FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
17-110-9001
Integrity Healthcare of Anna

[Case Summary – The Authority did not substantiate the complaint as presented below. However, the HRA made three corrective recommendations that were accepted by the facility regarding lack of documentation. The facility subsequently provided staff training documentation to address these issues.]

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Integrity Healthcare, a 68 bed acute rehab and long term care facility located in Anna. The census at the time of the report was 61 residents. Integrity Healthcare has a total of 13 facilities. The Anna facility employees 63 staff. There are 2 physical therapy (PT) assistants assigned to this facility and 1 certified occupational therapist. They have 2-3 physical therapy assistants and 1-2 other certified occupational therapy (OT) assistants that are frequently at the Anna facility depending on current patient needs. They are able to call in other staff within their organization when needed. The specific allegations are as follows:

A patient with a disability received inadequate care and treatment.

If substantiated, the allegations would be violations of the Nursing Home Care Act (210 ILCS 45 et al.), the Administrative Code for Skilled Nursing and Intermediate Care Facilities (77 IL ADC 300 et al) and the Code of Federal Regulations (42 CFR 483.10)

Complaint Information

According to the complaint, the facility is not providing necessary treatment for a person who is recovering from a stroke to allow for maximum recovery, specifically treatment involving physical therapy. Another allegation involved the patient not receiving appropriate medical care.

Investigation Information

The HRA Investigation Team (Team), which consisted of two members and the HRA Coordinator, spoke with the patient, Administrator and staff at the facility and reviewed the patient's chart with a signed release of information.

I. Interviews:

A. Complainant: The complainant alleges that the patient is recovering from a stroke that occurred in October, 2015. She was admitted to the hospital at that time and was discharged to Integrity Healthcare in December, 2015. Seven months after being admitted, the patient is not getting the necessary physical therapy to reach maximum recovery for her paralyzed limbs even though the patient has regained some use in the paralyzed limbs. Any therapy and recovery has been done independently by the patient without hands-on therapy from staff at Integrity. Trained staff is not available to work with the patient to assist her with learning to independently transfer or practice strength-building. Instead, the facility provides a loose wooden board to slide her from her chair to the bed which the complainant believes is unsafe due to her left side paralysis. There was also a concern of a recent mammogram that came back as "spotty" and the patient was told to have it re-checked in 6 months. This has caused the patient undue worry and stress and she would like to have a second evaluation right away due to the history of breast cancer in her immediate family; her mother and Aunt both passed away from breast cancer. There was also concern about a fall she had in her room on her paralyzed side and she was not evaluated immediately after the fall to check for broken bones or other injuries until the patient's power of attorney agent for medical requested it a week later. It was later reported to the HRA that a neurologist had ordered water PT but the facility was refusing to take her to the off-site facility to complete it.

B. Administration: The HRA interviewed the facility Administrator, Rehabilitation Manager, Care Plan Coordinator and Director of Nursing. They said the facility physician comes every other day or as needed but the patient had switched to another physician a couple of months prior to our interview and the facility transports her there when needed for appointments.

Initially, she received PT three times per week until it was deemed that she was no longer progressing. Some indicators that are used to evaluate progress are transferring from sitting to lying down; completing activities of daily living (ADLs); one leg assist versus no assist; and strengthening is rated on a 0-5 scale evaluating push back, etc. Now on restorative nursing, she is inconsistent with cooperation. She does well with PT but not with restorative nursing. However, if staff persons notice a decline she will be placed back on active PT rather than restorative nursing. Restorative nursing was described as maintaining what is gained with PT. Likewise, if progress is made, they will start PT back up to continue progress. She is screened quarterly and sooner if something is noticed by staff. It was noted that the patient did not like the sliding board; she had stated that she was uncomfortable using it.

C. Staff: The head of physical therapy and a therapist who have worked with the patient were both interviewed in August, 2016. They explained that she was discontinued from physical therapy in May due to lack of progress. It was explained that PT determines when someone is lacking progress based on notes, but the physician makes the final decision on whether or not progress is still being made and whether or not PT should be continued. A patient is not discontinued without a physician's signature to do so. She was staying consistent with "moderate assist" and not going further, so they determined she had reached a "lack of progress" status and switched her to restorative nursing. They will reevaluate her in 3 months and if there is any decline in her functioning level or any signs of further progression, they will reinitiate

physical therapy. She was enrolled in restorative nursing at the time of our interviews. She had exercises that she was to do for maintenance of the same level of functioning. They put in place a sliding board to assist her with transfers and help her to become more independent as "stand and pivot" was not an option without assistance, but she refused to use it after a week. She had a grab bar on her bed and a trapeze for bed mobility. Staff explained that if she could transfer herself independently, she could be transferred to an assisted living facility. At the time of our interview, the patient had made progress using "stand and pivot" *with assistance* and was transferring herself out of bed to her wheelchair *with staff assistance*. Staff monitored her transfers and used a gait belt for assistance. She was ambulating with her hemi walker with a gait belt and staff monitoring/assisting. When she was in her wheelchair, she ambulated independently from one place to another.

The HRA questioned staff about the water PT being ordered. They said she had been going three times per week and that she started attending water PT as soon as regular PT at the facility discontinued; this was due to payment/billing issues. Either 2 aides or 1 aide and a nurse had been taking her to water PT at the local hospital, depending on staff availability that day. She attended water PT for three weeks but the last week she refused the last two sessions. Staff stated that she did not do more physically after water PT than she had done with regular PT. If she was progressing, it would have continued.

When questioned about the "spotty" mammogram results, the staff explained that the mammogram was done in January, 2016 and the physician ordered another mammogram in 6 months and that was scheduled for July, 2016. They were unaware that the patient had concerns about having the mammogram repeated sooner and were simply going off of physician orders.

D. Patient: The HRA met with the patient at the facility. She confirmed that she was on restorative nursing and not receiving active physical therapy at that time. She understood the reason to be billing related and stated that she could not get Medicare prior to the age of 62 until she had been on Social Security Disability for 2 years which had just recently been approved. She did say that when she was discharged from the hospital to the facility that she had an order for PT and OT. She received PT twice a week for two weeks then they discharged her but she did not know the reason. She had been going to the PT room to do exercises on her own. She had an appointment scheduled with a neurologist shortly after our interview and was looking forward to what he would order as far as PT and OT. She did voice concern over her mammogram results but assumed she could not have the repeat test sooner due to billing / insurance reasons but she had not asked staff about it.

II. Chart Review:

A. PT/OT documents: The HRA requested a list of therapy dates from the facility for the patient due to her having several starting and stopping dates listed in their chart. The following dates were provided by Integrity:

Physical Therapy	Occupational Therapy	Speech Therapy	Water Therapy (Outside Agency)
12/9/15 – 1/25/16	12/7/15 - 1/11/16	12/4/15 – 1/11/16	
2/26/16 – 3/10/16	2/29/16 – 3/11/16		

5/4/16 – 5/20/16	5/4/16 – 5/20/16		
8/8/16 – 10/11/16	8/8/16 – 10/11/16		
			10/20/16–11/22/16
12/10/16 – 12/26/16			
	3/6/17 – 3/21/17		
4/13/17 – 4/16/17	4/13/17 – 4/16/17		

Another document was reviewed listing the patient's requirements for ADLs. It listed the focus as the patient requires extensive assist with bed mobility, transfers, toileting, dressing and bathing as a result of her stroke. It noted that she was able to slowly propel herself in her wheelchair but does require guided maneuvering at times. The Goal is for the patient to *"improve current level of function in bed mobility and transfers by next review date. Will require only 1 staff member date initiated 12/14/16 target date 8/15/16"* The initial date of this document is unclear but there are handwritten notes on this document as follows:

1/26/16 "*Discontinue skilled PT services"*
3/11/16 "*Q [qualified intellectual disabilities provider] review, no changes continue current goal. Discontinue skilled OT"*
5/19/16 "*Q review, extensive assist continues. History of refusing programs continue current goal"*
5/31/16 "*PT/OT to evaluate treatment"*

B. The Social Service Assessment and Note dated 12/14/15 documented that she was admitted on 12/3/15 from a hospital in Missouri and that she would be receiving therapy while at Integrity. The discharge plan stated that she would be discharged back to the community when she has successfully completed therapy. The review of care plan section simply stated that staff would encourage therapy, socialization and out of room activities.

C. Social Service Incidental Notes: The HRA reviewed typed notes from the Social Service Director dated October, 2016 through January, 2017. On October 17th the Director received a phone call from the patient's agent under a Power of Attorney for medical care regarding the patient being able to attend water therapy at the local hospital. The Director informed the agent that she had her initial visit and the facility was working on scheduling the appointments for therapy. It was explained that the times the water therapy department wanted to schedule, they had other appointments already made and could not cancel those to accommodate taking this patient to water therapy. It was noted that she was eventually scheduled to begin water therapy on October 20th and then Monday, Wednesday and Friday for the following two weeks. A note dated November 13th documented that the patient had cellulitis of the face and was unable to attend water therapy for a couple of days. It was noted that the patient was in agreement with not going. On November 17th the Director met with the patient and several church members regarding how the patient was doing. The patient gave permission to share information with the group. The patient voiced that she felt like she was doing better due to going to water therapy. The therapy manager explained that she had spoken with the hospital therapist and they would be discharging her the following week due to her reaching her maximum potential. A friend inquired as to if therapy would continue at the facility and it was explained that she would be receiving restorative nursing in place of therapy and those measures were explained to everyone.

The patient voiced that she was number 3 on a waiting list for a place in the community and that she would be moving when they call. It was explained to the patient that the facility needed to be involved in this transition to a new place and requested that the patient get with social services to contact this new place. There were three other notes dated November 16th, November 21st and November 25th when the Director attempted to call the new place and left voice mails. On November 22nd, the Director of Nursing (DON) asked the Director to meet with the patient about her refusal to attend water therapy that day. The patient stated "why should I go. I only have two days left." They discussed reasons she should go and the patient requested time to think about it and then returned saying that she would go. The following day, November 23rd, the patient again stated she was done with water therapy and there was no reason to go just one more time. The Director again voiced reasons to go but the patient decided she was not going. On December 21st the Director and patient met with the representative of the community place that the patient wished to move to and discussed the patient needing a wheelchair and walker upon discharge. The Director agreed to work on getting the physician orders for those items and to assist in attempting to get the insurance to pay for those items.

D. Post Admit Physical Evaluation: The HRA reviewed this document in the chart which described the patient's history and what lead up to her admission to Integrity. The treatment plan as described in this document indicated that the facility is to provide the following services: *"physical therapy: posture/stability, core strength and stabilization, balance and positioning, coordination and fine motor control. Occupational Therapy: Home safety, cognition and memory strategies, core strength and stabilization. Speech Language Pathologist: swallowing, speech intelligibility, cognition and memory strategies, language training. Rehabilitative Nursing: self-care, medication management and teaching, safety training. Case Management: discharge planning."*

E. Physician Orders: The HRA found a few documents regarding mammography exams in the chart. The first was a physician order in the chart with a handwritten note for a diagnostic mammogram scheduled for 1/20/16. Another order for a mammogram was dated 11/17/16 and was signed by the patient's primary care physician. This order noted that there was "other abnormal and inconclusive findings on diagnostic imaging." The order was for the mammogram to be repeated in January in follow up of abnormal findings. The HRA reviewed a letter from the radiology group that confirmed a mammogram was repeated February 1, 2017 with normal results and noted that the last mammogram was 6 months prior to then.

A 10/15/16 physician order stated *"post x-ray left shoulder and arm…fall with bruising."* On 10/18/16 another handwritten note per order of the physician ordered *"apply ice pack leave on 20 min 2-3 times daily for 1-2 days, then apply warm compresses for 1 day as needed to hematoma."*

F. Nurses' Notes were also reviewed. A 10/6/16 note at 4:20 p.m. stated *"resident noted saying 'help me' in room. Upon entering room res noted on floor by bed on right side, left hand holding grab bar on bed keeping res head off floor. This nurse and CNA assisted res to laying on back/supine position no complaints of pain. No signs or symptoms of injury at 4:23 p.m. res assisted to wheelchair by nurse and CNA, floor clean, dry, lights on, call light in reach from wheelchair res states she stood self with brace [intelligible]on left of grab bar to adjust garments*

and 'just fell over' no skid mark on brace [intelligible] primary care physician notified" On 10/7/16 it was noted that the patient had no complaints of pain or discomfort and no signs or symptoms of distress and no injury noted *"regarding prior event."* A note dated 10/8/16 noted that the patient *"returned from facility around 7 pm, with adverse effects from recent fall. Bruising on left upper 12 cm x 8 cm wide light bruising noted. Will monitor."* A 10/15/16 note documented that the patient was noted with bruising to her left bicep lump/knot noted mid bicep. The nurse called the physician and received a telephone order for an x-ray of the shoulder, arm and elbow. Approximately 4 hours later it was noted that *"x-ray report returned impression: no acute fracture or dislocation by plain radiography left shoulder. Left elbow no displaced fracture. Resident voices no complaints of discomfort…will continue to monitor bruising left upper arm."* On 10/18/16 it was again noted that the patient's left arm was *"flaccid and noted to be extra warm with knot on upper arm."* The patient requested to be taken to the emergency room. The facility transported her there with a staff member. She was returned with a diagnosis of hematoma and no new orders were received other than they may apply ice for 20 minutes, 2-3 times daily, for 1-2 days and apply a warm compress as needed once per day.

G. Physician Progress Notes were reviewed. The first note dated 3/18/16 stated that the patient *"has been discharged from PT due to lack of progress. I have discussed this at length with nursing staff and therapy, and it would appear from their point of view, she just is not trying as hard at working to assist her helpers as she might be able to. I spoke with her at length today…she feels as though the CNAs do not allow her to do as much as she would like and I will have to deal and talk to[illegible]. She inquired about nerve stimulator to help with her muscle strength, but this apparently is not safely done without the monitoring of physical therapy, and she has no access to that service at this point…"* The second note was dated 8/2/16 and stated that the patient's *"cerebrovascular disease is stable. Not really progressing. PT thought there was some issues of compliance…she has had a mammogram which showed an abnormality with a repeat recommended in six months. The patient has been informed and this has been added to the order sheet."* A repeat diagnostic mammogram was ordered for January, 2017. The next note dated 9/21/16 stated that the patient was *"doing about the same. Still is not able to transfer."* Finally, the 10/13/16 note stated the patient was doing well and was *"starting to make some progress with her strength in the lower extremities…"* The HRA reviewed the physician's letter stating that the mammogram was repeated on February 1, 2017 and was returned as normal with follow up ordered in one year.

H. Neurologist Note: The patient plan from the 9/16/16 neurologist appointment was reviewed. The plan was to re-check EEG and to generate PT and OT scripts that specifically encourage e-stim since the patient felt that helped in the past. A new EEG was ordered as well as water therapy.

The HRA also contacted the outside provider who provided the water therapy and the following dates of service for this patient were provided:

10/12/16 was the initial evaluation visit. Water therapy was initially ordered by the neurologist on 9/16/16. The following dates are actual water therapy appointments:

10/20/16 10/29/16 11/4/16 11/18/16

10/24/16	10/31/16	11/7/16	11/22/16
10/26/16	11/2/16	11/9/16	

III. Policy Review:

According to the facility's Administrator, the main guidelines for therapists providing Physical Therapy (PT) or Occupational Therapy (OT), other than their professional assessment of the individual, is found in Chapter 8 of the Medicare Benefit Manual. The therapists decide whether the care the individual requires can be safely provided by non-skilled personnel. If it is determined the services can be provided by non-skilled personnel, the therapist cannot continue to prescribe skilled therapy services to the patient and at that point, the patient receives the care by non-skilled personnel as part of the restorative program. Skilled services is defined in section 30.2.1 as *"those services, furnished pursuant to physician orders that require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists and must be provided by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result…Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.."* The types of services considered skilled and how the therapist decides when a patient needs skilled services versus non-skilled services was also provided to the HRA. Section 30.2.2 states *"If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service…The intermediary or MAC [Medicare Administrative Contractor] considers the nature of the service and the skills required for safe and effective delivery of that services in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled. EXAMPLE: When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient's potential for recovery, but whether the services needed require the skills of a therapist or whether they can be provided by nonskilled personnel…the medical condition of the patient must be described and documented to support the goals for the patient and the need for skilled nursing services. The importance of a particular service to an individual patient, or the frequency with which it must be performed, does not, by itself, make it a skilled service."* According to the Centers for Medicare/Medicaid Service website, MACs process Medicare Part A and Medicare Part B claims for a defined geographic area or jurisdiction. Section 30.2.2.1 of the Medicare Benefit Manual also requires documentation to support skilled services and states *"Claims for skilled care coverage need to include sufficient documentation to enable a reviewer to determine whether—*

• Skilled involvement is required in order for the services in question to be furnished safely and effectively; and

• The services themselves are, in fact, reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice.

The documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals. Such determinations would be made from the perspective of the patient's condition when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury. Thus, when a service appears reasonable and necessary from that perspective, it would not then be appropriate to deny the service retrospectively merely because the goals of treatment have not yet been achieved. However, if it becomes apparent at some point that the goal set for the patient is no longer a reasonable one, then the treatment goal itself should be promptly and appropriately modified to reflect this, and the patient should then be reassessed to determine whether the treatment goal as revised continues to require the provision of skilled services…It is expected that the documentation in the patient's medical record will reflect the need for the skilled services provided. The patient's medical record is also expected to provide important communication among all members of the care team regarding the development, course, and outcomes of the skilled observations, assessments, treatment, and training performed. Taken as a whole, then, the documentation in the patient's medical record should illustrate the degree to which the patient is accomplishing the goals as outlined in the care plan. In this way, the documentation will serve to demonstrate why a skilled service is needed…Therefore the patient's medical record must document as appropriate:

• The history and physical exam pertinent to the patient's care, (including the response or changes in behavior to previously administered skilled services);

• The skilled services provided;

• The patient's response to the skilled services provided during the current visit;

• The plan for future care based on the rationale of prior results.

• A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences;

• The complexity of the service to be performed;

• Any other pertinent characteristics of the beneficiary.

The documentation in the patient's medical record must be accurate, and ***avoid vague or subjective descriptions of the patient's care that would not be sufficient to indicate the need for skilled care.*** *For example, the following terminology does not sufficiently describe the reaction of the patient to his/her skilled care:*

• Patient tolerated treatment well

• Continue with POC

• Patient remains stable

Such phraseology does not provide a clear picture of the results of the treatment, nor the "next steps" that are planned. Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded so that all concerned can follow the results of the provided services."

Section 30.4 Direct Skilled Therapy Services to patients gives examples and guidelines regarding direct skilled therapy services including PT and OT and states *"Coverage for such skilled therapy services does not turn on the presence or absence of a beneficiary's potential for improvement from therapy services, but rather on the beneficiary's need for skilled care... If all other requirements for coverage under the SNF [skilled nursing facility] benefit are met, such skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified*

therapist are necessary for the performance of the rehabilitation services." Some examples of skilled PT modalities listed are Assessment, Therapeutic exercises that must be performed by a qualified PT due to either the type of exercise used or the condition of the patient, and Gait Training furnished to a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality often require skills of a qualified PT. However, repetitious exercises to maintain strength, improve gait can be appropriately provided by supportive personnel and would not necessarily require skills of a PT. Range of Motion tests can only be performed by a qualified physical therapist. However, range of motion exercises not related to the restoration of a specific loss of function may be provided by supportive personnel. Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by supportive personnel would not be considered skilled care. Maintenance therapy is considered skilled care if the services are so complex that they must be performed or supervised by a qualified therapist; otherwise therapy can be carried out by supportive personnel. Non skilled supportive or personal care services are listed in section 30.5 and includes general supervision of exercises for maintenance programs of repetitive exercises to maintain function or to improve gait, maintain strength or endurance and passive exercises to maintain range of motion in paralyzed extremities not related to a specific loss of function and assistive walking. Section 30.4.1 continues by stating *"Skilled physical therapy services must meet all of the following conditions:*

• The services must be directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a qualified physical therapist after admission to the SNF and prior to the start of physical therapy services in the SNF that is approved by the physician after any needed consultation with the qualified physical therapist...

The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified physical therapist;

• The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the establishment of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program…

• The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition; and,

• The services must be reasonable and necessary for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable."

The Resident's Rights handout for the facility states that patients have the right to participate in their own care and states *"your facility must develop a written care plan that states all of the services it provides…must make reasonable arrangements to meet your needs and choices…you have the right to choose your own doctor. You have the right to all information about your medical condition and treatment…you also have the right to see your medical records within 24 hours. You have the right to make a durable Power of Attorney for Health Care, Living Will, and Declaration for Mental Health or Do Not Resuscitate Order."* The handout also ensures the right to safety and good care by stating *"your facility* ***must*** *provide*

services to keep your physical and mental health and sense of satisfaction…" The right to privacy, to manage one's own money and the safety of your personal belongings and property are also ensured. The handout also states that the facility may not threaten or punish residents in any way for asserting their rights or presenting grievances. The steps to take if a person believes their rights are not being upheld in the facility are listed as 1. Define the Problem by writing down all the information, 2. Talk to the staff, 3. Participate in the Resident Council, 4. Ask for assistance from the Long-Term Care Ombudsman Program or 5. File a grievance with the central complaint registry. The HRA reviewed a signature page dated 12/3/15 verifying that the patient was given a copy of the Resident's Rights booklet as well as the other documents given at admission. The Administrator advised the HRA that Integrity has a resident council that meets every month and the ombudsman comes to the facility routinely and when requested by a resident or the Administrator.

The facility's admission policies were also reviewed. However, this policy covers mostly the process of admission, the financial aspects of admission and how to complete the paperwork. There was nothing in this policy detailing the residents' contracts and/or what services will be provided by the facility.

Statutes

The Nursing Home Care Act (210 ILCS 45/2-202) requires that *"(c) At the time of the resident's admission to the facility, a copy of the contract shall be given to the resident, his guardian, if any, and any other person who executed the contract… (e) The original or a copy of the contract shall be maintained in the facility and be made available upon request to representatives of the Department and the Department of Healthcare and Family Services.*

(f) The contract shall be written in clear and unambiguous language and shall be printed in not less than 12-point type. The general form of the contract shall be prescribed by the Department.

(g) The contract shall specify:
(1) the term of the contract;
(2) the services to be provided under the contract and the charges for the services;
(3) the services that may be provided to supplement the contract and the charges for the services;
(4) the sources liable for payments due under the contract;
(5) the amount of deposit paid; and
(6) the rights, duties and obligations of the resident, except that the specification of a resident's rights may be furnished on a separate document which complies with the requirements of Section 2-211."

According to the Nursing Home Care Act (210 ILCS 45/3-302.2a), *"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."

The Administrative Code (77 IL ADC 300.330) defines "representative" as "Resident's Representative - a person other than the owner, or an agent or employee of a facility not related to the resident, designated in writing by a resident to be his or her representative, or the resident's guardian, or the parent of a minor resident for whom no guardian has been appointed. (Section 1-123 of the Act)"

The Administrative Code (77 IL ADC 300.610) requires *"a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting…c) The written policies shall include, at a minimum the following provisions:*
1) Admission, transfer and discharge of residents, including categories of residents accepted and not accepted, residents that will be transferred or discharged, transfers within the facility from one room to another, and other types of transfers;
2) Resident care services, including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic services (including laboratory and x-ray);"

Section 300.1010 states that:
"a) Advisory Physician or Medical Advisory Committee

> *1) There shall be an advisory physician, or a medical advisory committee composed of physicians, who shall be responsible for advising the administrator on the overall medical management of the residents and the staff of the facility. If the facility employs a house physician, he may be the advisory physician*
>
> *2) Additional for Skilled Nursing Facilities. There shall be a medical advisory committee of two (2) or more physicians who shall be responsible for advising the administrator on the overall medical management of the residents and the staff in the facility. If the facility employs a house physician, the house physician may be one member of this committee.*

b) The facility shall have and follow a written program of medical services which sets forth the following: the philosophy of care and policies and procedures to implement it; the structure and function of the medical advisory committee, if the facility has one; the health services provided; arrangements for transfer when medically indicated; and procedures for securing the cooperation of residents' personal physicians. The medical program shall be approved in writing by the advisory physician or the medical advisory committee.
c) Every resident shall be under the care of a physician.
d) All residents, or their guardians, shall be permitted their choice of a physician.

e) All resident shall be seen by their physician as often as necessary to assure adequate health care. (Medicare/Medicaid requires certification visits…
h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B)i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures."

Section 300.12.10 requires that the facility *"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. Restorative measures shall include, at a minimum, the following procedures…4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.*

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.
2) All treatments and procedures shall be administered as ordered by the physician.
3) Objective observations of changes in a resident's condition, including mental 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.
4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:
A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.
B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene.
C) Each resident shall have clean, suitable clothing in order to be comfortable, sanitary, free of odors, and decent in appearance. Unless otherwise indicated by his/her physician, this should be street clothes and shoes.

D) Each resident shall have clean bed linens at least once weekly and more often if necessary.
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents."

Section 300.1420 requires *"If physical therapy, occupational therapy, speech therapy or any other specialized rehabilitative service is offered, it shall be provided by, or supervised by, a qualified professional in that specialty and upon the written order of the physician.*
a) In addition to the provision of direct services, any such qualified professional personnel shall be used as consultants to the total restorative program and shall assist with resident evaluation, resident care planning, and in-service education.
b) Appropriate records shall be maintained by these personnel. Direct service to individual residents shall be documented on the individual clinical record as set forth in Section 300.1810(c). A summary of program consultation and recommendations as set forth in Section 300.1810(h) shall be documented."

Section 300.1810 states in C 3) *"Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports… d) All physician's orders, plans of treatment, Medicare or Medicaid certification, recertification statements, and similar documents shall have the authentication of the physician… f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. 1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change."*

The Code of Federal Regulations (42 CFR 483.10) Residents Rights requires that: *"(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s), when there is*
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications)
(C) A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment…"

Regulations (42 C.F.R. 483.20) state that *"The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each*

resident's functional capacity…A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:(i) Identification and demographic information.(ii) Customary routine.(iii) Cognitive patterns.(iv) Communication.(v) Vision.(vi) Mood and behavior patterns.(vii) Psychosocial well-being.(viii) Physical functioning and structural problems.(ix) Continence.(x) Disease diagnoses and health conditions.(xi) Dental and nutritional status.(xii) Skin condition.(xiii) Activity pursuit.(xiv) Medications.(xv) Special treatments and procedures.(xvi) Discharge planning.(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts…(c) Quarterly review assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care."

Regulations (42 CFR 483.21) also require *"(b) Comprehensive care plans. (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at § 483.10(c)(2) and § 483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being…Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of [Preadmission Screening and Resident Review] PASARR recommendations…(iv) In consultation with the resident and the resident's representative(s)—(A) The resident's goals for admission and desired outcomes.(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.(2) A comprehensive care plan must be—(i) Developed within 7 days after completion of the comprehensive assessment.(ii) Prepared by an interdisciplinary team, that includes but is not limited to—(A) The attending physician.(B) A registered nurse with responsibility for the resident.(C) A nurse aide with responsibility for the resident.(D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s)…(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—(i) Meet professional standards of quality.(ii) Be provided by qualified persons in accordance with each resident's written plan of care.(iii) Be culturally-competent and trauma-informed."*

Regulations (42 C.F.R. 483.65) state that *"If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity as set forth at § 483.120(c), are required in the resident's comprehensive plan of care, the facility must—(1) Provide the required services; or(2) In accordance with § 483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.(b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel."*

Conclusion

The complaint alleged inadequate care and treatment for a person recovering from a stroke. Specifically, that she was not receiving necessary therapy to reach maximum recovery level and also that she did not have adequate follow up for an abnormal mammogram and a fall she had in her room at the facility. Facility staff said she had been doing PT three times per week initially and she went between active PT and restorative nursing several times due to lack of progress. Lack of progress is determined by the physical therapist in charge of treatment; however, the physician has to order PT to be discontinued before it can be. The physician noted on 8/2/16 that the patient was "Not really progressing." In September the physician noted that she was "about the same." The physician's 10/13/16 note stated the patient was doing well and was "starting to make some progress with her strength in the lower extremities…" The Medicare Benefit Manual requires that skilled services be provided with the *"expectation, based on the assessment made by the physician of the patient's restoration potential that the condition of the patient will improve materially in a reasonable and generally predictable period of time."* Section 30.4 of the Medicare Benefit Manual states that *"Coverage for such skilled therapy services does not turn on the presence or absence of a beneficiary's* ***potential for improvement from therapy services****, but rather on the beneficiary's* ***need for skilled care****…Such skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of the rehabilitation services."* Some examples of necessity for skilled services are: assessments and exercises that MUST be performed by a qualified therapist due to either the type of exercise or the condition of the patient. However, repetitious exercises to maintain strength or improve gait can be appropriately provided by supportive personnel and would not necessarily require "skilled services." Also, range of motion exercises **not related to the restoration of a specific loss of function** may be provided by supportive personnel. **Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by supportive personnel would not be considered skilled care.** Some examples of non-skilled (restorative nursing) services would include general supervision of exercises for maintenance programs of repetitive exercises to maintain function or to improve gait, maintain strength or endurance and passive exercises to maintain range of motion in paralyzed extremities not related to a specific loss of function and assistive walking. Therefore, the issue in this case seems to be whether or not this patient required the skills of a qualified therapist and if not then according to the Medicare Benefit Manual, she should have been

released from skilled PT/OT to restorative nursing. If the qualified therapist determined and the physician agreed that the patient had not been progressing and her PT/OT was not being done to restore *loss of function* but rather to *maintain range of motion in her paralyzed extremities*, then restorative nursing was appropriate. However, if it was determined that the patient's PT/OT was being done to restore loss of function then the services of a qualified therapist (skilled services) would have been more appropriate. Therapy staff told the HRA that the patient, in their opinion, was not progressing and that she had reached maximum potential for recover and therefore restorative nursing was appropriate. Physician's notes on 8/2/16 were found indicating that it was also his opinion that she was "not really progressing." Another physician's note in September indicated that she was "about the same", so the HRA contends that the physician was in agreement with the therapist at that point in time to have restorative nursing rather than skilled services. However, there were 3 time periods prior to 8/2/16 and 3 time periods following the September date when skilled care was discontinued that no physician notes were found noting his agreement or disagreement with the therapist's opinion that skilled care was not necessary.

The Administrative Code (Section 300.12.10) requires that *"Objective observations of changes in a resident's condition, including mental 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 300.1420 of the Administrative Code also requires that *"If physical therapy, occupational therapy, speech therapy or any other specialized rehabilitative service is offered, it shall be provided by, or supervised by, a qualified professional in that specialty and upon the written order of the physician…Appropriate records shall be maintained by these personnel. Direct service to individual residents shall be documented on the individual clinical record…A summary of program consultation and recommendations as set forth in Section 300.1810(h) shall be documented."* The HRA found no such documentation from therapy staff as to why skilled services were not necessary and found no physician note or order to discontinue PT/OT for the other timeframes. Therefore, due to lack of documentation, this portion of the allegation is **substantiated**. The following **recommendations** are made:

1. **Staff should be retrained on proper documentation as required by the Administrative Code and in the future the patient records should include notes explaining why PT/OT/ST/WT services are reinstated and/or discontinued and should also include notes of physician's orders to discontinue services.**

2. **The HRA requested a copy of the patient's care plan and did not receive a copy. The Nursing Home Care Act (210 ILCS 45/2-202 and 210 ILCS 45/3-302.2a) requires that a care plan be put in place for all residents upon admission and requires that it include measurable objectives and timetables to meet the resident's needs and allows 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 is to be developed with the active participation of the resident and the resident's guardian or representative, as applicable. It also requires that any changes to that care plan be noted as required services**

change. The facility should create care plans for the residents which complies with these regulations upon admission and as needed when required services change and that measurable objectives be used in determining the need for services.

In regards to water therapy, on 9/16/16 the neurologist ordered the patient to begin water therapy as well as PT and OT scripts. Staff at the facility told the HRA that once regular PT at the facility discontinued she was scheduled for water therapy, this was due to payment/billing issues. The Social Service Director notes documented contact by this patient's Power of Attorney agent on 10/17/16 questioning why water therapy had not yet begun. The Director informed the agent that she had her initial visit which was verified by the outside hospital's records indicating that 10/12/16 was the patient's initial evaluation visit. The agent was informed that the facility was working on scheduling the appointments for therapy. It was explained to the agent that the times the water therapy department wanted to schedule, they had other appointments already made for other patients and could not cancel those to accommodate taking this patient to water therapy. It was noted that she was eventually scheduled to begin water therapy on October 20th and then every Monday, Wednesday and Friday for the following two weeks. The outside hospital records verified that water therapy began 10/20/16 and continued through 11/22/16. Although the HRA contends that starting a physician ordered service, in this case water therapy, a month after an order was signed seems like an excessive delay, the Director's notes did indicate the reason why there was a delay which was lack of staff to accompany the patient to water therapy. This was also communicated to the agent when she called to inquire as to why there was such a delay in starting services. Therefore this portion is **unsubstantiated**. The HRA offers the following suggestions:

1. The facility should consider consulting with a transportation company to inquire about providing transportation for their patients when extenuating circumstances prevent the facility from providing the transportation itself. In this case, the facility could have possibly contacted the hospital to see if transportation arrangements could have been made for this patient to begin therapy sooner. This would help the facility comply with Federal regulations (42 C.F.R. 483.65) as well as the Administrative Code (77 IL ADC 300.1420) requirements to provide physician ordered services.

Regarding the allegation that mammography follow up was not adequately completed, the records at the facility showed that the patient had an abnormal mammogram in January, 2016 with an order to follow up in 6 months. Another note from the radiology group was found confirming that a February 1, 2017 mammogram was completed and that the last mammogram was 6 months prior to that. The patient did voice concerns to the HRA that she had to wait so long for a repeat mammogram due to significant family history of breast cancer, however she felt it was due to insurance and billing reasons and she stated that she had not mentioned her concern to the caregivers at the facility which corroborates the staff's statement that they were unaware of her concern and were just following physician's orders. Therefore, this portion of the complaint is **unsubstantiated.**

Finally, regarding the allegation of lack of follow up care after the patient's fall in her room at the facility, the patient's chart did contain documentation that the patient had a fall on 10/6/16 at 4:20 p.m. A nurse and a CNA were both in her room immediately and there was documentation that they assessed the patient and notified the physician promptly, however the nursing note did not document what the physician's directions were. Case notes on 10/7/16 noted that the patient had no complaints of pain or discomfort and no signs or symptoms of distress and no injury noted *"regarding prior event."* A note dated 10/8/16 documented that the patient returned to the facility around 7 p.m. with "*adverse effects from recent fall. Bruising on left upper 12 cm x 8 cm wide light bruising noted. Will monitor."* There was no documentation that a physician was notified regarding the bruising. A 10/15/16 note documented that the patient was noted with bruising to her left bicep with a lump/knot noted mid bicep. The nurse called the physician and received a telephone order for an x-ray of the shoulder, arm and elbow. Approximately 4 hours later it was noted that x-ray report returned showing no acute fracture or dislocation and that the patient voiced no complaints of discomfort and the nurse would continue to monitor bruising on her left upper arm. On 10/18/16 it was again noted that the patient's left arm was "flaccid and noted to be extra warm with knot on upper arm." The patient requested to be taken to the emergency room. The facility transported her there with a staff member and she was returned with a diagnosis of hematoma and no new orders were received other than may apply ice for 20 minutes 2-3 times daily for 1-2 days and apply a warm compress as needed once per day. There were physician notes indicating that he was kept informed throughout this process. The Administrative Code (77 IL ADC 300.610) requires that the facility "*notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident…The facility shall obtain* ***and record*** *the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B)i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures."* Due to lack of documentation of the physician's orders upon notification of the patient's fall, this portion of the allegation is **substantiated**. The HRA **recommends** the following:

1. **Direct care staff be retrained on the requirements of the Administrative Code to notify the physician and record his or her plan of care for the patient when significant changes in a patient's condition or an injury occurs.**

RESPONSE

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

Response to the Investigation Findings of

Illinois Guardianship and Advocacy Commission

Regarding HRA NO: 17-110-9001

It is the position of Integrity Healthcare of Anna (IHoA) the findings reported in the Illinois Guardianship and Advocacy Commission (IGAC) July 26, 2017 letter and accompanying Egyptian Regional Human Right Authority Report of Findings (HRA) regarding case number 17-110-9001 are incomplete. IHoA is presents the following compelling information to dispute the HRA findings and demonstrate the allegations against the facility are unsubstantiated.

IHoA judges the overall allegation of the complainant to be an inaccurate assessment of the care provided by IHoA medical and rehabilitative personnel (*listed in the last paragraph on Page 1 of the report and continues onto the first paragraph of Page 2 of the report*). IHoA asserts the care provided the patient was compliant with all regulations, adequate to meet patient needs, and delivered to the patient in a most professional and compassionate manner by the medical and rehabilitative personnel.

The findings listed in the HRA report of July 26, 2017 show two of the underlying allegations were deemed unsubstantiated by the HRA during the investigation. IHoA will therefore address the other two underlying allegations and will show them to be unsubstantiated as well.

Prior to presenting such evidence, IHoA first highlights the fact that nowhere in the findings of the investigation does the HRA indicate the alleged actions of IHoA in any way adversely affected the patient or hindered the patient reaching her maximum recovery level. In addition, IHoA feels important facts listed in the findings are imprecise. To show my respect to the council, instead of quibbling over the minor details throughout the report, I will direct my objections to items listed in the Conclusion of the report beginning on Page 15.

The first point of dispute is in the last line of the last paragraph of Page 15 which continues to the top of Page 16 of the July 26, 2017 report

IHoA's disputes the statement that the physician did not note his agreement or disagreement to the therapist's opinion that skilled care was not necessary. IHoA asserts the physician signing orders written by a therapist, either on a ***Telephone Order Form and/or Physician Order Sheet***, is evidence he agrees with assessment and prescribed treatment. IHoA further asserts that if the physician disagreed with the therapists' assessments or prescribed treatments; the physician would not sign them.

On the following attachments, IHoA will demonstrate the physician's participation and agreement with the therapists' determination to begin, continue, and end physical therapy, occupational therapy, and speech therapy:

- (Attachment 1, *15 pages*) - Orders to discontinue physical therapy, occupational therapy, and speech therapy for each date the patient was discharged from therapy. There are many other examples in the patient record.
- (Attachment 2, *30 pages*) – Other therapy orders written for the patient throughout her stay. There are many other examples in the patient record.
- (Attachment 3, *7 pages*) - Examples of the PT Evaluation and Plan or Treatment Forms. On Page 2 of each form is the physician's signature showing agreement to the therapist's assessments and prescribed treatments. There are many more examples in the patient record.

The provided attachments all come from the resident record which IHoA provided the survey team during the investigation. The administrator assumes responsibility failing to recognize the assessment process and order process was not clear to the investigative team during the investigation. If the process was made clearer to the team during the investigation; IHoA is confident the investigative team could see that the physician(s) are the authority by which the nursing and therapy teams begin, continue, or end treatments and therapies.

The second point of dispute is in the third line of the first full paragraph of Page 16 of the July 26, 2017 report

IHoA disputes the statement that the "HRA found no documentation as to why skilled services were not necessary and no physician orders to discontinue therapies, and because of that lack of documentation, this portion of the complaint was substantiated". IHoA presents the same evidence to dispute this statement as it did the prior statement. The attached provides ample proof through the signed ***Telephone Order forms and/or Physician Order Sheets*** that the physician ordered therapy to be discontinued each time it was stopped.

The third point of dispute is the third paragraph on Page 16 of the July 26, 2017 report

IHoA's disputes the statement the "HRA requested patient's care plans and did not receive them and that IHoA failed to have a care plan in place upon admission". The IHoA MDS Coordinator supplied the team with the patient's care plan during the investigation. Not only did the MDS Coordinator develop a care plan for this patient, the therapy department assessed the patient's therapy needs the day of her arrival and began physical, occupational, and speech therapy with the patient. IHoA develops care plans for every patient upon admission and reviews and amends patient care plans routinely and as necessary. This patient's care plan is attached for the investigative team to further review if it wishes to do so. (Attachment 4, *18 pages*)

The HRA cited lack of documentation as the reason for finding this portion of the complaint substantiated; and based on those findings made recommendations for IHoA to retrain staff on documentation, have physician orders before discontinuing services, and to create care plans for patients. IHoA has provided evidence that it does not begin, continue, or end any therapy or treatment until assessments are completed and reviewed by the physician and the physician orders a therapy or treatment. IHoA did provide the investigating team with the patient's care plan while the team was in the facility and explained to the team that care plans are created for all patients upon admission. Therefore IHoA requests this entire portion of the allegation **be unsubstantiated and the recommendations withdrawn.**

The next point of dispute is found in the last paragraph of Page 17 of the July 26, 2017 report and continues on to Page 18. The dispute is related to the allegation IHoA failed to notify physician and document when the patient experienced significant changes or injury.

The first point of dispute is in the first line of the last paragraph on Page 17 of the July 26, 2017 report, which states the patient chart did not contain documentation of a fall. IHoA takes exception to this statement because in the next several sentences the HRA uses quotes from the patient chart regarding the fall and follow-up to the fall as evidence of IHoA failing to document.

IHoA contends the patient record contained clear evidence the patient's fall was documented. Evidence that describes the scene of the fall, the circumstances surrounding the fall, documentation of the physician and power of attorney being notified of initial fall, documentation the physician was kept aware of the patient's condition for several days following the fall. Also documented clearly were the assessments, orders, x-ray results, discharge instructions, etc. The following attachments are examples of some items pulled from the

resident record as evidence the IHoA nursing team and physician were fully aware of the fall and they dealt with the fall timely and appropriately:

- (Attachment 5, *14 pages*) – The attachment consists of nursing notes, physician order sheets, treatment records, x-ray results, signed physician orders, and emergency room discharge instructions that demonstrate the nurses and aides knew of the fall from the moment the patient had fallen, and they began assessing the patient for pain and injury immediately. The nursing notes indicate no reported pain and no apparent injury. The nursing notes further indicate notification of the fall and patient's condition to the physician and the power or attorney. Because there was no complaint of pain and no apparent injury; the physician's orders were to continue monitoring the patient. The nursing team did so and documented they did so.

  The nursing notes provide even more evidence of the nurses' attention to, and continued assessment of, the patient's pain scale and potential signs/symptoms of injury resulting from the fall. The patient never complained of pain. When bruising did develop, the physician was notified and then he ordered x-rays. The x-rays revealed no fracture or dislocation. Orders remained to continue monitoring, which the nursing team did and documented it did so. When the nursing team observed a knot on the patient's arm and that her arm was warm to touch, the physician ordered her transferred to local emergency room. The patient was transferred to the local emergency room. The patient still had no complaint of pain. The patient returned to the facility with a diagnosis of a hematoma and discharge instructions for ice and warm compresses which were provided by nursing team along with continued monitoring.

The HRA cited lack of documentation of the physician's orders upon notification of the fall as the reason for finding this portion of the complaint substantiated. IHoA provided evidence the physician was notified of the fall and the patient's condition. IHoA provided evidence there was no apparent injury and no complaint of pain by the patient at the time of the fall; therefore no treatment was indicated at the time of the fall. IHoA provided evidence the nursing staff continued to monitor the patient's condition and notified the physician of condition changes. IHoA provided evidence the nursing staff followed all physician orders while continuing to monitor the patient for changes in condition. IHoA requests the provided documentation considered as evidence to declare this entire portion of the allegation **to be unsubstantiated and the recommendations withdrawn.**

In conclusion, after review of the all the facts, the IHoA respectfully requests that all portions of the allegation that a patient with a disability received inadequate care and treatment be found unsubstantiated and the recommendations withdrawn. IHoA believes evidence does not exist to substantiate the allegation and re-emphasizes the fact that nowhere in the report is there indication this patient (or any other) was affected negatively by any actions of the facility personnel.

Additionally, IHoA would like to express objection to other sections of the July 26, 2017 report so the objections of IHoA are clearly stated should the findings be released in a public report.

- In regards to the complainant's allegations listed on Pages 1 and 2 of the July 26, 2017 report:
  - "Any therapy and recovery has been done independently by the patient without hands-on therapy from staff at Integrity."
    - This statement is simply false. The patient was actively involved in therapy the majority of her stay at IHoA. When the patient was not actively involved in therapy, the patient was on restorative programming and receiving assistance from registered nurses, licensed practical nurses, and certified nurse aides. In short, the patient received services to either increase functioning or maintain functioning 100% of her stay at IHoA.
  - "Trained staff is not available to work with the patient to assist her with learning to independently transfer or practice strength building. Instead, the facility provides a loose wooden board to slide her from her chair to the bed . . ."
    - This statement is simply false. Every person on the nursing and therapy team is either licensed or certified to assist the patient in learning and practicing those skills; and the patient received daily assistance from those personnel.
    - The facility agrees the patient was supplied with a wheelchair transfer board, but affirms it was never recommended, instructed, or expected the patient would use it without assistance. Wheelchair transfer boards help individuals with disabilities move to and from a wheelchair to a chair, an automobile, a bed, etc. Transfer boards are lightweight, durable, and easy-to-use and keep patient safe and secure during such activities. The nursing and therapy personnel are trained in assisting patients in the use of these assistive devices. The patient's training with the wheelchair transfer board was recommended to allow the patient to use the side of her body not affected by the stroke to transfer; thus giving the patient more mobility and greater independence.
  - In regards to a follow-up mammogram the complainant reports the patient "would like to have a second evaluation right away . . ."
    - While IHoA cannot say whether the patient did or did not want to have a second evaluation right away; IHoA can report the mammogram was scheduled as ordered. IHoA can also report that according to the patient's own words from the HRA interview with the patient (*third paragraph of Page 3*), the patient reported she did not voice concerns to the IHoA staff because she assumed she could not have a repeat test sooner due to billing and insurance reasons. The patient also reported to the HRA that she had not asked IHoA staff about it.
  - In regards to the statement made by the complainant that she had "concern about a fall she had in her room on her paralyzed side and she was not evaluated immediately after to the fall to check for broken bones or other injuries until the patient's power of attorney agent for medical requested it a week later."

- This statement is simply false. Ample evidence provided to the HRA proves IHoA nursing personnel immediately after the fall began assessing the patient for pain and injury. There were no signs or symptoms of injury and at no point did the patient voice any pain as a result of the fall. The IHoA personnel continued monitoring the patient and assessing for pain or injury. When a bruise developed, x-rays were ordered that showed no fracture or dislocation. When the IHoA personnel noted changes in patient's condition, the patient was sent to the local emergency room where the patient was diagnosed with a contusion (bruise) and prescribed an ice pack or warm compress when needed.

- In regards to the statement made by the complainant that the facility refused to take the patient to off-site water therapy:
  - This statement is simply false. IHoA provided the patient transportation to and from every scheduled off-site water therapy session and provided the patient with either two aides or a nurse and an aide to assist the patient with changing into and out of a bathing suit and getting into and out of the pool. IHoA continued to do so until the patient chose to not attend the last few scheduled water therapy sessions, and the water therapy sessions were discontinued.