FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
CHICAGO RIDGE NURSING HOME– 14-040-9005
HUMAN RIGHTS AUTHORITY- South Suburban Region

[Case Summary— The Authority did not substantiate the complaints as presented below. However, the HRA made one corrective recommendation that was accepted by the facility. The public record on this case is recorded below; the provider did not request that its response be included as part of the public record.]

INTRODUCTION

The South Suburban Regional Human Rights Authority has completed its investigation into allegations concerning Chicago Ridge Nursing Home. The complaint stated that a resident was prevented from seeing her private physicians three times because the facility did not make transportation arrangements for the scheduled medical appointments. The resident was reportedly told that she should ask her mother to take her to medical appointments. Additionally, the complaint alleged that the resident is not allowed snacks that contain sugar because the facility's nursing staff said that she has high blood sugar, but her private physician disagrees with this.

If substantiated, these allegations 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) and the Centers for Medicare and Medicaid Services, Department of Health and Human Services' (CMS) Requirements for Long Term Care Facilities (42 C.F.R. Part 483).

Chicago Ridge Nursing Home provides 24-hour skilled nursing care and offers a range of programs. The 241-bed facility located in Chicago Ridge had 213 residents when the complaint was discussed with the facility staff.

METHODOLOGY

To pursue the investigation, a site visit was conducted at which time the Facility Administrator, the Director of Nursing and the Director of Social Services were interviewed. The complaint was discussed with the resident by phone several times. Sections of the resident's record were reviewed with written consent. Relevant policies were reviewed. Additionally, the facility provided the HRA with a calendar showing the resident's medical appointments from May through December 2013 that was not part of the record reviewed.

COMPLAINT SUMMARY

The complaint stated that the resident did not see her Neurologist twice on or around February 2013 because the facility staff did not make transportation arrangements for the scheduled visits. Then, she missed an appointment at an eye clinic for the same reason about four months later. It was reported that an unidentified staff person told the resident to ask her mother to take her to scheduled medical visits. The complaint further stated that the resident's private Endocrinologist disagrees that the individual has diabetes, but the facility staff will not provide her with food items that contain sugar.

FINDINGS

After reviewing the record, the HRA determined that the resident was admitted to the facility on November 2nd, 2012. She was diagnosed with Schizoaffective Disorder, Multiple Sclerosis with Paraplegia, Anxiety, Diabetes, Myalgia, Myositis and Chest Pains. The physician's orders indicated that medications for the resident's psychiatric and physical problems were prescribed. Her care plan consisted of goals such as psychotropic medication and diabetic management. Her medication regimen included Metformin (for diabetes) and orders indicated that her glucose blood level should be checked daily and that a hemoglobin A1c test should be done every six months and a general diet with no concentrated sweets was recommended. She was described as being obese and was seen by the facility's Registered Dietician upon her admission to the facility. She was referred to the program restorative therapy department for weight management and a gradual weight loss was encouraged and excessive food intake was discouraged. According to the nursing notes, the resident was compliant with medication, and her blood sugar level was checked daily. Also, laboratory reports showed that hemoglobin testing was done as ordered.

The resident's face sheet documented that the attending physician, a psychiatrist and a dentist were involved in her care. However, documentation such as notes and orders indicated that she was being seen by other medical providers. For January, February and March 2013, there were no mentions about medical appointments found in her record or on the facility's monthly calendar reportedly used to keep up with her medical appointments. The first documented reference concerning a medical appointment was written by a nurse on April 1s. According to the nursing note, the resident was scheduled to have a hearing examination on May 7th because of pain in her ears. The nurse also recorded that the front office staff were informed about the transportation arrangements for the medical visit. There was no more information concerning the appointment found in her record. We also noticed that the facility's monthly calendar reflected that transportation services were scheduled for a hearing examination for May 28th versus the 7th but whether she had actually attended the medical appointment was not recorded in her record.

The facility's monthly calendar documented that the resident was scheduled to see her Gastroenterologist on June 14th. Her record contained an order for a scan of her abdomen written by the same physician on that same day. Also, a progress note dated June 15th stated that the resident told her therapist that she had seen her Gastroenterologist on that previous day. It was documented that the abdominal scan was scheduled at local hospital for June 28th, and that the resident's mother was going to escort her to the medical appointment. Two weeks later, a progress note recorded that the resident told her therapist that she was nervous about her

upcoming medical appointment that was rescheduled for July 1st. According to a nursing entry, the resident left the facility with her mother on the scheduled medical appointment day. The next documented medical appointment indicated that transportation arrangements were made for the resident to see her eye care provider on July 17th. Again, the HRA found no documentation that she had actually attended the medical appointment as planned.

The facility's monthly calendar recorded that the resident was scheduled to see her Endocrinologist on September 23rd. And, the therapy notes stated that the resident talked about her upcoming medical appointment and about her fear of taking the bus to appointments. As before, there was no written indication that she had actually attended the medical appointment. Her record also lacked documentation that her Endocrinologist had questioned the use of Metformin in her care as stated in the complaint. For October, a form indicated that the resident had a hearing examination. A Computed Tomography (CT) scan was ordered by the resident's Otolaryngologist (a physician who specializes in disorders of the ear, nose and throat) because of an abnormal growth in her neck. It was documented that the CT scan was scheduled at nearby hospital for October 14th, and that the resident's father was going to take her to the medical appointment. A hospital's discharge form instructed that Metformin should be held for three days because of the contrast injection given for the medical procedure above. These instructions also were reflected in a nursing note and a physician's order. The resident told the HRA that her family member took her to the medical appointment and that the CT scan confirmed the diagnosis above.

For November, the facility's monthly calendar documented that the resident was scheduled to see her Gynecologist and her physician who specializes in internal medicine on the 1st and the 4th respectively. Whether she saw her private physicians as scheduled was not found in her record. During that same month, the resident signed a form releasing the facility and its physician of any responsibility for failing to adhere to her prescribed diet. It documented the right to make decisions about her diet. She signed the form on November 27th, a week after the HRA's opening letter concerning the complaint was sent to the facility. There was no documentation concerning any medical appointments for December.

When the complaint was discussed with the facility staff, the HRA was informed that the resident's attending physician and the psychologist are associated with the facility. The resident had at least three community medical providers (an Endocrinologist, a Gynecologist and a physician who specializes in pain) involved in her care. Sometimes, she chose to make her own medical appointments and used a public transportation service. According to the Administrator, a physician had requested that the resident should not return to his office because she was "drug seeking." She was unable to remember the physician's name and her statement was not found in the resident's record. The Social Services Director told the investigation team that the resident had unlimited passes in the community because she was compliant with medication and attended therapy groups. She said that the resident was able to take public transportation by herself. However, she was not sure whether or not the resident had attended medical appointments when she left the facility on passes in the community. She said that the resident might have missed a medical appointment if she did not inform the staff about the appointment. The staff interviewed reported that the resident had a medical appointment on October 31st, but neither her record nor the facility monthly calendar shows this.

The Administrator explained that she is responsible for making transportation arrangements for medical appointments. She reported that a medical vehicle is used for these visits and that paperwork is sent with the resident but community medical providers usually do not return the paperwork. On questioning about billing documentation for transportation services, the Administrator reported that the transportation company does the billing now for the medical visits. She said that she disposes of transportation requests once services have been completed. She was unable to provide any billing documentation concerning this issue. The investigation team mentioned that only a few notes suggest that the resident had actually attended scheduled medical appointments. According to the staff interviewed, this information ideally should be documented in the nursing notes. At the meeting, the staff reviewed the facility's monthly calendar used to keep up with the resident's medical appointments for 2013. Subsequently, the HRA was provided with a copy of the facility's monthly calendar documenting the resident's scheduled medical appointments reflected in this report. We noticed that the facility's working calendar does not include January through March 2013.

According to the Administrator, the resident's admitting diagnoses included diabetes and that this medical condition had been determined by her private physician. She explained that the resident's blood sugar level was usually 5.7 and was under control because of medication. She wanted to eat food items that contained sugar and that she continued to gain weight. She usually would buy chips and other snacks from the facility's mobile store and the vending machine. The Administrator said that she had explained to the resident that her glucose level was high. She reported that the resident had refused to give consent for her private physician to share information with the facility. According to the Administrator, she asked the Social Services Director to talk to the resident after she had received the opening letter from the Authority about the complaint. She reportedly told the staff person that her mother did not want to be her legal guardian. She also said that her diet was different (for example, no frosting on cake, no white sugar, etc.) than some of her peers at which time she signed a waiver that released the facility of any liability for choosing to not follow her prescribed diet. We were told that the resident was discharged from the facility in March 2014 and she lives in her own apartment. According to the staff, the resident did not file a written grievance concerning the complaint issues mentioned in the report with the facility.

The resident told the HRA that she had missed three scheduled medical appointments because the facility staff did not make transportation arrangements for the visits. She reported that she had three upcoming medical appointments for October 2013 and that she was concerned about missing them because of possible transportation problems. One of the appointments was for a hearing examination. Subsequent to the site visit, the resident reported that she had a CT scan in October as scheduled. She said that her appointment with her Rheumatologist was canceled because of the lack of transportation in October. She then told the HRA that her appointment was canceled because the physician above would not accept her medical insurance because she lives in a nursing home. The resident's record indicated that she had a hearing examination on that same month. Additionally, the resident told the investigation team that her private physician, who allegedly told her that she did not have diabetes, might not have shared this information with the facility. She acknowledged that she did not sign a release for her private physician to share information with the facility as reported by the Administrator.

The HRA reviewed a policy stating that the facility strives to provide its residents with as many health care services within the facility as possible. However, this is not always possible because some services cannot be done on the facility's premises and some health providers are not able to come to the facility. According to the policy, all residents are offered and provided with appointments with community health care providers and services. It states that the nursing staff is responsible for making medical appointments as requested by the attending physician, the resident (if appropriate), and others. Once, the appointment is verified by the nurse and placed in the appointment book, a transportation form is completed and reviewed by the Director of Nursing and then given to the front office staff to make the transportation arrangements. The policy states that residents may choose to have a family member escort them to medical appointments or they can take public transportation if the nursing and social services staff and physician believes that this is safe. Also, the policy states that a resident might require an escort based on an assessment or the health care providers' policies. If so, the facility will make every effort to have a family member to go with the resident or a qualified staff member will accompany the individual when available.

The facility's grievance policy directs its administrative staff to make every effort to promptly and satisfactorily resolve any complaint, concern or grievance brought to the staff's attention. It states that the facility respects the resident's right to voice grievances without discrimination or reprisal. Grievances include those involving treatment which has or has not been provided. According to the policy, the Administrator will determine the facility's response, and the resident or family member will be promptly informed of the grievance outcome.

According to Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities and Sections 45/2-104 of the NHCA and 300.3220 of the Illinois Administrative Code,

> A resident shall be permitted to retain the services of his or her own personal physician at his or her own expense or under an individual or group plan of health insurance, or under any public or private assistance program providing such coverage.... Every resident shall be permitted to participate in the planning of his or her total care and medical treatment to the extent that his or her condition permits....

The Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities further states that the facility must make reasonable arrangements to meet the resident's needs and choices.

CMS' Requirements for Long Term Care Facilities Section 483.15 (b) guarantees a resident the right to self-determination and to make choices about aspects of his or her life in the facility that are significant to the resident.

The Administrative Code (77 Ill. Admin. Code 300.205 (b)) states that physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or therapeutic diet. The diet shall be given as ordered.

Section 300.4040 (f) of the Illinois Administrative Code states that,

> A facility shall document all leaves and therapeutic transfers. Such documentation shall include date, time, condition of resident, person whom the resident was released, planned destination, anticipated date of return, and any special instructions on medication dispensed.

COMPLAINT #1

The complaint stated that a resident was prevented from seeing her private physicians three times because the facility did not make transportation arrangements for the scheduled medical appointments. It was reported that the resident did not see her Neurologist twice on or around February 2013. The complaint also alleged that the resident had missed an eye appointment about four months later. The HRA found no documentation of any medical appointments until April 2013, which was a hearing examination. We found evidence that the resident had eight medical appointments. The record lacked adequate documentation that she had actually attended five medical appointments, although transportation arrangements reportedly were made to accommodate them. Two of the medical appointments she attended with her parent. She went to a third medical appointment but there was no documentation concerning how she got to the physician's office.

The Authority cannot substantiate the complaint as presented above. No clear violations of the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities, Section 45/2-104 of the NHCA, Section 300.3220 of the Illinois Administrative Code and CMS' Section 483.15 (b) concerning the right to participate in one's care and to make choices that are significant to the resident. However, the facility violates Section 300.4040 (f) of the Illinois Administrative Code because her record lacked adequate documentation indicating whether or not she left the facility to attend the scheduled medical appointments. No violations of the facility's policies were found.

RECOMMENDATION

1. Document all leaves such as medical appointments in the resident's record as required by Section 300.4040 (f) of the Illinois Administrative Code.

COMPLAINT #2

The complaint stated that the resident is not allowed snacks that contain sugar because the facility's nursing staff said that she has high blood sugar, but her private physician disagrees with this. The record documented that the resident was diagnosed with having diabetes and Metformin was prescribed upon her admission to the facility. The staff interviewed reported that

the resident's private physician had made the clinical determination above, and that her blood sugar level was being controlled by medication. According to the staff, the resident wanted to eat food items of choice, and she eventually signed a form releasing the facility of any liability for not following her prescribed diet that lacked concentrated sugar. We found no evidence that the resident's private physician had questioned the use of Metformin in her care as stated in the complaint.

The Authority does not substantiate the complaint. There were no violations of the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities, Section 45/2-104 of the NHCA, Section 300.3220 of the Illinois Administrative Code or CMS' Section 483.15 (b).