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East Central Human Rights Authority
Report of Findings
Case 15-060-9003
Effingham Rehabilitation and Health Care Center

The East Central Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning nursing home services at the Effingham Rehabilitation and Health Care Center (Effingham Rehab) located in Effingham, Illinois:

Complaints:

1. The nursing home fails to provide timely medication;
2. The nursing home does not provide adequate and humane care.

If found substantiated, the allegations represent violations of the Nursing Home Care Act (210 ILCS 45 et seq.), and the Skilled Nursing Facility Code (77 Ill. Admin. Code 300 et seq.).

The complaint alleges that a resident, who is receiving hospice services, has had property thrown away by staff. That pain medication has reportedly not been provided timely. Sometimes pain medication has allegedly been delayed up to 2-4 hours. According to the complaint, the resident has terminal cirrhosis of the liver and has had dementia related to the illness. A family member actually observed items previously given to the patient in the trash the day after receiving them as per the complaint. The administrator reportedly has asked the family to move the patient to a psychiatric ward because of the dementia, but she will lose hospice services if the move is made.

INVESTIGATIVE INFORMATION

The HRA proceeded with the investigation having received written authorization to review the patient's record. To pursue the matter, the HRA visited the facility where the administrator and staff were interviewed. Relevant practices and policies, and portions of the patient's record were reviewed.

Interview

The HRA asked what types of services were provided at Effingham Rehab. Staff explained that it is a skilled nursing facility. The nursing home has external providers for hospice services. The nursing home can provide care for 62 residents; currently the home’s

census averages between 37 to 42 residents. The geographic area served is mostly Effingham and small local towns. There are 50 staff who provide services.

The HRA asked what training is in place to assist staff in providing adequate and humane care. The administrator shared that there is human rights training at hire, there is biannual training at which rights are reviewed. If there are any issues, they reiterate rights training and have regular in-service training. General staff training is provided upon employment. Annual training covers general policies, rights and abuse protection.

The HRA asked about the availability of Public Health and third party advocacy contact information for residents and staff. Staff explained that contact information is posted in multiple locations and for employees. It is also placed where there are resident activities. The HRA asked if staff are trained on recognizing and reporting incidences of abuse. The response was yes. The HRA asked if confidential reporting could occur. Staff responded that is all part of the abuse training. Staff know what the proper procedures are and should respond immediately.

The HRA asked staff to explain the difference between hospice services compared to regular nursing care. Staff explained they would refer to hospice as comfort care, making end of life more comfortable. Hospice can go a step beyond. Hospice can implement medication changes very quickly. Hospice provides additional staff. Reimbursement is not changed for the nursing home when a resident has hospice.

The HRA asked if there are residents in the nursing home who have dementia. The response was yes. The HRA asked if a resident would be discharged for having dementia. The response was no. The HRA if a resident would be discharged due to mental illness. The response was no.

The HRA asked what the benefit is of transferring this resident to a psychiatric ward. Staff explained that the staff did not want to transfer her out, but they wanted her to receive psychiatric services in an inpatient hospital setting. The intent was never to discharge the resident permanently; the hope was to have the resident assessed for mental illness and have her medication adjusted to meet her needs. The facility had a care plan meeting with the resident's physician and family. The decision that the patient should be transferred to the psychiatric ward in the end was determined by the individual and her family. The individual agreed to going to the hospital to be assessed. After the family and the individual had consented, the crisis unit at the hospital determined the resident was not acute enough for treatment in an inpatient hospital setting. Psychiatric services are very limited in this area. No psychiatric assessment was scheduled because the resident was not deemed as needing emergency psychiatric treatment. There is no psychiatrist in the county. Because of the payer source for the resident the facility has not found any other inpatient unit that would accept her.

When asked why the staff and the resident's physician wanted this resident to be assessed for mental illness staff responded that whatever drugs and alcohol the resident consumed has not treated her well. The resident has advanced end stage cirrhosis of the liver and diagnoses of Bipolar Disorder, Depression, Alcoholism, COPD, and Anorexia. Some of her behaviors in the beginning were food hoarding. Professing to be incontinent she would have a bowel movement

on the bed and sometimes on the floor. She would refuse to have a bedside commode. There have been several incidents of fecal smearing on every surface in the room. With regard to food hoarding, the resident would ask for 2 whole trays and would play with the food and would not let staff take the tray away when the food had set for several hours. Staff had to redirect her to eat. She did not want an aide with her. The CNA would go to her room several times and give multiple verbal cues then bring the resident the multiple trays. The resident would make an unbelievable chaotic mess sometimes combining food and feces everywhere in her room. The resident was encouraged to ask for help. This resident could ambulate with a wheel chair or walker and could walk without assistive devices. The resident weighed 107 pounds. She had put on 10 pounds since she has lived there.

Her behaviors had gotten better because her family became more understanding of the situation; at first they reacted in a defensive way to protect the resident. The family stated staff were not cleaning the resident's room and she was not being bathed enough. There was concern because of the recommendation of the psychiatric inpatient stay. Family would state that the resident is in the last days of her life. A typical stay in the psychiatric ward is approximately 7-10 days.

One of the HRA team members asked if possibly this could be attention seeking behavior. Staff responded there are some that feel that the resident's actions were just behaviors, because the individual scores fairly high on mental tests. The HRA asked if this resident received her medication timely. Staff explained that the resident took Zoloft for the depression. Xanax and Ativan were discontinued. The family complained that the resident was not getting PRN medication for pain as needed. When the medical administration record was reviewed it showed that medication was given per the dosage prescribed and as scheduled. The narcotic count sheet, when reviewed, showed she had to ask for PRN pain medication. The resident would tell staff she needed more pain medication even with hospice providing morphine. Her pain level was the same with and without the medication. Her pain level was subjective, but her pulse and blood pressure ran on the low side of the normal when she was claiming to be in pain.

Regarding staff throwing away food that the family had left, the only reason staff would throw away her food was that it was unsafe. Some examples of what they considered unsafe was spoiled food, or contaminated food that was not covered or next to feces.

The HRA asked what would be the typical process for discharge. The administrator responded that they were never trying to discharge this resident. The mental health referral was to assist the resident.

The HRA asked how residents and families are informed of the grievance process. If there is a complaint the administrator talks to the staff, she reviews the paperwork, and she talks to the resident and to the family to see what happened and how it could be resolved. The grievance process is also explained in the *Resident Grievance Program* policy given at admission.

Records Review

The HRA reviewed the records of the resident. The discharging hospital instructions on 12/16/14 included medication orders. The primary diagnosis was alcoholic liver cirrhosis with multiple end stage medical problems. The resident had stated she had quit drinking alcohol in the past 3-4 weeks in the discharge record of the hospital. The resident was discharged to Effingham Rehab.

The HRA reviewed the resident contract with the facility signed 12/16/14. In the contract it covered payment terms and conditions. It also covered involuntary transfer or discharge of the resident by the facility. “A facility may transfer or discharge a Resident contrary to the Resident’s wishes (hereafter “Involuntary Transfer or Discharge”) during the term of this Contract or at the expiration of this Contract only for one or more of the following reasons:

A. For medical reasons;
B. For the resident’s physical safety;
C. For the physical safety of other residents, other individuals, the Facility staff or Facility Visitors;
D. For either late payment or non-payment for the resident’s stay…”

The contract was signed by the resident and the admissions coordinator. Included with the contract were the resident consents and acknowledgements such as a consent for treatment and a protection of valuables statement which stated that: “I hereby acknowledge that I have been advised that the facility cannot guarantee the protection of any valuable items except those that are given to the Administrator for safekeeping. I further acknowledge that I have been advised not to bring sums of cash, items of value, or items of sentimental value to me or my family to the facility.”

There was the resident’s first choice for a physician with his name documented. Included in the list of documents that were explained to resident were the *Resident Rights Handbook, Your Rights under Medicare, Your Rights under Medicaid, Resident Council Program, Resident Grievance Program* and basic information on advance directives. Included as part of the process of admission was a statement signed the resident: "I hereby acknowledge that I have been provided with copies of the following documents and they have been explained to me in terms that I understand. I have been provided with the opportunity to ask questions, and those questions have been answered to the best of the facility's ability. Additionally I have received copies of all appropriate handouts and supplemental materials."

The nursing admission assessment was completed on 12/16/14. It stated that the resident was admitted with end stage renal disease. Regarding discharge potential it was documented that the resident was on hospice, but stated she still plans on returning home.

The social service admission assessment was completed on 12/22/14. It documented that the resident could make her needs known. The resident was cooperative and was able to converse. She did use tobacco daily, her usual alcohol intake was discontinued and as far as caffeine she had a soda. Her diet was diabetic, but she was able to have comfort foods. For ambulation she would need a walker that was to be supplied by the facility.

The reason for her admission was that she was unable to care for herself. She had good hearing, speech and vision. The change that led toward the admission was developing end-stage cirrhosis of the liver that was alcohol related. Regarding the resident's placement, admission notes stated that the resident was very unrealistic towards her health status and placement. She listed her daughter and sisters for family support system. Under coping, she had unrealistic thoughts; social service progress notes document: "That the resident was admitted on 12/16/14 at age 49. She had told social services she plans to return to her apartment, although now she is on hospice…"

Social Services documented that the resident asked if she was expected to pay all of her income and was informed yes, per Medicaid's requirement, she was expected to pay all income. It had been already explained to her prior to her admission. Social services notes documented that they are to assist as needed. A different note on the same day documented the resident stating all the things her brother would be doing to make her apartment safer for her to go back home.

Social services documented the resident's spiritual preferences. Her physical functioning was that she could walk with assistance and she was able to make decisions in organizing daily routine.

Her Psycho-Social history was completed on 12/22/14 and documented that the resident is receiving hospice services as of 12/19/14. Under history of mental illness, it was documented that the resident had Bipolar Disorder that was managed by medication. Her perceived strengths were cognition and communication. Her perceived weaknesses, based on her admission assessment, was end-stage renal failure and cirrhosis of the liver and alcoholism. It was also documented that she had unrealistic thoughts. Part of the orientation included facility policy, resident rights and facility routines.

The physician's notes document on 12/18/14: "The resident is a 49-year-old female patient with end stage cirrhosis of the liver….She appears to be willfully ignoring the severity of her illness and does not recognize her end-stage disease." Her diagnoses were listed as Alcoholism, Cirrhosis, Pulmonary Fibrosis, COPD, Gastritis, Pressure Ulcer, Anxiety, Chronic Pancreatitis, Fibromyalgia, Bipolar Disorder and nicotine abuse.

Dietary assessments documented that the resident needed a diet order of low calorie sweets and was able to feed herself. The nursing home's monthly report of weight and vitals documented that the resident's weight is 81.5 pounds as of January 2015. Notes documented in February that the resident's weight increased to 96 pounds. Her height was 5'6". It also documented that the resident was ambulatory and alert, with acceptable hearing and vision. She had her own teeth and could feed herself. The resident's food preferences were noted. Some risk factors were Diabetes, COPD, UTI and mental disorders.

Social service progress notes documented on12/30/14 that a hospice worker shared with the director of nursing (DON) that the resident could benefit from a psychiatric evaluation and treatment. On the same day the social services worker documented that she was stopped by the resident. The resident requested that the worker bring her two more cups of bouillon drink. She

already had several drinks as well as both regular and substitute meals. There were numerous canned drinks in a tub in her room. The only thing the resident had consumed was her supplement shake. She was just stirring the other foods with her spoon and not actually eating any of it. She became agitated when staff asked if she was finished with the meal because it had been in her room for approximately 45 minutes. She had been found to be hoarding and hiding food in her bedside table and dressers. When asked why she wanted to save so much food, when it was apparent she wasn't eating it, she replied "I feel so hungry all the time." Notes documented she was not eating it. The resident appeared very confused and manic; paranoid behavior was noted. The staff continued to monitor her for signs of hoarded food to ensure she did not eat any (spoiled) foods during periods of confusion. Per discussion with the DON, the resident would benefit from a psychiatric evaluation and treatment. The DON placed a call to the physician.

Notes documented on 12/31/14 that the social worker asked the CNA if they had issues with picking up the resident's tray. The CNA stated the resident did not consume much, but wanted to save most of it in her refrigerator. The refrigerator was already full.

Hospice notes documented on 12/19/14 that the hospice nurse met with the patient. "The patient understands no further hospitalizations for terminal diagnosis of cirrhosis. The patient agrees with the plan of care." The hospice nurse documented on 12/30/14 that "The patient is in a manic state. Anxiety is high. She complains of pain, but exhibits no signs or symptoms of pain. Patient appears to be very paranoid about staff at the facility." Hospice notes documented on 1/2/15 that "The patient continues to be manic and suffering from psychosis. The worker advised that the resident might benefit from an inpatient stay behavioral health unit."

Hospice notes documented on 1/5/15 that "The patient was upset about facility staff, states her safe key is missing and was found in the patient's purse during my visit..."

Social service notes documented on 1/9/15 that information was faxed to another nursing facility for placement per the family.

Notes documented on 1/14/15 that a bag of trash was thrown out of the resident's room. The nurse walked into the room and sat the bag of trash inside the door. A family member stated "That's been in here for 2 f------- days." The nurse explained that they should ask to have the trash taken out properly. The resident stated "There's nothing toxic in it." The family member yelled "You're not hospice anyway so who gives the f---." The resident then asked for something for pain. The resident was sitting in bed eating pizza. The nurse told her that she had to check to see what was due. The resident stated "I begged for it all night and I didn't get anything." The family member then stated "Just like every other f------ day you have been here." The nurse at this point left the room. The administrator was called and notified of the situation. The (Pro re nata) PRN medication, Hydrocodone, for pain was taken to the resident. Per the medication administration record (MAR), the medication was given within 10 minutes after the request. The record showed that within an hour the nurse checked back with the resident who said that it was helpful. The website, Drugs.com, (http://www.drugs.com/search.php?searchterm=hydrocodone&a=1) describe Hydrocodone as an

opioid pain medication. The MAR also showed she received the Hydrocodone at 8:15 pm again that evening.

The MAR also showed that regular, twice per day, pain medication had been given as prescribed to the resident that day. It showed that the resident was given MS Contin twice daily since12/29/14 to 2/24/15. Her dosages prescribed were to be given at 7:30 am and 7:30 pm. Per Drugs.com: http://www.drugs.com/ms_contin.html "MSContin (morphine) is an opioid pain medication. An opioid is sometimes called a narcotic. Extended-release MS Contin tablets are used when around-the-clock pain relief is needed…."

On the same day, social services notes documented: "The administrator and the social worker spoke with the resident regarding the nursing home she had requested admission to. That nursing home had denied her admission. They also spoke to her about behaviors that she was exhibiting. Staff reporting that the resident was not only hoarding food, but also soiled linens. She was also refusing to go to bed and let staff assist her with incontinent care. She blamed these behaviors on her pain. The administrator reminded her about her obligation to pay her financial portion set up per the Medicaid policy. The resident stated she couldn't pay because she didn't have any money and no access to it. The administrator reminded her that she and her family knew she would owe her portion of her monthly income to the facility. Per Medicaid policy an involuntary discharge would be given for nonpayment if payment is not received."

On 1/15/15 the hospice notes reported that the patient was very anxious. She threatened to get the hospice nurse fired because she was not getting her the medications that she wanted. The resident complained of pain all throughout the morning, but showed no signs or symptoms of pain.

The HRA reviewed the MAR for 1/15/15. The resident received Hydrocodone at 5:30 am and at 10:30 am, as well as the MS Contin at 7:30 am and 7:30 pm.

Social service notes documented on 1/23/15 that the social worker was told about complaints regarding a foul odor coming from the resident's room. It was making other residents complain. The social worker and the administrator investigated the situation. The room did have a very foul smell, but the resident denied having spoiled food. The social worker observed the resident's bedside table which was entirely covered and a full tray that she had not touched since breakfast. She would not allow the tray to be removed. Also on the table were numerous cups, a paper plate and a takeout container from a local restaurant. The social worker opened her fridge to put away her orange juice and the fridge had a very rank odor. The resident said everything in it was good. She stated her sister had just cleaned it. The social worker noticed a maxi pad had been stuck on the shelf. The resident stated she had put it there to catch drips. The administrator explained to her that peers were complaining about the smell. The resident did not want anything removed. The administrator called the family to explain the situation and asked the family to assist. Family members stated that if pain was kept under control there wouldn't be a problem.

Per the MAR for 1/23/15 the resident received Hydrocodone at 1:00 am, at 11:30 am, and at 3:30 pm. She also received the MS Contin at 7:30 am and 7:30 pm.

On 1/20/15 hospice notes documented that “The patient continues to have paranoia and false accusations toward staff. No further decline questioning if patient is hospice appropriate at this time.”

On 2/4/15 notes documented that the patient was discharged from hospice because she was no longer considered terminally ill and did not meet hospice requirements. “Continue current medications.” The physician was notified of the discharge.

On 2/5/15 the physician that the resident had chosen when admitted documented: “The patient keeps her rooms in squalor with rotting food under the bed, refuses to bathe, and refuses to let staff clean the room. The patient reports continued diffused pain, attributes the past injuries and pancreatitis ongoing for years. The patient specifically requests Dilaudid or Fentanyl. The patient reports she is stronger, doing better, determined to go home. She was convinced that she is strong enough. That she will have help and she is getting better....The patient has detailed desires to go home and I do not feel her capable of doing so and don’t feel she is mentally able to understand or care for herself. However she has a power of attorney and if someone in the family is willing to seek guardianship, I will have little choice but to let her leave. I feel that while her pain is partially real, the current regimen should more than adequately cover her needs. Part of her pain is clearly staged for my benefit and the patient fakes pain poorly.”

Social worker notes documented that on the same day the care plan was held with the resident, her family, her physician, the social worker, DON and the administrator. The issues discussed were lack of bathing, allowing staff to assist with activities of daily life (ADLs), and keeping her room environment clean and healthy. The resident denied any issues occurred, then in the next sentence would begin with excuses of why they were occurring: depression, crying all the time and finally she does all those things because of her pain. The family had asked the physician if this happens because of her liver disease. He stated he didn't think so; he felt it was her anxiety/depression etc. The resident finally agreed to go for a psychiatric stay for medication management. The family also encouraged this. The family agreed to stay with the resident until she was sent to the emergency room. The process for psychiatric evaluation was explained to the resident and her family. The resident did become very angry during the care plan specifically when it was discussed that staff (two different witnesses) removed soiled depends and pads from the resident’s dresser.

Social service progress notes documented that the resident was sent back to the nursing home around 11:30 PM, the hospital that evaluated her stated the resident would benefit from a psychiatric evaluation, but would not admit her. The resident returned to the nursing home.

The HRA reviewed the resident’s pain management flow sheet from 12/16/14 through 3/6/15. It documented the date and time that the resident was in pain, the location of the pain, the intensity of the symptoms, the type of interventions used and the effectiveness of the interventions. In most instances the intensity of the symptoms were close to a 10 out of a scale of 1 to 10. The effectiveness of the interventions were usually some relief and in some cases little relief. In most cases, nursing staff were following up in about an hour to see if the resident had some relief from her symptoms after taking the medication.

Social service notes on 2/26/15 documented two separate occasions in which staff were accused of stealing items: one was a notebook, when the resident was sitting on top of it. Another incident occurred when the resident accused a staff member of stealing the key to her safe. Upon investigating, the key was found taped to the resident's body.

Notations on universal progress notes documented from 12/25/24 through 3/4/15 issues with hoarding food and personal care items, sometimes with urine and feces, fecal smearing, refusing to bathe and refusing to let housekeeping clean her room on 12/25/14, 12/29/14, 12/30/14, 1/4/15, 1/25/15, 1/29/15, 2/2/15, 2/3/15, 2/4/15, 2/9/15 2/10/15, 2/11/15, 2/12/15, 2/13/15, 2/15/15, 2/16/15, 2/17/15, 2/18/15, 2/19/15, 2/21/15, 2/24/15, 2/26/15, 2/27/15, 2/28/15, 3/2/15, 3/3/15, and 3/4/15. The HRA reviewed the signatures on the notes on the documentations to see if only specific staff observed these behaviors. There did not appear to be any pattern. Documentation was completed by 16 different workers, including social services, the director of nursing, the administrator, the physician, and various nursing staff.

There were quite a few notations that when the behaviors occurred staff attempted to educate the resident of the health risk she was creating for herself such as the importance of keeping her room clean, and only eating and drinking off of clean items as well as the danger of skin breakdown and/or infection. This was documented on 12/30/15, 1/25/15, 2/1/15, 2/10/15, 2/19/15, and on 2/24/15.

Notes documented that a psychiatric consult was scheduled on 3/9/15.

Policy Reviews

The HRA reviewed the *Medication Administration Policy (7/3/13).* Drugs and biological are administered by physicians and licensed nursing personnel. In procedures, section 3 states:" Medication must be prepared and administered within one hour of the designated time or as ordered...." It also listed specific safeguards to keep the medications safe and the preparation of taking the medication safely.

There was also a *Self-Administration of Medication Program Policy (04/07)* which states: "It is the policy of Peterson healthcare to assist residents to reach and maintain their highest level of independence practical. For those residents who have the cognitive and physical functioning and expresses a desire increase their level of independence and self – administration of medications, program will be initiated." It explained that a licensed nurse and the interdisciplinary team would identify residents who had expressed a desire to self-medicate and would determine appropriate candidates for the self-administration of medication. Residents would be reassessed every 90 days, or more frequently if the goals had been met or due to a change in condition. It also stated that license staff will complete documentation of a resident's response to self-medication.

The *Resident Grievance Program (No Date) Policy* states: "It is the policy of Peterson healthcare to actively encourage residents and their representatives to voice grievances and complaints on behalf of themselves and/or others without discrimination or reprisal. Grievances and/or complaints may be reported to the administrator, any staff member the resident advisory Council, the long-term care advisory board, and to state agencies. All staff are required to report

any and all grievances and complaints received from residents. The administrator is responsible to promptly resolve complaints and grievances." It listed the process and the responsibility of house staff to respond to complaints including offering multi-disciplinary interventions if necessary. There was also an opportunity for residents to address complaints grievances and concerns at Resident Council meetings.

Included was the *Peterson Healthcare Companies Abuse Prevention Program Facility Policy (11/11/11)* is the statement that: "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 re-occurrences of mistreatment, neglect or abuse of our residents." Some of its practices to prevent abuse included conducting pre-employment screening of employees and orientating and training employees on how to deal with stress and difficult situations.

The *Protection of Valuables policy* includes the following statement*:* "I hereby acknowledge that I have been advised that the facility cannot guarantee the protection of any valuable items except those that are given to the administrator for safekeeping. I further acknowledge that I have been advised not to bring sums of cash, items of value or items of sentimental value to me or my family to the facility."

CONCLUSION

Regarding the complaint that medication has not been provided timely, the HRA looked at the evidence in the medication administration record. There was evidence that the resident could not obtain the medications she sought. However the pain medication that the resident received was determined by her own physician whom she had chosen. Pursuant to the Skilled Nursing and Intermediate Care Facilities Code regarding Resident's Rights (77 IL ADC 300.3220): "a) A resident shall be permitted to retain the services of his or her own personal physician at his or her own expense under an individual or group plan of health insurance, or under any public or private assistance program providing such coverage. …." The Nursing Home Care Act regarding for Medical treatment reiterates this resident right (210 ILCS 45/2-104(a)): "A resident shall be permitted to retain the services of his own personal physician…." And, the Act further states in the same section that: "All medical treatment and procedures shall be administered as ordered by a physician." Her physician had documented: "The current regimen (for pain) should more than adequately cover her needs. Part of her pain is clearly staged for my benefit and the patient fakes pain poorly". Hospice staff documented the resident had complained of pain all throughout the morning, but showed no signs or symptoms of pain. When the HRA reviewed the MAR the resident was receiving prescribed pain medication timely twice a day at 7:30 am and 7:30 pm. There was also PRN medication that the resident could request.

The HRA reviewed the Effingham Rehab's *Medication Administration policy* (7/3/13) procedures; section 3 states: "Medication must be prepared and administered within one hour of the designated time or as ordered...." Pursuant to nursing home regulations that govern the development of medication policies (77 IL ADC 300.1610): "1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering,

returning, and disposing of drugs and medications…." Sub-section d) of the same regulation states: "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." The HRA did not see any evidence that pain medication had been delayed. **Based on the evidence in the record, the complaint the nursing home fails to provide timely medication is unsubstantiated.**

Regarding the complaint the nursing home does not provide adequate and humane care, the HRA looked to see if the nursing staff intended on discharging the resident because she had dementia related to end stage cirrhosis of the liver. Per the interview, nursing home staff realized they could not adequately provide mental health services that the resident may have needed. However, according to staff, any discharge to an inpatient hospital setting was for the purpose of having the resident's medication adjusted to meet her needs with the intent of the resident's return to Effingham Rehab. Per the record, there was a care plan meeting with the resident, her physician and her family pursuant to the Nursing Home Care Act (210 ILCS 45/2-104 (a)) which states that "… Every resident shall be permitted to participate in the planning of his total care and medical treatment to the extent that his condition permits…."

The resident exhibited some very difficult behaviors documented from 12/25/24 through 3/4/15 for hoarding food and personal care items, sometimes with urine and feces, fecal smearing, refusing to bathe and refusing to let housekeeping clean her room. There were also false allegations of staff stealing specific items, when the resident had been found with these items in her possession. What is commendable was when the behaviors occurred, the staff attempted to educate the resident of the health risk she was creating for herself. There was also the potential for her to be a health risk to the staff and to other residents. Nursing home regulations (77 IL ADC 300.3300 c) 1)) also state that: "A facility may involuntarily transfer or discharge a resident only for one or more of the following reasons: for medical reasons, for the resident's physical safety, for the physical safety of other residents, the facility staff or facility visitors, for either late payment or nonpayment for the resident's stay, except as prohibited by Titles XVIII and XIX of the federal Social Security Act…." However there was no evidence that the nursing home attempted to discharge the resident.

As far as the resident loosing hospice services, per the record it was hospice services that determined that the resident did not meet hospice requirements, not the nursing home.

Regarding personal property, the Nursing Home Care Act (210 ILCS 45/2-103) states: "A resident shall be permitted to retain and use or wear his personal property in his immediate living quarters, unless deemed medically inappropriate by a physician and so documented in the resident's clinical record….The facility shall provide adequate storage space for the personal property of the resident. 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….The facility shall make reasonable efforts to prevent loss and theft of residents' property…." Effingham Rehab did have a policy to protect small valuables. Per the record the items the staff had thrown away were food and a notebook when it was unsafe to consume or use, because it had been spoiled or contaminated by urine and feces. **Based on interviews with staff, the evidence in the record and the policies maintained by the facility**

the complaint the nursing home does not provide adequate and humane care is unsubstantiated.

The HRA does take this opportunity to offer a suggestion. In this case the resident had stated in her discharge records from the hospital she had quit drinking alcohol only a few weeks prior to her discharge from the hospital and her admission to the nursing home. The resident may have been dealing with issues of alcohol addiction which may have triggered her behaviors. It may be advantageous for all parties to connect residents suffering from the effects of alcoholism to the services of a specialist in alcohol and drug abuse counseling.

The HRA would like to thank the staff at Effingham Rehab for their full cooperation with this investigation.