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HUMAN RIGHTS AUTHORITY-CHICAGO REGION

REPORT 21-030-9022
Parkshore Estates

INTRODUCTION

The Human Rights Authority (HRA) reviewed the care and treatment provided to a resident at Parkshore Estates (Parkshore). The complaint under investigation was that the guardian was not allowed to participate in the formulation of the treatment plan and did not receive notification of information regarding treatment.

The rights of mental health patients at Park Shore Estates are protected by the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Nursing Home Care Act (210 ILCS 45/2). Substantiated findings of this complaint would constitute violations of these Statutes.

Parkshore Estates is a long-term care center in the Hyde Park community of Chicago. The facility was opened in 1977. According to Illinois Department of Public Health (IDPH), Parkshore is a 318-bed facility. The facility provides a range of treatment services to the residents including, physical therapy, podiatry, pain management and behavioral health services.

The HRA discussed the complaint with the facility's administrator, social worker, and nurse via WebEx and conference call due to COVID -19. Relevant policies were reviewed as was the medical record with proper authorization.

COMPLAINANT SUMMARY

It was reported that a resident under guardianship was transferred from a neighboring facility due to a guardian's request. The report indicated that the resident obtained COVID and was hospitalized and treated without the guardian's consent or knowledge. It was further reported that the facility did not include the guardian in the formulation of the resident's treatment plan.

FINDINGS

"Parkshore" Record Review

The facility provided a record that included a face sheet, progress notes, a care plan with treatment plan attached, lab result report, diagnosis report and a document scan transaction list. The record illustrates that the resident arrived at the facility in March of 2021 from a local hospital. However, the face sheet provided in the record lists the resident's previous address as another nursing facility.

According to the progress notes included in the record, the resident was diagnosed positive for COVID-19 on March 30, 2021. The resident was then moved to a room on the sixth floor of the facility. The notes indicate that while housed in the new room the resident received all regular care with contact precautions.

The record then details that the resident was sent out to the hospital in early April of 2021 due to erratic behavior. The notes illustrate that he had barricaded himself in his room and was "throwing water and glass out of the room at staff." The note furthers that the police were called, and the patient was sent to the nearest psychiatric hospital for monitoring. The note also indicates that the guardian was made aware of this incident.

The record does have a care plan that was initiated on March 30, 2021. The care plan appears to be completed with the resident's input only. The plan has various goals that staff assist the resident in completing. Finally, the plan is reviewed monthly with some health goals being reviewed every two weeks.

The record is absent any formal complaints or grievances filed by the resident or guardian. The record does contain in the document scan transaction list that guardianship paperwork was received by the facility on April 8, 2021. The document scan transaction record also indicates that the resident's complete medical record was received from another facility in mid-April after the guardianship paperwork was received.

Site Interviews

In response to the complaint, the HRA conducted a WebEx site visit on December 1, 2021. The HRA opened the visit asking the staff to explain the intake process for the resident. The administrator indicated that the resident came to the facility by referral from the hospital on March 29, 2021. The administrator furthered that the resident was already approved for Medicaid and consented for placement in the facility. Thus, there was no paperwork to be completed.

The HRA asked the staff to verify when the patient contracted COVID-19. The administrator stated that per the medical record the patient was positive on March 31, 2021. The HRA then asked the administrator to explain the COVID-19 policy and procedure. The administrator,

stated “if a resident has a guardian, they will be notified.” He furthered that in this resident’s case the resident did not self-report having a guardian, so none was known.

The administrator continued to state that “when a resident is positive, they isolate the resident for 10-days or whatever the new CDC guideline is.” The HRA asked the staff how residents are isolated. The administrator informed the HRA that residents are transferred to the sixth floor as this is the floor which all COVID positive residents reside temporarily. The administrator explained that this floor has about 20 rooms and typically residents are there for about 14-days.

The HRA followed up this question inquiring if guardians can participate in treatment and care planning. The staff responded that guardians could participate. The administrator then indicated that guardians are invited to care plan meetings but in this resident’s case the facility was not aware of the guardian until April 8, 2021. Therefore, the guardian did not participate in the initial formulation of the care and treatment plan. Lastly, the administrator indicated that the guardian is currently engaged in the resident’s treatment.

Policy Review

The HRA reviewed Parkshore’s “Resident’s Rights” pamphlet. The document is given and explained to all new residents and guardians entering the facility. The document informs residents and guardians that they have the right to participate in their own care. The pamphlet furthers that the facility must make reasonable arrangements to meet the needs of the residents. The pamphlet also states that all health information is confidential, private, and protected.

It further educates residents on their ability to have private visits with any person of their choosing, to make and receive phone calls, to manage their own personal funds, and, it lists the grievance process with contact information for outside support agencies. Lastly the pamphlet notifies residents of their right to inspect their records. Therefore, this document meets the requirements of 405 ILCS 5/2-200, which stipulates that each recipient of services must receive an explanation of their rights orally and in writing. Furthermore, the pamphlet meets the stipulations of providing “each resident and resident’s guardian or other person acting for the resident shall be given a written explanation … of all the rights …” that are protected by the Act. (210 ILCS 45/2-211)

CONCLUSION

A guardian was not allowed to participate in the treatment plan.

From the information reviewed, the HRA is aware that the guardian did not participate in the formulation of the treatment plan. However, the facility was not made aware of the resident’s guardian until after the initial treatment plan and care plan was created. The facility provided

records detailing that the guardianship paperwork was provided about a week and a half after admission. Therefore, a rights violation is unsubstantiated.

A guardian was not notified of information regarding treatment of COVID.

Per the record, the resident was diagnosed with COVID-19 in late March. The resident was moved to a floor that contained only positive diagnosed patients. There are not any notes indicating that the guardian was informed. However, as previously noted by the record and interview the facility was unaware that the guardian existed. There are notes indicating that the guardian was made aware of subsequent hospitalizations and treatment in the record. Therefore, a rights violation is unsubstantiated.