FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 16-030-9002
California Gardens Nursing and Rehab Center

Report Summary: The HRA substantiated the complaint that the facility did not follow Nursing Home Care Act requirements when it did not allow a resident access to his record. The provider response follows the report.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at California Gardens Nursing and Rehab Center (California Gardens). It was alleged that the facility did not follow Nursing Home Care Act requirements when it did not allow a resident access to his record. If substantiated, this would violate the Nursing Home Care Act (210 ILCS 45) and regulations that govern the Health Insurance Portability and Accountability Act (HIPAA) (45 C.F.R 164.501, 164.524).

California Gardens is a 297-bed rehabilitation and nursing facility located in Chicago, IL.

To review these complaints, the HRA conducted a site visit and interviewed the Facility Administrator and the Director of Nursing. Facility policy was reviewed as were the adult recipient's records upon written consent.

COMPLAINT SUMMARY

The complaint alleges that a resident requested his hospital record, and initially, the facility outright refused. The resident then contacted the Ombudsman, who visited the facility twice to address the concern. The resident continued to request his record and then the Records Personnel accused him of stalking her.

After two months the staff met with the resident and allowed him to view his file, telling him he could review it for an hour and a half with staff supervision. The resident has very complicated and extensive health problems and has a pending lawsuit against an area hospital for the loss of his leg.

FINDINGS

The record shows that the recipient, a 55 year old male, was admitted to California Gardens on 4/15/15 after having been hospitalized for cardiac arrest and acute respiratory failure at another Chicago area hospital. Among the recipient's many physical diagnoses were diabetes, cardiac arrest, myocardial infarction, respiratory failure, cellulitis and abscess of his leg, viral hepatitis, muscle wasting and atrophy, embolism and thrombosis of the arteries of his lower extremities, pneumonia, abnormal blood chemistry, abnormal electrocardiogram, and many other conditions. The recipient had his left leg removed while hospitalized, had very little use of his right leg and was confined to a wheelchair.

The first entry into the record regarding a request for records occurred on 6/23/15 by the Social Service Director. It states, "Writer met with resident regarding his medical records from … hospital, to which he was explained that it is the policy of this facility that records from other facilities cannot be released to the resident from this facility. Resident was provided with a release of information and additional information, as well as stamped envelope, to request the records from … hospital himself and have them delivered to this facility. Resident became upset at this and stated that he would be contacting the Ombudsman in regards to this matter. Writer encouraged resident to invite Ombudsman to the facility if he would like this matter attended to further."

On 6/10/15 the record contains another note written by a social worker which states, "Writer informed by 1st floor Manager that resident is requesting medical records from hospital he was in over a year ago. Despite being informed that it is against the law for this facility to give out that information, and that we can only give him records from our facility. Resident began acting out with staff and following staff around demanding his records. Resident is not receptive at this time to information to follow up with hospital to obtain his records. Staff will continue to monitor behavior closely, and provide intervention as needed."

On the same day another note was written by the Director of Nursing regarding the request. It states, "Resident seen by MD today, resident insisted that staff give medical records to him. Explained to him that the doctor can review his medical records with him but cannot physically give the papers/records to him. Resident was also explained that he would have to request them himself from the hospital. Resident became upset and stated that the medical records director and writer were wrong and didn't know what we were talking about. Resident became verbally aggressive and stated he was going to sue everyone including the 'white doctors that cut his fucking leg off!' Resident was redirected. MD made aware of resident's behavior toward staff. MD stated that he will review old hospital medical records from his amputation during next visit. Resident made aware and left room still using inappropriate language."

FACILTY REPRESENTATIVE RESPONSE

Facility representatives were interviewed about the complaint. They indicated that when the recipient requested his record, the staff met with him and reviewed the facility policy regarding patient records. Staff indicated that at that time the recipient was provided with his record. Staff also indicated that the recipient had requested records from his previous hospital,

and they told him that he would have to request those records from the hospital from which he received treatment. The staff were asked by the HRA if the recipient's current record contained medical records from another hospital that were pulled from the record that he received and they stated that yes, there was information from another hospital which was not given to the recipient. The HRA requested the policy for patient records, which had been requested in the opening letter, and the staff produced this policy, however it was noted that the policy is misleading in that it suggests that the clinical record is only the information from California Gardens and not any information from other hospitals that is included in the record. The HRA indicated that information in the clinical record that impacts the recipient's plan of care and relates to his well-being is part of his record for which he has a right to view and copy. Also, the HRA notes that the recipient's clinical record did not contain the Medical Record Request Protocol or the recipient's Authorization for the Release of Protected Health Information which the staff indicated is the hospital policy. Additionally, although the progress notes indicate that the recipient's physician would review the recipient's record with him, the notes do not indicate that this ever happened.

The Ombudsman for this region was contacted and interviewed by phone regarding the complaint. She indicated that the resident had contacted her and requested advocacy regarding his record. The Ombudsman stated that she went to the facility several times and that initially the facility did not realize that the resident had a right to his record, even that portion of the record that had come from the previous hospital. She indicated that the facility was willing to let the resident view his record, however he had wanted to show it to his attorney and others, and the facility would not agree to this. She also stated that he was allowed to have a copy of his record for a fee. When asked how much a record would generally cost, she indicated between $250 to $400. The Ombudsman stated that she felt that the issue with this resident and his record was that he did not want to pay for his record. She felt the facility had been very accommodating of his requests.

STATUTORY BASIS

The Nursing Home Care Act states, "Every resident, resident's guardian, or parent if the resident is a minor shall be permitted to inspect and copy all his clinical and other records concerning his care and maintenance kept by the facility or by his physician. The facility may charge a reasonable fee for duplication of a record." (210 ILCS 45/2-104 d).

HIPAA regulations (45 C.F.R. 164.524 (a)) also guarantee "…a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set…." with certain exceptions noted. A "designated record set" is defined in part as "A group of records maintained by or for a covered entity that is:…Used, in whole or in part, by the covered entity to make decisions about individuals." (45 C.F.R. 164.501). Further, Section 164.524 provides guidance on access implementation including timely access (less than 30 days), written notices of access denials, a means to complain about denials and provisions for allowing access to other records not subject to the denials.

HOSPITAL POLICY

California Gardens provided their Medical Record Request Protocol. It states, "Hospital records are **NOT** included in the records to be released to the resident/or requesting person/body" and "Any documentation, paperwork, clinic information, etc., that is not related with this facility, i.e. Hospital records, - have to be requested from the original source." The policy allows for residents to view the record after submitting a request to the Director of Nursing. This eliminates the copying fee.

The fee schedule for copying records is as follows:

Fee	Paper record	Electronic Record
Handling charge	$26.58	$13.29
Copy: pages 1-25	$1.00	$0.50
Copy: pages 26-50	$0.66	$0.33
Copy: 50+	$0.33	$0.17
Microfiche/film	$1.66	$1.66

Hospital staff were interviewed about recipients who might not be able to pay for their records and they were not aware of any help available for payment to receive records or a reduced pay schedule.

CONCLUSION

The recipient in this case was taken to California Gardens after a very serious and life-threatening medical event which then resulted in the loss of his leg. Additionally, he suffered from numerous medical conditions causing him pain and suffering. Hopefully, California Gardens would incorporate the information that transferred with the recipient from the hospital where he was treated into the plan of care for the recipient while residing at California Gardens. This transfer of medical information, which impacted and drove the continuum of care for the recipient, then became his clinical record at California Gardens, and thus the recipient had the right to view and copy it upon request and for a "reasonable" fee. The HRA finds that the fees listed in the policy comply with Illinois Statute adjustments for inflation 2015 (735 ILCS 5/8-2006). The clinical record received by the HRA did not contain the protocol that the facility policy mandates must be given to the recipient, and the progress notes do not indicate that he ever received an opportunity to view his complete record or copy it. Additionally, the facility staff as well as the Ombudsman both indicated that the facility did not include the hospital information in the recipient's record. The HRA substantiates the complaint that the facility did not follow Nursing Home Care Act and HIPAA Act requirements when it did not allow a resident access to his record.

RECOMMENDATION

1. Revise hospital policy to allow recipients their access and ability to copy their entire California Gardens record and all medical or mental health data which transfers with them to the facility and informs their care per 210 ILCS 45/2-104 d of the Nursing Home Care Act and regulations that govern the Health Insurance Portability and Accountability Act (45 C.F.R. 164.524).

SUGGESTION

1. Ensure that recipients receive written notice of any record access denials and that the written notice includes a complaint mechanism.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

M | K | B

Patricia C. Betzen
Illinois Guardianship and Advocacy Comission
West Suburban Regional Office
Madden Mental Health Center
PO Box 7009
Hines, IL 60141

RE: 16-030-9002

Dear. Ms. Betzen:

I am counsel to California Gardens Skilled Nursing and Rehabilitation Center and in receipt of correspondence dated July 14, 2016, from Ms. Casati regarding report #16-030-9002. In it, Ms. Casati details circumstances regarding concerns you had regarding medical record requests at California Gardens Skilled Nursing and Living Center; specifically, the disclosure of hospital records when a medical record request is tendered to the facility. While Ms. Casati indicates that a copy of the report was enclosed with her correspondence, there was none included so I am somewhat handicap in being able to fully respond to the details of the report. Notably, I have bene unable to locate the specific Policy and Procedure that was the subject of your concern.

Notwithstanding, I have consulted with our Health Information Officer and confirmed that when a request for medical records is submitted to the facility the requesting party has the opportunity to copy any and all hospital records that are in the facility's possession. A copy of the facility's current "Medical Record Request Protocol" details, in bullet point #3, that hospital records are tendered. There is no restriction on a requestor's ability to obtain this information.

While I have not seen the source document that prompted your office's concern, and to the extent that the facility did not provide hospital records in its possession to a requesting party, that is no longer the facility's practice.

I trust this information will permit you to close your file in this matter. If you have any additional questions or concerns, please feel free to contact me directly at 847-745-6212.

Very truly yours,

Ari B. Kirshner

ABK/tm
Enclosure

Medical Record Request Protocol

- POA/Guardianship or Next of Kin requests - a Government issued ID **MUST** be present to complete the Medical Records Request;
- If a resident is deceased a death certificate **MUST** be included with the Medical Record Requests (no exceptions);
- Hospital transfer documents that the facility has can be provided if specifically requested – to obtain a complete copy of the record contact the originating healthcare facility;
- All medical records requests will be accompanied by a fee, depending on the number of pages of the record this fee will fluctuate;
- If the resident/requesting person/body wants to look over the records, you can contact the DON/ADON at the facility and discuss setting up a meeting time to go over the records – this will eliminate the fee for the records.

This is the fee schedule and we have attached the Illinois Comptrollers Guidelines:

Fee – 2015	Paper Record	Electronic Record
Handling charge	$26.58	$13.29
Copy: pages 1-25	$1.00	$0.50
Copy: pages 26-50	$0.66	$0.33
Copy in excess of 50	$0.33	$0.17
Copies made from microfiche or microfilm	$1.66	$1.66

Code of Civil Procedure 735 ILCS 5/8-2001(d):

- The person requesting copies of records shall reimburse the facility or healthcare practitioner for all reasonable expenses, including the costs of independent copy service companies, incurred in connection with such copying not to exceed a handling charge for processing the request;
- and the actual postage or shipping charge, if any;
- plus copy charges;
- The facility or healthcare practitioner may, however, charge for the reasonable cost of all duplication of record material or information that cannot routinely be copied or duplicated on a standard commercial photocopy machine such as X ray films or pictures;
- Records retrieved from scanning, digital imaging, electronic information or other digital format do not qualify as microfiche or microfilm retrieval for purposes of calculating charges;
- For electronic records, retrieved from a scanning, digital imaging, electronic information or other digital format in an electronic document, a charge of 50% of the per page charge for paper copies listed above. This per page charge includes the cost of each CD Rom, DVD, or other storage media;
- Records already maintained in an electronic or digital format shall be provided in an electronic format when so requested. If the records system does not allow for the creation or transmission of an electronic or digital record, then the facility or practitioner shall inform the requester in writing of the reason the records cannot be provided electronically.

Requestors Signature: _____ Date: _____