. If someone steals an item, residents can inform any staff member. Once staff is informed, they tell a supervisor and the theft is investigated. Residents are informed of the inventory policy upon admission and, also during resident council meetings. Resident council meetings are held once a month. At resident council meetings, staff review the policies that residents recieve on admission. The facilities also have an advocate that visits the facility and reviews policy. Staff also said there is a list of contraband items in the admission packet and, if staff believe that the resident has contraband, then they perform a search.

Staff stated that the resident had a prescription for Geodon and did not miss a dose. The resident took the medication twice a day and it was always administered. If medication had been missed then staff would complete medication error documentation. Staff said there is a form that is completed prior to a home visit that explains what medication was sent home and this resident recieved medication when she left. The facility staff stated that they are mandated by law that if a resident leaves, they are given all their medication, especially if they are discharged.

The staff said that if a resident is admitted and has a criminal history, they will be identified as an offender. If they are identified, the resident must be fingerprinted. The results of the fingerprinting are sent to El Paso along with the resident's risk level. Staff did not recall this resident having a criminal record but the resident could have been fingerprinted because of having a common name that matched someone else who has a criminal record. The staff usually takes the residents to Bloomington for fingerprints but it is a time sensitive situation so they sometimes take them to Canton if there are no times that work with the schedule in Bloomington. There is a form that is given to the residents to sign regarding the fingerprints and the process is explained to them.

Staff explained that the resident had an interim treatment plan but was not at the facility long enough to have a full treatment plan or a treatment plan meeting. They explained that after

14 days they create a minimum data set (MDS) for the resident and then create a care plan and conduct a care plan meeting within 90 days. Staff said that the resident had not been there 90 days. Staff explained that every 90 days they meet with each resident and each department will assess the resident and then write a goal that is added to the care plan. If the resident or family requests a care plan meeting, then a meeting will be held. The staff said they mail out care plan invitations to the resident's family or anyone else that the resident may want to invite. Staff explained that within 24 hours of admission they start assessments. They did state that there was no discussion about school with the resident and they would not have transported her to school regardless. Staff said that the facility does not provide transportation for residents to attend colleges. They said there is one resident who goes to school because the resident is so young. Staff said that residents do not automatically recieve a copy of the 14 day MDS but they can request a copy.

The staff stated that the response time on the call lights are quick. Staff randomly monitor call lights, but they have never had complaints about poor response time. Staff explained that most of the residents are independent so the call lights are not utilized often. Staff stated that there are four wings in the facility and four nurses. One wing is very independent so they only have one nurse and the remaining nurses focus on the other wings. There is one social services staff member assigned to each wing and each wing also has unit aides.

Findings (Including record review, mandates, and conclusion)

Due to similarities between the complaints, complaint #1 and #5 have been combined in this report.

Complaint #1 - Inadequate treatment, including staff ignoring residents, punishing residents, and acting in a rude manner towards residents. Also a resident was not examined by a physician until 30 days after the resident was admitted. And, the facility ignored a resident's complaints regarding pain. & Complaint #5 - Inadequate safety of residents and inadequate staff supervision, including violence between two residents not being prevented by staff.

The HRA reviewed multiple documents including nursing notes, care plans, etc. and saw no evidence that staff ignored a resident who needed insulin, ignored a resident requesting nurses, punished a resident for having a bowel movement, or acted in a rude manner towards a resident. The HRA also did not see any evidence that a dietary worker was rude towards a resident. The HRA did see that an allegation was presented to administration, according to the nurse's notes on 7/13, and reviewed a document that was a follow-up to the allegation which stated that the resident accused a staff member of denying treatment. The facility investigation found no evidence that treatment was denied, and when the resident was interviewed and asked about complaints and concerns, the resident had no complaints against the staff.

In reviewing the resident's records, there is a resident admission sheet that indicates the individual was admitted on 6/21/12 from a hospital. There is evidence that the resident received an examination from a physician on 7/20/12. The examination form stated that the patient's abdomen was checked and the examination results indicated no masses/tenderness, a normal

liver/spleen/kidney, normal bowel sounds, no hernia, and a negative hemoccult. The HRA saw no indication that the resident was examined prior to admission or 72 hours after admission; the transferring facility's record was not reviewed.

According to nursing notes and pain management flow sheets, there were only two occasions between 6/21/12 and 7/21/12 when the resident indicated that she was in pain and it appeared that there were interventions on both occasions (although the 7/16 intervention was barely legible). Although the HRA cannot state that there was a pain management check on 7/16 due to illegible charting, according to the nursing notes the resident had a burning sensation during urination on that date but the 7/20/12 physician examination had no statement regarding urination issues. It appeared that the resident was asked daily about pain. The HRA saw no indication that the resident stated she was in pain on 6 different occasions or that a family member took the resident to the ED and discovered the resident had a UTI. There was also a bowel and bladder assessment done on 6/22/12 and 6/28/12 which both indicated that the resident had no history of urinary tract infections. There was no bowel or bladder assessment done at a later date.

The facility right's statement provided to all residents reads "Your facility **must** provide services to keep your physical and mental health, and sense of satisfaction." It also reads "You **must not** be abused by anyone - physically, verbally, mentally, financially or sexually." The facility also has an "Abuse Prevention Program Facility Policy" which reads "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to *assure* that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents." The policy proceeds to state that some of the procedures for the prevention of abuse include: pre-employment screening so that the facility does not employ any individual who has been previously convicted of resident abuse; the orientation and training of employees on topics such as sensitivity to resident rights and needs; the reporting of abuse; assessing, preventing and managing aggressive, violent and/or catastrophic reactions of residents; and, how to recognize and deal with burnout, frustration, and stress that may lead to inappropriate treatment of residents. The policy also emphasizes "establishing a resident sensitive environment." The majority of the policy deals with the process for reporting and investigating abuse allegations.

In regard to complaint #5, the HRA reviewed a list of approved belongings as well as a list of contraband not allowed in residents' rooms. Neither document mentions weapons or the facility inspecting rooms for weapons. The HRA did review a list of visitor rules which state that visitors must check in all items brought to the resident at the nurses' station prior to providing them to the resident and that visitors who threaten the well being of any resident or employee or violates visiting rules will be requested to leave, and if they do not leave, the facility will call enforcement authorities.

The HRA viewed a passage in the nurse's notes, dated 7/30/2012 that states the resident was still agitated with roommate placement. The HRA requested clarification on the statement and the facility stated that they have no documentation of alleged complaints against the

resident's roommate. In an email, staff wrote "[Resident] was delusional and her roommate talks to herself so it was not a good roommate match. Social Service asked if she would like to try a different room with a new roommate and [resident] agreed." The HRA reviewed a room change check list dated 7/9/12.

The HRA saw no evidence of verbal threats or physical abuse between the resident's roommate, roommate's boyfriend, the resident or other individuals in the facility.

The Center for Medicare and Medicaid Services requirements state "(c) Frequency of physician visits. (1) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter" (42 CFR 483.40). The Skilled Nursing and Intermediate Care Facilities Code reads "Each resident admitted shall have a physical examination, within five days prior to admission or within 72 hours after admission" (77 Il Admin Code 300.1010). The requirements also state "(c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (1) The facility must-- (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion" (42 CFR 483.13).

The Skilled or Intermediate Care Nursing Home Regulations read " a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.*(A, B) (Section 2-107 of the Act)" (77 Il Admin Code 300.3240). The Nursing Home Care Act establishes the same (210 ILCS 45/1-107).

Conclusion - Complaint #1

The HRA saw no evidence indicating the complaint to be factual and finds the complaint **unsubstantiated.** Although the resident was not seen by a physician within 72 hours after admission, the HRA considers it likely that the recipient was seen by a physician prior to being transferred to the facility from a hospital. The resident was seen by a physician within 30 days of admission. And, complaints of pain appeared to be addressed as per record documentation.

Conclusion - Complaint #5

The HRA saw no evidence of violence/abuse occurring between the resident and the resident's roommate. The HRA also reviewed the facility abuse policy which attempts to prevent abuse as well as abuse reporting requirements. Because of this, the HRA finds the complaint **unsubstantiated** but offers the following **suggestion:**

- We encourage the facility to include weapons, drugs, etc. on their list of items not allowed into the facility just to ensure that residents/family are assured those items will not be tolerated in the facility.

Complaint #2 - Communication violation including a resident was not allowed stamps or told about phone calls.

The HRA reviewed a document titled "Resident's Rights for People in Long-term Care Facilities" which indicates that the resident has a right to private visits unless there is a medical reason to limit visitation and also the resident has the right to make and receive phone calls in private. The HRA found no evidence that the resident was denied stamps or incoming telephone calls. The HRA requested a communication policy from the facility and did not receive one or a statement that the facility has a communication policy.

The Nursing Home Care Act reads "Every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or visitation. (a) The administrator shall ensure that correspondence is conveniently received and mailed, and that telephones are reasonably accessible" (210 ILCS 45/2-108).

Regarding resident rights, the Act also reads "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 in Part 4 of Article III. For residents of facilities participating in Title XVIII or XIX of the Social Security Act, the explanation shall include an explanation of residents' rights enumerated in that Act" (210 ILCS 45/2-211). The Act also states "A facility shall establish written policies and procedures to implement the responsibilities and rights provided in this Article. The policies shall include the procedure for the investigation and resolution of resident complaints as set forth under Section 3-702. The policies and procedures shall be clear and unambiguous and shall be available for inspection by any person. A summary of the policies and procedures, printed in not less than 12 point type, shall be distributed to each resident and representative" (210 ILCS 45/2-210)

Conclusion - Complaint #2

Because the HRA did not find any evidence that a resident was denied communication rights and facility communication practices appeared consistent with resident rights, the HRA finds this allegation to be **unsubstantiated** but offers the following **suggestions:**

- The HRA suggests that the facility create and implement a communication policy consistent with Act requirements (45 ILCS 5/2-210). Staff should be trained on the policy.

Complaint #3 - Inadequate inventory process.

The rights forms we reviewed state that the resident has the right to the safeguarding of their personal belongings and property. The HRA also reviewed a contract between the resident and the facility which states the Facility will provide a means of safeguarding small items of value for the Resident. Also, in the visitor rules, it states that all items brought into the facility should be checked at the nurse's station to assure "proper labeling of clothing items, and proper documentation on the resident's possession sheet."

The HRA reviewed a nursing inventory checklist dated 6/21/12 that is signed and dated by the resident and has items listed. There is an area on the form for notes on articles that are

damaged, lost, etc. and no items appear on the list. The HRA also saw no evidence of the resident reporting any items missing to the facility. The facility did not have a documented inventory process, only the nursing checklist referenced above.

The Skilled Nursing and Intermediate Care Facilities Code states "The facility shall provide a means of safeguarding small items of value for its residents in their rooms or in any other part of the facility so long as the residents have daily access to such valuables" (77 Il. Admin. Code 300.3210 e) and that "The facility shall make reasonable efforts to prevent loss and theft of the residents' property. Those efforts shall be appropriate to the particular facility and may, for example, include, but are not limited to, staff training and monitoring, labeling property, and frequent property inventories" (77 Il. Admin. Code 300.3210 f). The Code also states that "The facility shall develop procedures for investigating complaints concerning theft of residents' property and shall promptly investigate all such complaints" (77 Il. Admin. Code 300.3210 g).
The HRA also reviewed the Nursing Home Care Act regarding policies, procedures, and grievances. The Act states "A facility shall establish written policies and procedures to implement the responsibilities and rights provided in this Article" (210 ILCS 45/2-210).

Conclusion - Complaint #3

Because there is a signed inventory list and there is no evidence that the resident's belongings were stolen, the HRA finds this complaint **unsubstantiated** and offers the following **suggestion:**

- The HRA suggests that the facility create a specific inventory policy, separate from the resident's rights and contract, which can be provided to the staff and the residents. Staff should be trained on the policy.

Complaint #4 - Facility not following physician's orders by not providing resident prescribed medication.

The HRA reviewed the resident's medical administration record which indicates that the resident was given 60mg of Geodon twice a day (8am and 4pm) starting on 6/22/12 and this order was discontinued on 7/14/12 when the resident started receiving 80mg (at 8am and 8pm) of the medication until 7/23/12. There is an illegible note for the 8pm dose of the medication on 7/23/12.

There is a sheet completed by a physician that states the individual left for a home visit on 7/21 and was to return on 7/22. The document indicates that the resident is now discharged against medical advice.

The HRA also reviewed a Day Visit Request Slip that was dated 7/20/12 which states that the resident is going on a visit for 2 days with an individual. The form stated that the resident was leaving Saturday night at 7:30 or 8pm and returning Sunday night at 9pm. There are no actual dates given as to when the resident was leaving. Also, there is no indication as to whether the resident's medication was given to her to take home. The HRA saw no indication of this on the form or any evidence of this in the documentation that we reviewed.

On the Day Visit Request Slip, it states "Explanation of New Policy Being Implemented To Ensure Resident Safety Before, During, and After Day Visit." The explanation states that the resident must complete a Day Visit Request Slip prior to the visit. The slip must be signed by the Case Manager and Wing Nurse and then the Responsible Person taking the resident on the Day visit must sign the resident out and sign them back in upon return. This was signed by the individual who was considered the Responsible Person to the resident.

The Facility Sign Out Policy reads "If a resident leaves the facility grounds either with family or on their own to go for a walk, shopping, etc., it is the policy of the facility that either the Responsibility Party of the Resident **MUST** sign out at the nurse's station and sign in when they return to the facility." Nothing states that a resident's medication should be sent with them when they are signed out.

The Nursing Home Care Act reads "(b) All medical treatment and procedures shall be administered as ordered by a physician" (210 ILCS 45/2). The Skilled and Intermediate Care Facilities (SNF/ICF) regulations read "f) A facility shall document all leaves and therapeutic transfers. Such documentation shall include date, time, condition of resident, person to whom the resident was released, planned destination, anticipated date of return, and any special instructions on medication dispensed" (77 Il Admin Code 300.4040).

The SNF/ICF regulations also read "d) All medications administered shall be recorded as set forth in Section 300.1810. Medications shall not be recorded as having been administered prior to their actual administration to the resident." (77 ILCS 300.1630) The regulations proceed to read "g) A medication administration record shall be maintained, which contains the date and time each medication is given, name of drug, dosage, and by whom administered" (77 ILCS 300.1810). The regulations also read " The facility shall notify the Department of any incident or accident that has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents" (77 Il Admin Code 300.6045) and " Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report" (77 Il Admin Code 300.1630). The regulations also read "a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, 'serious' means any incident or accident that causes physical harm or injury to a resident" (77 Il Admin Code 300.690).

Conclusion - Complaint #4

In reviewing documentation and records, the HRA saw no evidence that medication was sent home with the resident, but the resident's medication administration record states that medication was given to the resident on 7/21, 7/22 and 7/23, which were days and times that the

resident was absent from the facility. The HRA **substantiates** the complaint that the facility did not follow physician's orders with regard to prescribed medication and makes the following **recommendations:**

- To assure that all medical treatments and procedures are administered as ordered by a physician (210 ILCS 45/2) the HRA recommends that the facility document when medication is dispensed for a resident's leave. The HRA recommends that the Day Visit Request Slip is updated to adhere compliance with the Act as well as 77 Il Admin Code 300.4040. The HRA requests a copy of the updated request form as evidence that action was taken and also evidence that staff was trained on the updated request form.
- The HRA recommends that staffs adherence to 77 ILCS 300.1630 and 77 ILCS 300.1810 be reviewed and the facility educate staff regarding following medication administration records. The HRA requests evidence of the education session.
- The HRA considers the documentation of medication administration to an absent resident to be considered a medication error and, due to the seriousness of the situation with regard to patient welfare, the HRA recommends the facility report the incident per the SNF/ICF regulations (77 Il Admin Code 300.6045 & 300.690).

Complaint #6 - Inadequate communication between facility and resident.

In reviewing the resident's records, the HRA reviewed a fax dated 6/21/12 from the Illinois State Police in response to a non-fingerprint conviction information request. The fax states that during the process of the facility's background check request, the police found multiple records with the data elements provided with the request. The fax states that in order to determine if any of the records pertain to the resident, the facility was to complete another form and have the resident fingerprinted.

In reviewing the identified offender policy and procedure of the facility, it reads that the facility must request a live scan Uniform Conviction Information Act (UCIA) fingerprint check "a. If the UCIA name check states a fingerprint inquiry must be submitted; or b. If the identifying information on the UCIA name response is inconclusive; or c. It does not match the individual submitted."

The HRA also reviewed two separate documents that were signed by the resident, both on 6/22/12 authorizing the fingerprint background check. One signed form states "I, the undersigned, hereby authorize the release of any criminal history record information that may exist regarding me from any agency, organization, institution, or entity having such information on file." The other form has a similar release but it is for the fingerprinting company to capture and transmit the fingerprints to the police.

The SNF/ICF regulations read " e) *In addition to the screening required by* Section 2-201.5(a) of the Act and this Section, *a facility shall, within 24 hours after admission* of a resident*, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as*

required by the Department of State Police.(Section 2-201.5(b) of the Act)" and "g) *If the results of the background check are inconclusive, the facility shall initiate a fingerprint-based check …".* The regulations also read *"*i) *The facility shall provide for or arrange for any required fingerprint-based checks to be taken on the premises of the facility. If a fingerprint-based check is required, the facility shall arrange for it to be conducted in a manner that is respectful of the resident's dignity and that minimizes any emotional or physical hardship to the resident.*(Section 2-201.5(b) of the Act) If a facility is unable to conduct a fingerprint-based background check in compliance with this Section, then it shall provide conclusive evidence of the resident's immobility or risk nullification of the waiver issued pursuant to Section 2-201.5(b) of the Act" (77 ILCS 300.615)

Conclusion - Complaint #6

Because the resident signed two separate forms, both indicating exactly why the resident was signing the form, the HRA finds this complaint **unsubstantiated** but offers the following **suggestions:**

- The regulations also state that "*The facility shall provide for or arrange for any required fingerprint-based checks to be taken on the premises of the facility"* (77 ILCS 300.615) but the facility does not fingerprint at the facility. The HRA suggests compliance with the regulation.
- Fully explain a fingerprinting request to the resident and any other person the resident requests to be informed.

Complaint #7 - Inadequate treatment planning.

The HRA viewed a Care Plan for the resident that had various dates of 6/21/12, 6/22/12 and 6/24/12. The HRA did see that there was no indication who participated in the development of the care plan or if the individual met with staff. The HRA asked for clarification as to whether the resident was a part of the interdisciplinary (IDT) team and the facility responded that "No, resident was delusional and refused to cooperate for initial care plan which was completed by day 21. Resident would not cooperate when staff attempted to communicate." Part of the care plan does discuss discharging the resident. A section of the plan dated 6/22/12 has a goal that reads "Staff will follow up with the States Attorney after 90 days to discuss need for further placement/discharge plan." The plan also mentions goals for the resident to reach prior to discharge. The HRA also reviewed the resident's court order which states the resident is involuntarily admitted to El Paso Healthcare and Rehab for 90 days. The HRA did not see any evidence of an IDT meeting prior to the patient's discharge.

In reviewing a document sent by the facility titled "Interim Assessment and Care Planning" it states "The Care Plan Coordinator shall establish a Interim Conference time for all disciplines, and resident/responsible party when appropriate, within 72 hours of admit." Another document titled "Comprehensive Assessment/Care Planning" states that the resident is assessed in a timely manner upon admission and that a Resident Assessment Instrument (RAI) is used for comprehensive assessments. The document proceeds to state "A variety of information sources shall be used to complete the RAI including, but not limited to: … b. Direct communication with

the resident." The document proceeds to state that "The Comprehensive Care Plan shall be developed within 7 days of the completion of the RAI. Components of the CPC may include: … Attendance Sheet - A form that contains the signatures of all persons in attendance, date of conference, and the response of the resident to the items discussed." The document also states that the Care Plan Conference should "Be attended by the resident, unless the resident is incapable of understanding the proceedings or chooses not to attend."

The HRA also saw no evidence that the facility discussed the resident going to community college or that the resident being enrolled in college was brought to the facility's attention. One of the complaints also claimed the facility was not aware that the individual had been at the facility for 30 days but the HRA saw no evidence in support of that allegation.

The SNF/ICF regulations state "b) An ITP shall be developed within seven days after completion of the comprehensive assessment. c) The plan for each resident shall state specific goals that are developed by the IDT. The resident's major needs shall be prioritized, and approaches or programs shall be developed with specific goals, to address the higher prioritized needs. If a lower priority need is not being addressed through a specific goal or program, a statement shall be made as to why it is not being addressed or how the need will be otherwise addressed" and "h) The ITP shall be reviewed by the IDT quarterly and in response to significant changes in the resident's symptoms, behavior or functioning; sustained lack of progress; the resident's refusal to participate or cooperate with the treatment plan; the resident's potential readiness for discharge and actual planned discharge; or the resident's achievement of the goals in the treatment plan" and "i) The resident's individual treatment plan shall be signed by all members of the IDT participating in its development, including the resident or the resident's legal guardian. j) If the resident refuses to attend the IDT meeting or refuses to sign the treatment plan, the PRSC shall meet with the resident to review and discuss the treatment plan as soon as possible, not to exceed 96 hours after the treatment plan review. Evidence of this meeting shall be documented in the resident's record" (77 Il Admin Code 300.4030).

The regulations also state "a) The facility shall establish an Interdisciplinary Team (IDT) for each resident. The IDT is a group of persons that represents those professions, disciplines, or service areas that are relevant to identifying an individual's strengths and needs, and that designs a program to meet those needs. The IDT includes, at a minimum, the resident; the resident's guardian …" (77 Il Admin Code 300.4010).

Conclusion - Complaint #7

The resident was not at the facility for a full quarter which means that the resident was not there long enough to have a treatment plan meeting. The facility stated that the resident would not participate in her treatment planning, which the HRA saw no evidence of, but there is no regulation requiring the facility to document treatment planning participation outside of the IDT meeting or care plan documentation. Because there is no evidence that the resident did, or did not, participate in treatment planning, the HRA finds this complaint **unsubstantiated** but offers the following **suggestions:**

- Although there is no defined regulation that the facility needs to indicate that the resident is not involved with their treatment plan, the HRA believes it is best practice to document their lack of participation within the treatment plan and suggests that the facility begin adding this information regardless of if it is prior to the IDT meeting or not.