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East Central Regional Human Rights Authority
Symphony of Lincoln
Case #17-060-9008

Case Summary: The HRA did not substantiate the complaint that staff repeatedly harassed a resident, making false allegations, in an attempt to have the resident discharged. The HRA did substantiate the complaints that a nurse removed from a resident's care continues to be involved in that resident's care, a resident is being inappropriately treated as a patient with behavioral health needs when she actually has a traumatic brain injury along with other stressors, there is a pattern of reoccurring problems with the resident on weekends, and the resident's guardian is not kept informed of issues of concerns, meetings, etc. The provider response was accepted by the HRA but not made public.

Report of Findings

The East Central Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning Symphony of Lincoln:

1. **A nurse removed from a resident's care continues to be involved in that resident's care.**

2. **Staff repeatedly harass a resident, making false allegations, in an attempt to have the resident discharged.**

3. **A resident is being inappropriately treated as a patient with behavioral health needs when she actually has a traumatic brain injury along with other stressors.**

4. **There is a pattern of reoccurring problems with the resident on weekends.**

5. **The resident's guardian is not kept informed of issues of concerns, meetings, etc.**

To investigate the allegations, an HRA team interviewed facility staff, reviewed the resident's record, with guardian consent, and examined facility policies and other documents.

If found substantiated the allegations represent violations of the Nursing Home Care Act and regulations that govern skilled/intermediate long-term care facilities.

According to the Illinois Department of Public Health (IDPH) website, Symphony of Lincoln is a long-term care licensed facility with 101 skilled and 25 intermediate care beds. The facility's web-site indicates that it specializes in sub-acute care.

Complaint Statement

According to the complaint, a long-term resident with a traumatic brain injury (TBI) and quadriplegia as well as other medical concerns had conflicts with a nurse, and the nurse was removed from her care but continued to be involved in the resident's business, including making calls about the resident and harassing the resident. The complaint states that the resident has been targeted to be discharged, including inappropriately labeling the resident as having mental health related issues. However, attempts to admit the resident to a hospital behavioral health unit have mostly been unsuccessful as the resident's needs are primarily related to a TBI. The nurse in question and sometimes other staff reportedly harass the resident and make false allegations, including allegations that she is intoxicated and aggressive which sometimes leads to multiple calls and attempts at hospitalization with the ultimate goal of having the resident discharged. The complaint states that there are frequently problems on weekends and the nurse in question is often working then even though she is no longer assigned to the resident's care. In addition, the guardian who is also a family member is allegedly not kept informed of incidents, calls and attempts at hospitalization.

Guardian Report

The HRA examined documents and information provided by the guardian. The guardian's documented concerns dating back to 2012 stated that the resident incurred 3 fractured ribs after the facility tried to force her to see a psychologist; this resulted in the resident being put on suicide watch and the guardian had to take the resident to a psychiatrist to have her removed from the watch list. The guardian documented that the facility locked the resident out of the facility in 2014, and the resident only regained facility entry after the involvement of an ombudsman and police force. The guardian stated that the resident was erroneously reported as being intoxicated after nighttime medication was administered, and when the resident took naps in her wheelchair. The guardian referenced a purse search on 07-25-16 when the resident was accused of having narcotics even though nothing was found. The guardian also stated that facility staff have given the resident alcohol and cannabis. The guardian stated that the resident has a medical cannabis card but the nursing home refuses her use of it. The resident was sent to the hospital for a psychiatric evaluation after the aides dropped the resident on the floor and she became upset; the staff claimed she was intoxicated but her lab work was normal; the facility claimed that they called the guardian but the guardian stated she was not notified. The guardian also reported that Risperdal was discontinued on 06-21-16 but the nurse pulled from the resident's care called the physician on 09-03-16 stating that the resident refused to take her prescribed Risperdal; the nurse also reported that the resident was intoxicated and having behaviors even though she had been out of the facility and at home for the day. On 09-07-16, the nursing home spoke to the nurse about having no contact with the resident as per the guardian. The guardian stated that the resident was very sick on 07-26-16 with repeated vomiting but she was not notified. The guardian stated that the nursing home has made many accusations about the resident's behavior; however neither family nor the neurologist have witnessed such behaviors. The home also falsely accused the resident of stealing while the guardian reported that she has replaced numerous items that would come up missing, including IPods, IPads,

cigarettes, money, and clothing. The guardian contends that the care plan was full of half-truths and no other facility would subsequently consider admitting the resident. The guardian reported concerns that the resident was being labeled as a psychiatric patient when she has never been diagnosed as such emphasizing that the resident has a TBI, is quadriplegic and only has the use of her right arm. The guardian stated the resident is confined to an electric wheelchair and the nurse in question threatened to take the wheelchair away. The guardian shared communications between her and an ombudsman dating back to August 2016 in which the guardian reiterated concerns about the nurse but the nurse's continued to be involved in the resident's care; the ombudsman indicated contact with the facility administrator who confirmed that the nurse was relieved from the resident's care.

Staff Interviews

An HRA team interviewed facility staff beginning with general questions regarding the facility's services and then more detailed discussion about the allegations. The facility stated that it primarily provides nursing home services based on resident needs, including ventilator care, short-term rehabilitation and dementia care. The facility typically does not serve individuals with a serious mental illness. The facility serves a wide range of individuals with most residents being age 55 or older. The facility is licensed for 120 Medicare beds with 80 beds filled at the time of the HRA's visit. A total of 144 staff are employed at the facility. With regard to a resident's average length of stay, the facility stated that length of stay is based on the payer. Most residents are from Logan or Sangamon Counties; however, residents needing ventilator care may come from farther away.

The HRA team then inquired about the situation in this case. The facility stated that the resident had been there for 8 years and has a TBI. She was described as being much loved by staff and that staff went above and beyond to accommodate the resident's requests, including lunch purchases, requested staff assignments and even allowing her to run some activities. Staff stated that the resident had behavioral issues that ranged from simple to difficult. The facility reported that her residency ended when she threatened to kill another resident and that resident requested assistance in protecting herself.

When questioned about any underlying causes for behaviors, the facility responded that the resident did not want to be around older persons and preferred contact with younger persons which caused her to be angry. Staff stated that the guardian was reluctant to move the resident.

With regard to the resident's medical needs, the facility stated that the resident had few medical needs but did need assistance with transferring from her wheelchair, toileting, transferring to the shower and reminders on medications. Staff stated that the resident had "left-sided neglect" which is defined by Wikipedia as "a neuropsychological condition in which, after damage to one hemisphere of the brain is sustained, a deficit in attention to and awareness of one side of space is observed. It is defined by the inability of a person to process and perceive stimuli on one side of the body or environment, where that inability is not due to a lack of sensation."

The HRA questioned the facility as to what evaluations would indicate a resident's need for mental health treatment. Staff explained that mental health services were offered but declined.

Staff stated that there are psycho/social service professionals who come to the home who could provide mental health related evaluations.

The HRA also questioned if the resident and/or guardian filed any grievances regarding the facility. Staff confirmed that there were complaints about the resident being sent to the hospital for behaviors. The facility felt that the behaviors were out of control and warranted hospitalization but the guardian requested that the resident not be sent to the hospital. The facility then requested that the guardian come to the nursing home to help calm the resident when she had behaviors. When the guardian refused, the facility stated that they had no other choice but to pursue hospitalization. When the resident was sent to the hospital after threatening to kill the other resident, she was involuntarily discharged from the facility. Staff also confirmed that there was a request that a particular staff person be removed from the resident's care and that staff person did not provide any further care after the request was made.

The HRA requested information as to why the resident was not allowed to return to the facility. The facility explained that it is a home for all residents and they needed to protect other residents. The resident who was threatened (referred to later in this report as Resident #2) has a history of post-traumatic stress disorder, anxiety and depression; she had never previously felt threatened until the most recent threat. The two residents lived at opposite sides of the building, would interact while outside smoking and each used wheelchairs for ambulation. A complaint was filed for which IDPH initially substantiated violations related to the involuntary discharge but the findings were later reversed by a senior IDPH reviewer.

The HRA questioned if the other resident had been coached in any way to file an order of protection and the staff responded, "no." Staff reiterated that the resident was not happy at the facility and did not want to be there. If she could have a caregiver she possibly could be out on her own as per staff. Staff reported that the resident was smart; she wanted to have a normal lifestyle and do what other young people do. According to staff, there were a lot of tears shed by staff when she left and although they kept an eye on her, she did not have any enhanced supervision; she went all over the facility. The facility stated that when the guardian refused to help with calming over the threat, the physician was called but was unavailable; therefore, the facility contacted the medical director who provided the involuntary discharge order which was sent by certified mail to the guardian. The guardian claimed she had not been notified but the facility stated that she had already filed an appeal; the guardian knew that the resident was being sent to the hospital as per staff.

Staff reported that the resident still calls the facility and has requested that aides from the nursing home come to the hospital to help with bed and shower transfers. Staff stated that the resident had connected with facility staff because they were within the resident's age range.

With regard to the topic of resident rights, staff stated that rights information was shared with the resident in this case. The HRA team did note record documentation about impeding and/or screening calls coming in to the resident. Staff reported that the resident had her own private phone and they did not know of any issues regarding personal calls but they did have issues with the resident calling a taxi driver to bring her alcohol and the facility's concern about alcohol

interaction with her medication. According to staff, the resident voiced frustration over not having her own rights and that the guardianship was established when she had been in a coma.

The HRA team then proceeded with questions regarding facility policies and practices. The facility reported that, with regard to resident rights, rights information is included in every admission packet and discussed with residents at admission, including information about how to access the ombudsman. All new hires receive training on resident rights with refreshers provided at staff meetings. A resident council is available for all residents to attend. Individual care plans are created for each resident and residents and/or their guardians can participate in treatment planning. Quarterly reviews of care plans are conducted as part of quality assurance measures. Other quality assurance measures include daily house reports on morning and afternoon rounds, basic resident checks, a staff position focused on customer services, gold standard protocol used by the Ritz Carleton and resident interviews.

The HRA team questioned staff training specific to crisis intervention and evidence based treatment. The facility reported that staff must complete abuse training with frequent refreshers. The HRA specifically asked about any de-escalation training and training specific to resident behaviors. The facility reported that most aggression is resident-to-resident and the facility incorporates a calm approach, monitors the situation and notifies families and the physician.

Facility Tour

In a tour of the facility, the HRA team found the facility to be very clean and neat with no odors present. Residents and staff were interacting appropriately. Rights information was visibly posted along with phone numbers for third party advocacy groups. An activity board posted various available activities, including church services and bible studies. The cafeteria was observed and staff reported that residents could eat in their rooms. The team also examined family rooms that allowed for private visitation. The HRA team examined the resident's room which was still packed with the resident's belongings, including two motorized wheelchairs. One HRA team member suggested to staff to keep the wheelchair charged or the normally expensive batteries would die. The HRA team spoke privately to one resident outside of the facility and she stated that staff are usually very nice and professional.

Record Review

The HRA examined the resident's care plan which listed the following diagnoses: muscle spasms; major depressive disorder, single episode, unspecified; quadriplegia; involuntary movement; generalized anxiety disorder; gastro-esophageal reflux disease; insomnia; myalgia, dermatitis; pelvic and perineal pain; urinary incontinence; history of TBI; muscle atrophy and weakness; systemic lupus erythematosus, unspecified, etc. The care plan identified numerous goals related to the resident's medical needs such as skin care, nutrition, pain care, insomnia, etc. However, there were numerous other goals related to the resident's behaviors as follows:

Goal Issue	Approaches/Interventions
Depression	Medication, monitoring for signs/symptoms, quarterly psychotropic assessment
Anxiety	Medication, monitor for safety, quarterly medication assessment
Refusing guardian	Guardian and resident notification of care plan meetings

involvement in care plan meetings	
Verbal abuse	Analyze triggers, anticipate needs, assess resident coping skills, assess resident understanding, allow self-expression, monitor medication side effects, offer choices, intervene by approaching in a calm manner, divert attention and remove from situation, monitor behaviors to determine any underlying cause, activity participation, re-approach with requests, etc.
Community living	Assist guardian in communicating with other facilities at guardian's request
Resistance to care	Allow control about treatment regime, education resident about care outcomes, encourage resident participation in care, praise appropriate behaviors, re-approach, address calmly, etc.
Negative behaviors toward staff	Calm approach, redirect, determine root cause, offer activities, offer different staff, offer calls to family, offer to sit outside,
Behaviors related to TBI	Counseling, medications, allowing vent, music, monitoring, educate, physician reports, encourage home visits, involve ombudsman as needed, report behaviors to guardian, switch staff, etc.

The care plan section regarding guardian involvement in care plan meetings stated that, "Resident chooses not to involve her [guardian] during quarterly or significant change care plan meetings. Resident request staff not to send letters to [guardian] and prefers symphony of Lincoln to invite who she wants to care plan meetings….Guardian request care plans to be a conference call and prefers for resident to not be present during the care plan conference call. Resident is made aware of when care plans are scheduled as well as the guardian."

The care plan section regarding verbal abuse stated that the "Resident has potential to demonstrate verbally abusive behaviors r/t [related to] resident's declining condition, depression and her desire for not being in a nursing home. Behaviors are intensified when staff does not do anything exactly how she tells them to, meal times, meal substitutions, showers, staff or other residents in her pathway, staff not purchasing alcohol for her….Resident will deny medication and will attempt to pocket specific medications. When staff attempts to collect medication and re-administer, she becomes irrational."

The care plan section regarding behaviors related to TBI stated that "She is often unable to control emotions when she feels upset, striking out at others, name calling, cursing and yelling. She exhibits episodes of verbal abuse, profanity, cursing, degrading remarks toward others, demanding, scratching, pinching, hitting, grabbing of staff, frequent accusations against others of stealing, manhandling, refusal of med-calling 911, running into objects and people with her w/c, slamming doors,….She is known to have behaviors of making false, unfounded accusations against staff and stating 'I'll get you fired.' Resident has had to be sent to emergency room due to behaviors with staff and external departments fore de-escalation. Resident has returned with Risperdal from ER that Guardian refused to sign consent for." There is no indication if the approaches to behaviors have been reviewed or revised subsequent to repeated behaviors or a documented history of attempts to address the resident's behaviors.

The care plan section on community living stated that the guardian expressed interest in a specialized facility for persons with a TBI but such a facility has been difficult to locate. The guardian requested that the facility discourage ideas of pursuing discharge to the community due to the residents 24-hour needs.

The HRA examined 3 different types of forms used for documenting behaviors noting inconsistencies between documentation of the resident's behaviors in each type of forms. Some forms documented behavioral occurrences while other forms did not. The 3 different forms included incident forms, survey reports and "SBAR" (situation, background, assessment, and request) forms.

A summary of Incident forms from 2016 are documented below:

> 03-11-16: The guardian called to report a nurse brought alcohol in for resident although the nurse was not identified; staff investigated with no findings and the resident refused to discuss.
>
> 03-17-16: A dietary aide reported that a CNA was mean to the resident but the resident denied this and other staff who were interviewed denied witnessing anything. The form indicated that "family" was notified as per a check mark on the incident form.
>
> 03-25-16: A peer made a gesture and cursed at the resident and the resident responded likewise; the residents were separated. On the same day, the resident alleged money and items were missing from her room; an investigation resulted in the items being found in the resident's room. At a later time, resident #2 reported that the resident cursed at her and a peer which the resident denied. The forms for all indicate that family was notified.
>
> 04-02-16: The resident signed a statement that the nurse identified in this complaint and the resident "…have grown up and come to agreement that it's cool for her to give me my pills and be my nurse!!" There is no documentation as to the purpose of this statement or if the guardian received it.
>
> 04-27-16: The resident reported a missing e-cigarette after which an investigation was conducted and family was notified. The facility could not locate so it transported the resident to the store and replaced it.
>
> 05-12-16: The resident and a peer had a verbal altercation and were separated. The resident was upset over the peer having call light on continuously. The family was notified.
>
> 06-03-16: A general report that the resident has increased behaviors and cursing toward staff, including being combative although specific details were not provided. The incident form stated that staff would calm and redirect. The family was notified. A different report on the same date stated that the resident cursed at a peer who was in her way; the resident was redirected and family was notified.

06-16: The resident's behavior was described as escalated and disruptive with staff being unable to calm or redirect. The guardian, physician and police were notified. The police received a call regarding a combative resident and the nurse named in this complaint reported that the resident was believed to have had alcohol mixed with a can of coke; the nurse stated that the resident was using her electric wheelchair to run into staff and other residents and that the resident is a threat to staff and other residents. An order was secured for transport to the hospital for a mental health evaluation.

06-16: The resident approached a taxi driver in the parking lot and requested assistance in purchasing alcohol; when the taxi driver returned with the alcohol, staff intercepted it and locked it up. Family were notified.

06-24-16: Another resident made a general statement, which was documented in an incident report, that the resident was verbally abusive to staff and staff try to do everything they can for her. Family was notified.

08-07-16: The resident had an argument with a visitor. Staff intervened and family were notified.

09 - 16: The resident cursed at Resident #2 and another resident. Staff intervened and the resident was redirected. The family was notified. Then behaviors continued and the physician was notified and recommended hospital transport. The nurse in this case notified the police but when police arrived the resident calmed and went to bed.

09-16: The resident called Resident #2 a name and staff asked that they stay away from each other after which the resident made a threat toward Resident #2. The "police were notified per [Resident #2]'s request." Family was notified.

10-12-16: Another resident asked the resident to move her wheelchair resulting in cussing between the two. Staff intervened and redirected. The "POA" was notified.

11-2-16: Another resident struck the resident when she bumped his wheelchair; staff intervened and separated and family was notified.

11-30-16: "Resident's POA…stated she feels like [the nurse removed from care] is still involved in resident's care. Resident has previously expressed that she doesn't want this nurse taking care of her. When [the resident] was interviewed, [the resident] states [the nurse] doesn't take care of her but feels like she has heard [the nurse] say [the resident's] name. [The resident] unable to state what [the nurse] has said other than hearing her say her name." A follow-up report states that the nurse "…has been educated to ensure she is not involved in resident care ongoing. Resident has been informed that nurse may state her name to ensure that she directs the staff if she sees res. Call light on or if there is a safety issue. Nor further concerns at this time."

12-03-16: There was a verbal encounter between the resident and Resident #2. The residents were separated and there was no physical encounter; "both safe and secure."

12-11-16: The resident and Resident #2 were in wheelchairs in smoking area in front of facilities and their wheelchairs locked. "wheelchairs separated – residents secured – assessed – no injury." The physician and guardian were notified of the incident at 11:58 a.m. and 11:59 a.m. respectively.

12-11-16: The physician and guardian were notified at 2:58 p.m. and 3:05 pm respectively that the resident made a statement to Resident #2 after which the residents were separated and assessed. There was no physical contact and both residents were safe and secure.

12-12-16: At 1:30 p.m. Resident #2 was waiting to see the administrator and the resident approached resident #2 and started cussing at her. The residents were separated and the physician and guardian were notified. The resident was sent to the ER for evaluation. A separate form for the same day stated that after the incident the resident was being involuntarily discharged from the facility for the safety of residents, staff and visitors. Involuntary discharge forms were completed and given to the resident, the Department of Public Health, the ombudsman and by certified mail sent to the guardian.

There were no further incident reports provided to the HRA, including no form for the incident that led to involuntary discharge or corresponding incident report forms for behaviors documented in survey reports for November 3, 5, 8, 16, 19, 26, and December 2 as documented in the next paragraphs.

November and December 2016 facility "survey reports" for the resident were reviewed with notes made for each shift in various categories, including behavioral monitoring. On most days in November, the behavioral survey reports documented either NA for not applicable or NR for no response needed, suggesting that there were no behavioral incident. The November exceptions as well as December exception reports through December 7, 2016 documented the following behavioral occurrences:

Date	Day	Shift	Behaviors
11-03-16	Thursday	2nd	Yelling/screaming
11-05-16	Saturday	3rd	Abusive language, pinching/scratching/spitting
11-08-16	Tuesday	2nd	Yelling/screaming
11-16-16	Wednesday	2nd	Yelling/screaming, kicking/hitting
11-19-16	Saturday	2nd	Yelling/screaming, repeats movement
11-26-16	Saturday	2nd	Refusing care, yelling/screaming, abusive language, repeats movement
11-27-16	Sunday	3rd	Kicking/hitting, yelling/screaming, abusive language, wandering
12-02-17	Friday	3rd	Refusing care, yelling/screaming, abusive language, sexually inappropriate.

In reviewing staff schedules for the dates above, the nurse in question who had been removed from the resident's care was working the following dates: November 16 on 2nd shift; November 26 on 2nd shift; and November 27 on 2nd shift. She was always assigned to Harmony Hall II. The medication administration records for the resident in this case documented that the resident resided on Harmony Hall II.

The 3rd set of forms in which the resident's behaviors were documented was the SBARs. The HRA examined SBARs dating back to July 2016. One report dated 07-24-16 and another 07-25-16 described symptoms in which the resident had slurred words and a CNA reported 12 pills in the resident's purse labeled as Ativan and Xanax; the resident subsequently reported that her guardian told her to flush the medications which she stated she did as per the 07-25-16 report. The resident was monitored and the physician was notified; however, it is unclear if the guardian was notified. A similar incident report dated 08-08-16 completed by the nurse identified in the allegation as being removed from the resident's documented behavior concerns in the middle of the night that included yelling/cursing at staff and being disruptive to the sleep of other residents; the document also stated that the guardian and physician were notified. The on-call physician recommended sending the resident to the hospital for a psychiatric evaluation if the behavior continued. An SBAR report dated 09-08-16 again completed by the nurse identified in this case stated that the resident exhibited behavior when returning from an outing and had slurring words and was yelling/cursing loudly toward staff while residents were trying to sleep; the physician and guardian were notified and the resident refused vitals and neuro checks. A note stated to send the resident to ER for evaluation if behavior escalated. A form completed on 09-14-16 described the resident as being physically and verbally aggressive toward other residents and staff when she hit another resident with her wheelchair and attempted to run over staff; the physician ordered that the resident be sent to the ER for a psychiatric evaluation. There was no documentation that the guardian was notified. A 10-12-16 report stated that the resident was yelling, cussing and swinging; there was no documentation that the physician or the guardian was notified. On 11-13-16, the resident reportedly ran into a CNA using her wheelchair while cussing at the CNA; there was no documentation that the physician or guardian was notified. A 12-07-16 report stated that the resident bumped into another resident with wheelchair in hallway at 15:30; there were no further notes regarding the incident. A report on 12-11-16 stated that the resident's wheelchair became entangled with another resident and the other resident thought she ran into her on purpose and called police. The police arrived with no directive and stated that this was not a crime the physician and guardian were notified. Later on 12-11-16, there was a verbal interaction between the resident and another resident in which the resident stated "I am gonna go Bruce Lee on your stupid ass."which was witnessed and acknowledged by the resident; the physician and guardian were notified. On 12-12-16, a report stated that the resident made verbal threats to another resident and was aggressive toward staff by biting and kicking; the guardian was notified and request for assistance was sought by facility.

Of the 3 different forms used for behavioral documentation, the HRA found only three dates (09/16; 10/12; 12/11) in which behavioral occurrences were documented on both SBARs and Incident Forms. And while the survey reports documented behavioral occurrences, none matched the dates on the SBARs or the Incident forms; in fact, on the survey reports, some days in which incidents were listed in either the SBARs and Intake forms there was documentation in the behavioral sections of survey reports indicating NA (not applicable) or NR (no response).

An examination of involuntary discharge forms created by IDPH indicated that a notice of involuntary transfer or discharge was completed on 12-12-16 due to the endangered safety of individuals in the facility. Section 42 CFR 483.12 (a) (2) (iii) of Medicare/Medicaid regulations is cited. A separate, similar IDPH form cites the physical safety of other residents, the facility's staff or visitors as the reason for discharge as per Nursing Home Care Act provisions in 210 ILCS 45/3-401 (c). An ambulance transported the resident out of the facility. Appeal rights were included with the notice. The guardian requested a hearing. Witnesses provided statements in preparation for the hearing, including a statement by Resident 2 describing threats throughout the weekend, including hitting Resident 2 with her wheelchair, cursing at resident #2 and threatening to kill or "get" Resident #2. A CNA's statement referenced the resident calling the CNA names, attempts to bite and kick and voicing threats against another resident. Another staff person documented statements made to him by Resident #2 about the resident's threats. Another staff person documented statements made to her by Resident #2 about the resident's threats and hitting her with her wheelchair. Included in the discharge documents were the guardian's phone records for December 11th and 12th. The records indicate that there were incoming calls to the guardian from a phone number that matched the facility's phone number on 12-11-16 at 4:02 p.m. and on 12-12-16 at 1:44 p.m., at 2:01 p.m. and at 2:35 p.m. An order of protection was filed against the resident by Resident #2 after the involuntary discharge.

The HRA examined a prior notice of involuntary discharge dated 05-01-14 that was rescinded. The reason stated for this discharge was twofold: endangered safety of individuals in the facility and the health of individuals in the facility would otherwise be endangered as documented by the physician.

A neuro Psych evaluation completed in 2011 described the resident's deficits in memory, language processing speed, etc. She was described as being "…quite impulsive and quick to become irritable."

A 09-05-12 letter from an attorney to the facility on behalf of the guardian questioning retaliation after the resident spoke to state investigators and a reporter regarding facility problems. The letter referencing sending the resident to the hospital without reason and without notifying the guardian and staff ridicule of the resident.

A psychiatric evaluation completed on 10-05-12 documented the resident's TBI resulting from a car accident in 1997. The evaluation was due to the facility placing the resident on 1:1 supervision after staff indicated that the resident made suicidal gestures. The psychiatrist noted that the resident's use of profanity is a common occurrence for persons with TBI who become excited. According to the psychiatrist, the resident voiced concern about facility care and a gesture she made in front of staff when she placed her brassiere around her neck because of her frustration. The psychiatrist documented multiple questions regarding feelings of harm to self or others and found her to have no self-harm ideations in his presence; he wrote an order to lift the 1:1 supervision.

The HRA reviewed the resident's history and physical completed by the hospital to which the resident was transferred as part of the involuntary discharge on 12-12-16. The physical stated that the resident "…is a long term resident of Symphony of Lincoln was taken to the Emergency Room for psych evaluation for aggressive and violent behavior. Apparently the patient is known by Emergency Room physician secondary to her history of posttraumatic brain injury and she's had behavioral difficulties since then. According to the history, patient has been more aggressive over the past 2 days at the nursing….According to the Emergency Room physician, he was told the patient had violent behavior and had threatened to kill another resident. The nursing home apparently is in the process of completing an involuntary discharge for the patient. Since she has been having a lot of behavioral problems she was sent to the Emergency Room for psych evaluation. Patient has apparently been cooperative in the Emergency Room….Since the patient is not a danger to herself or others, patient is not a candidate for psych admission." The patient is described as being irritable and wanting to return home to where her belongings were.

The HRA examined a sample of medication administration records from July and August of 2016. The records indicated that the resident routinely accepted administrations of the medication Lorazepam for an anxiety disorder but refused medication administrations for Risperdal for behaviors described in the medication sheets as aggressive and violent. The HRA noted that, on occasion, the nurse who was removed from the resident's care administered the resident's medication. The HRA also found that the medication sheets included checks of medication side effects. Medication records were reviewed for November and December 2016 with similar results although Risperdal was no longer listed but Prozac was added and was accepted by the resident. Occasional administrations by the nurse in question continued.

The resident's record also documented that the resident was receiving physical therapy as a result of a TBI and to address muscle weakness and atrophy. Physical therapy discharge notes indicated that the resident needs continued assistance with standing and transferring from her wheelchair. The resident also received occupational therapy to address muscle contractures, systemic lupus erythematosus, quadriplegia and muscle weakness. The occupational therapy discharge notes stated that the resident needed assistance with many activities of daily living and it was recommended that she needs 24-hour care.

Several screening and "look back" nursing documents were reviewed. Some examples of descriptors included in these screenings are as follows. A fall risk screen dated 07-07-16 identified "agitated behavior in last seven days" as "wandering; verbally abusive; physically abusive; socially inappropriate, e.g. is noisy, screams, disrobes, self-abusive, rummages, hoards, etc." A quarterly psychotropic drug review dated 07-07-16 included the following descriptors of the resident's behavior: depression; verbally abusive; physical abusive; compulsive behaviors; anxiety; insomnia; wandering; intrusive to others; inappropriate sexual gestures/statements; and disruptive behaviors. Corresponding interventions included: redirection, reassurance, reduce stimulation, distract, comfort measures, repositioning, allow venting, removing from situation, offer choices and as needed medication. A pain screen dated 07-07-16 indicated that the resident experienced frequent pain for which she received medication as needed. An annual social service assessment dated 07-11-16 described the resident as having an involved guardian and son, being social, having some memory loss/confusion, having coping issues, having depression and being verbally and physically aggressive toward staff. Psychiatric diagnoses of major

depressive disorder and anxiety are included in the social service assessment. A social service quarterly report dated 09-01-16 documented that the resident "is not always pleasant or cooperative with staff. With physical and verbal explosive behaviors toward staff….Discharge not anticipated at this time." A 12-02-16 social service quarterly report documented that the resident can be verbally and physically resistive and that discharge was not anticipated.

Progress notes dating back to July were reviewed. On 07-02-16, the resident was very argumentative and cussed at nurse; she was given medication. On 07-13-16, the resident was yelling and crying throughout evening stating she would like to move to another facility with younger residents. On 07-15-16, the physician reported that the guardian refused physician's request for a drug screen and the physician terminated the patient. As per notes on 07-21-16, the resident was cussing and yelling at staff. Later the resident and guardian visited a new physician and there was disagreement over whether or not the prior physician prescribed medical marijuana as reported by the resident and guardian but discounted by the facility nursing staff. On 07-24-16, a CNA reported that she witnessed resident having plastic bag with 14 pills labeled Xanax and Ativan. Resident denied and refused purse search; the physician and guardian were notified. The guardian agreed to have son check the resident's purse. Resident later told staff as per notes that she flushed the medications at per guardian directive. On 07-26-16, the resident had a verbal outburst in front of a new resident's family member. A note on 07-27-16 stated that the guardian stated that "…she doesn't take her phone to bed anymore because the facility calls her way too much…." The nurse removed from the resident's care documented verbal outbursts on 07-29-16, 07-31-16, 08-07-16, including the nurse's contact with the physician about behaviors and the physician's indication that if behaviors continue to pursue hospitalization. The notes for 08-07-16 also indicated that the resident confronted the nurse about not being able to administer the resident's medication.

"Concerns" reports were also reviewed. These appeared to be used to document complaints registered by residents or family/guardians. On 01-15-16 a Conerns report stated that the resident was missing $97; the administrator documented that the money was found in items on table in resident's room. The resident reported a missing shirt on 01-29-16 which the facility found and returned. A missing ring was reported on 01-29-16 but it was not found after a search; the Illinois Department of Public Health and the guardian were notified. Food complaints as voiced by the resident were documented in a form dated 03-02-16; the facility purchased a meal from a resident and the dietary manager interviewed the resident about likes and dislikes. According to a form dated 09-15-16, the guardian was upset about police involvement for the resident. A form completed on 11-15-16 indicated that the resident's coat was missing but the form stated that it was found in the closet.

Physician reports for 2016 were reviewed. A report dated 02-03-16 stated that the nursed called and reported that the patient had asked for pain medication which was given along with Xanax; then, when the patient woke about in the late morning her speech was slurred and she was weak. The resident refused having her vitals taken or lab work; the physician ordered that she be sent to the ER for evaluation if the resident worsened. A report from 02-11-16 stated that the guardian question why Ativan was stopped and it was explained that the patient was placed on Xanax and could not take both, thus, the Ativan was stopped. The guardian also questioned random urine test. The guardian later contacted the nursing home and told them that the resident was to only

be tested for medications the resident is on. On 07-11-16, the physician terminated the resident as a patient with the following explanation: "She [the resident] has some issues going on at nursing home facility with the staff and the management for past many months. Nursing home has been reporting behavioral problems from her for long time that patient has always denied in the past. There has been conflict between patient and nursing home regarding her care and I am aware of and has been getting regular calls from the nursing home and also from patient's [guardian] regarding that. In the past few days patient did have some problem with the nursing home staff and I got a phone call about her being cursing the nursing home staff, trying to bite her and getting very aggressive. She was transferred to the hospital for psychiatric evaluation as she was considered a risk to herself and nursing home staff. Patient was evaluated in hospital and initially was thought to be under alcohol intoxication but later on her alcohol level came normal. She was transferred back to the nursing home facility after being stabilized and was advised to start risperidone. Patient however never took the medication and refused it despite me being recommending to continue that. Patient has problems following my recommendations in the past too. Patient is accompanied by her [guardian] today who denies all of the above and states that nursing home is trying to get rid of her so they are accursing her of things that she never does. She however admits that patient has tried getting alcohol bottle from an outside source few days ago against the nursing home policy and without their knowledge. Pt. during the office visit got very upset about nursing home situation, however her [guardian] is stating that they are trying to manage those issues. Patient is also here to follow-up on her chronic pain issues. She is currently on Tylenol with Codeine and also takes benzodiazepines for anxiety issues. We have requested patient couple of times in the past to submit a urine drug screen as patient has a controlled substance agreement with our office, however pt has refused that in past. Informed patient today that we'll like her to submit a urine today so we can keep monitoring the medication we're prescribing. She denies any complaints today." The resident refused to submit the urine sample.

Policies and other Documents

The HRA examined the facility contract signed by the resident's guardian in 2008 noting that the facility's name has changed since then. The contract includes the facility's agreement to provide a range of care and treatment as well as certain rights. On the topic of transfer or discharge, the contract states that the facility may transfer/discharge a resident due to the resident's health or safety or the health and safety of others, if the resident no longer needs the facility's services, and/or the resident fails to pay for any facility charges. A termination section states that the contract terminates on 7 days' notice if the resident has a change in physical or mental health. A checklist that accompanies the contract indicates that a residents' rights handbook was provided to the guardian. The guardian signed as acknowledgement that rights information was received.

An "amended Statement of Deficiencies" which referenced a survey date of 12-22-16 stated that the facility is in compliance and no further action is required. The accompanying complaint determination form indicated that a complaint regarding involuntary transfer was invalid and there was no violation.

Resident Council meeting minutes for November and December 2016 and January 2017 were reviewed. Each set of minutes indicated that resident rights were reviewed as well as the location of the survey book. The ombudsman role was reviewed in the December 2016 and

January 2017 meetings. There were 15 – 18 residents in attendance at each meeting. There were no complaints voiced, only compliments about staff, food, activities, etc. It was unclear who prepared the meeting minutes or if there were any staff in attendance.

Quality Assurance meeting minutes March, June, September and December 2016 were reviewed. Notes were frequently abbreviated and discussion topics were not clear. Some of the items listed included: stats-review; cust/serv/resident serv; action plans; system reviews; res cust serv/intervies; nursing/therapy/Act of Life. The December 2016 minutes were more narrative and indicated that there was discussion about diagnostic testing, the percentage of psychotropic medications being administered, wounds, infections, restorative programs, psychotropic program, weight program, immunizations, and falls for the prior 3 months. A physician was present who discussed concerns with the nursing director who was to resolve although it is unclear as to what the physician's concerns were.

The HRA concluded its review of documentation by examining pertinent policies. The resident rights policies require that residents be given a copy of rights at admission and whenever they request a copy, that the facility abide by resident rights and the rights be reviewed during resident council meetings. The admission policy prohibits discrimination and states that certain residents will not be accepted for admission, including individuals who are destructive of property or themselves.

Procedures for the facility's abuse prevention program explains that there are pre-employment screenings of potential employees as well as pre-admission screenings of potential residents that seek to screen out individuals who have criminal backgrounds. The procedures require that new employees receive orientation that covers such topics as sensitivity to resident rights and needs, understanding abuse and obligations to report, "…how to assess, prevent and manage aggressive, violent and/or catastrophic reactions of residents in a way that protects both residents and staff…," how to deal with stress, and obligations to report criminal activities. According to the abuse procedures, staff are to receive annual training on these topics. The procedures then outline approaches for "establishing a resident sensitive environment" which include, identifying and addressing resident and family concerns, identifying residents at risk for abuse or have needs/behaviors that could lead to conflict and then addressing those needs through the care planning process, examining patters of incidents via a quality management committee, and staff supervision to monitor the ability of staff to meet resident needs and correct staff deficiencies through training. The procedures also list the reporting process including, contacting law enforcement when there is a "…physical injury inflicted on a resident by another resident except in situations where the behavior is associated with dementia or developmental disability." Finally, the procedures include a section entitled "Protection of Residents" which states that residents who mistreat another resident will be removed from contact and the accused resident will be evaluated for treatment approaches and placement.

The facility also maintains a grievance procedure which states that any employee can accept a complaint from a resident or family member and attempt to resolve or direct the resident/family to the appropriate department head or supervisor. If the administrator or department head is unavailable, staff are to complete a complaint form and submit to the department head who will then investigate the complaint and resolve, noting on the bottom of the complaint form the

resolution. The complaint forms are then submitted to the administrator who reviews and provides any needed follow-up. All complaint forms are discussed at quality improvement meetings.

The HRA reviewed the Brain Injury Association of Illinois website and found the following information related to TBIs:

> Results of a brain injury
>
> Whatever the cause, a brain injury can, according to the Brain Injury Association of America, result in "an impairment of cognitive abilities or physical functioning. It can also result in the disturbance of behavioral or emotional functioning." Cognitive consequences can include memory loss, slowed ability to process information, trouble concentrating, organizational problems, poor judgment, difficulty initiating activities, among others. Physical consequences can include seizures, muscle spasticity, fatigue, headaches, and balance problems, among others. Emotional/behavioral consequences can include depression, mood swings, anxiety, impulsivity, agitation, among others.
>
> Seven things families need to remember
>
> 1. Reinforce the behaviors you would like to see increase. Like a garden "water the behaviors you'd like to grow."
> 2. When safety is not an issue, ignore the behavior you would like to decrease.
> 3. Model the behaviors you would like to see.
> 4. Avoid situations that provoke behaviors you are trying to reduce.
> 5. Structure the environment, use cues for positive behaviors. Plan rest periods.
> 6. Redirect the person rather than challenging them.
> 7. Seek professional help sooner than later.

Mandates

The Probate Act of 1975 (755 ILCS 5/11a-23) requires that "Every health care provider and other person (reliant) has the right to rely on any decision or direction made by the guardian…that is not clearly contrary to the law, to the same extent and with the same effect as though the decision or direction had been made or given by the ward."

The Nursing Home Care Act (210 ILCS 45/2-112) allows residents to file grievances without threat of discharge or reprisal. Corresponding regulations governing skilled and intermediate care facilities (77 Ill. Admin. Code 300.3210) require facilities to have procedures for investigating complaints; this same section requires the facility to notify a resident's guardian "…whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences…or related administrative matters arise." Regulations that govern a resident's medical care (77 Ill. Admin. Code 300.3220) require that residents participate in treatment planning to the extent his/her condition permits, that all treatments be administered as ordered by a physician, and that residents be permitted to refuse treatment and know the consequences of the

refusal, "…unless such refusal would be harmful to the health and safety of others and such harm is documented by a physician in the resident's clinical record." The regulations (77 Ill. Admin. Code 3310) reiterate the Act's provisions that residents be permitted to submit grievances to the facility, including the resident council, without fear of reprisal.

Section 300.3240 protects residents from abuse and neglect and requires abuse/neglect reporting; if an employee is the perpetrator of abuse, the employee is to be barred from contacts with residents pending an investigation and if a resident is the perpetrator of abuse, "…that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility." The facility is to provide residents and guardians with a copy of rights as per Section 300.3330.

Section 300.1210 requires the following:

> Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)
>
> The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident…. Objective observations of changes in a resident's condition, including mental health and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3000 governs discharge and states that a facility may involuntarily transfer or discharge a resident for medical reasons, for the resident's physical safety, "…for the physical safety of other residents, the facility staff or facility visitors….", and for late or nonpayment. The regulations protect against discrimination if the resident is a Medicaid recipient. The regulations further state that involuntary transfer/discharge shall be preceded by a 21-day written notice except when an emergency transfer is ordered by the attending physician or when the transfer is needed to protect the safety of other residents and facility staff as documented in the clinical record, then the notice is to be provided as soon as practicable and include the reason for discharge, the effective date and appeal information.

Conclusions

Complaint #1: A nurse removed from a resident's care continues to be involved in that resident's care.

In an interview with facility staff, the facility confirmed that a particular nurse was removed from the resident's care. It was unclear when this removal occurred and there was nothing formally documented in the resident's record. However, the HRA examined August e-mail communication between the guardian and an ombudsman indicating that the ombudsman reminded the administrator that the nurse was to be removed from the resident's care.

The HRA found numerous examples in which the nurse remained involved in the resident's care, including June 2016 documentation when the nurse called the police regarding the resident's behavior and suspicion of alcohol when tests came back clean, July 29 and 31 progress notes by the nurse, July and August medication administration records indicating that the nurse administered medication to the resident, an August SBAR in which the nurse was involved, a September incident in which the nurse was involved, police were called and the resident was sent to the hospital, November 16, 26 and 30 documents indicating that the nurse was working and assigned to the resident's wing.

The HRA also noted that the resident signed a statement on 04-02-16 stating that it was allowable for the nurse to administer the resident her medications. Although it is unclear what precipitated this note or its purpose, it is not signed by the guardian, not addressed in the treatment plan or any other document reviewed by the HRA and there was no indication if the guardian received a copy or agreed to the arrangement.

The Probate Act requires that health care providers be reliant upon guardians. The Nursing Home Care Act requires that facilities have a grievance process and that residents and guardians participate in treatment planning.

By the facility's admission, a particular nurse had been removed from the resident's care; it is unclear from the records reviewed by the HRA the underlying rationale for the nurse's removal except that e-mail documentation between the guardian and the ombudsman indicated that the guardian was involved in this decision and was involving the ombudsman to help further address the situation. However, records repeatedly indicated that the nurse remained involved in the resident care. **Based on the record documentation, the complaint is substantiated. The HRA recommends:**

1. **Consistent with Nursing Home Care Act guarantees related to guardian participation in treatment planning and grievance filings, when a guardian or resident makes requests related to care or file grievances, ensure that provisions for guardian/resident participation in treatment planning and grievance resolutions are followed. Clearly document resident/guardian treatment planning requests and grievances as well as resolutions. Include any specifics, such as staff assignments, in the treatment planning document.**

Complaint #2: Staff repeatedly harass a resident, making false allegations, in an attempt to have the resident discharged.

There was significant documentation of the resident's behaviors. Some, but not all, of the incidents that resulted in police involvement and ER visits seemed to also involve the nurse who had been removed from the resident's care. There was one documented incident in which alcohol use was suspected but test results came back negative. And there were other reports of the resident reporting missing items when the items were found in her room. Records also indicated repeated conflicts with residents including incidents involving resident #2 in September and then again on December 3, 11, and 12 which ultimately led to the facility pursuing involuntary discharge. However, the majority of the reports from diverse sources indicated repeated behaviors, mostly yelling although some indicating the resident's aggression using her wheelchair. Social service notes also documented behavioral issues but with no discharge plan being considered.

The Nursing Home Care Act and accompanying regulations allow for involuntary discharge due to the physical safety of residents.

The HRA is concerned that the continued involvement of the nurse removed from the resident's care could be considered a form of harassment. And, the HRA notes the negative results of the suspected alcohol use. Still there were multiple behavioral incidents reported from various sources beyond the one specific incident and because of this, the HRA cannot definitely substantiate that the resident's discharge was because of false allegations or harassment. However, the HRA strongly suggests the following:

1. When a resident has repeated conflicts with a peer or staff person, address via care planning.

2. If a resident chooses to consume alcohol, address through resident education and treatment planning to consider what, if any, alcohol could be consumed without adverse effects.

3. Document attempts to resolve conflicts and behaviors before considering involuntary discharge.

4. Documentation from multiple sources, including physical and occupational therapy notes, also indicated the resident's greatly compromised physical condition which led the HRA to question the resident's physical ability to put the safety of others at risk. While a resident may display incidents of yelling, agitation, and making verbal threats, given her physical limitations, the HRA questions if her behaviors rose to the level of involuntary discharge to protect the "physical safety" of other residents – a matter which is currently under appeal with the Illinois Department of Public Health.

Complaint #3: A resident is being inappropriately treated as a patient with behavioral health needs when she actually has a traumatic brain injury along with other stressors and Complaint #4: There is a pattern of reoccurring problems with the resident on weekends.

The HRA examined several incidents in which the facility attempted to admit the resident to a hospital psychiatric unit; such attempts in the recent past failed with the hospital denying that she met criteria for admission to such a unit. A psychiatric evaluation in 2012 documented that the resident's use of profanity is a common occurrence for persons with TBIs. And, upon her December 2016 involuntary discharge from the facility to a hospital for psychiatric admission, the hospital again found her not to be a danger to self or others, and thus not appropriate for psychiatric admission. At the same time, the HRA notes the many behavioral incidents. The resident's care plan noted some medication changes and goals and objectives related to TBI. However, the HRA did not see documentation of treatment plan revisions or a history of attempts to resolve the ongoing behavioral issues after behavioral occurrences; the HRA also saw no evidence of the facility's attempts to pursue additional resources, services or staff training. Nursing home regulations require that a care plan meet the medical, nursing, mental and psychosocial needs of residents and that observations of changes in a resident's condition, including emotional changes should be analyzed to determine the need for further evaluation and treatment. **It is beyond the HRA's scope of expertise to determine if behaviors are the result of a TBI or due to a psychiatric condition; however, the HRA does substantiate a rights violation pertaining to inappropriate treatment, given the continuing issues and the lack of attempts to review and address the behaviors through the treatment planning process.** With regard to complaint #4 and the occurrence of the incidents on the weekends, upon further review of all the incident reports, survey reports and SBARs examined by the HRA, 53% of the incidents occurred on the weekends (Friday through Sun) and 47% occurred during the week. Of the weekend incidents, 39% occurred on Fridays, 39% occurred on Sundays and 22% occurred on Saturdays. It appears from the documentation that there were slightly more incidents occurring on the weekends than during the week. The HRA contends that the frequency and occurrence of incidents be part of treatment plan review.

1. **The HRA recommends that when a resident has repeated and increased behaviors to review the treatment plan to ensure that it is meeting the resident's needs or determine if further treatment or evaluation is warranted consistent with nursing home mandates. Document treatment plan reviews and revisions.**

The HRA suggests:

1. When a resident presents with unique diagnoses or needs, to seek out appropriate specialized resources, information and staff training to facilitate the care planning process. The HRA also notes that the SBAR form allows for the documentation of additional evaluations, psychiatric referrals, etc. and might be resource for documenting care plan reviews.

2. The HRA suggests that any treatment plan reviews include a review of any patterns of behaviors.

Complaint #5: The resident's guardian is not kept informed of issues of concerns, meetings, etc.

The HRA found documentation of the guardian being notified in incident reports and most SBARs with the exception of SBARs dated 07-25-16, 09-14-16 and 11-13-16. The survey report documents do not include a section regarding guardian notification.

The Nursing Home Care Act and corresponding regulations require guardian notification of incidents and the Probate Act states that health care providers are to be reliant on the guardian's decisions.

The HRA finds that the complaint is substantiated with regard to 07-25-16, 09-14-16 and 11-13-16. The HRA recommends that:

1. **Ensure guardian notification of incidents as required by nursing home mandates. Document notification accordingly.**

2. **Educate staff on guardian notification requirements.**

The HRA also submits the following suggestions related to guardian notifications:

1. Document in resident care plans any guardian preferences for notification, including the types of incidents needing guardian notification.

2. The documentation in this resident's record often referred to the guardian as the "POA". A guardian's authority is court-ordered and has different parameters than a power of attorney. The HRA suggests that the facility review this with its staff.

3. The documentation in the record also indicated that the resident preferred that the guardian not participate in the resident's care planning; however, there was no follow-up on this matter. The HRA suggests that such issues be reviewed with the resident and guardian and addressed via the treatment planning process.

There were some additional items that the HRA would like to address related to this case:

1. The HRA questions the use of multiple forms to document behaviors and suggests that there be one centralized form to document behaviors, follow-up, guardian notification, etc.

2. The resident council minutes do not indicate who compiled the minutes and if there was staff participation. The HRA suggests that the minutes be signed and document any staff involvement.

3. Most quality assurance minutes do not fully describe what was reviewed and discussed. The HRA suggests that the minutes better reflect quality assurance reviews. The HRA

also suggests that the committee consider reviews of patterns of behaviors, occurrences, and complaints that could impact a resident's continued status at the facility.