Life After Reversal of Inappropriate Discharge

The nursing home failed to ensure residents could exercise their rights without interference, coercion, discrimination, or reprisal from the nursing home for resident 1. The nursing home placed resident 1 on continuous one on one (1:1) supervision without justification when he readmitted to the nursing home after winning his appeal against inappropriate discharge by the nursing home. The nursing home failed to inform resident 1 why he was placed on 1:1 supervision, how long the supervision was meant to last, and what steps were to be taken to remove that level of supervision. It also failed to allow the resident personal privacy and privacy with visitors and phone calls.

The failure resulted in resident 1 experiencing increased emotional distress and decreased quality of life by feeling like his home and feeling of security were in jeopardy. Resident 1 was a young man with "no cognitive delays" and "no short or long-term memory problems." He needed extensive assistance of one to two staff for bed mobility, transfers, toilet use, bathing, and personal hygiene. The MDS assessment indicated that he had verbal behavioral symptoms directed toward others, but the behaviors did not put residents at risk for injury or intrude on the privacy of others.

The resident received an immediate discharge letter stating the safety of individuals in the nursing home was endangered due to aggressive behaviors with residents, family members, and staff to include verbal threats to cause physical harm to residents and a staff member. The nursing home did not have documented evidence that the resident was harmful or had the potential to be dangerous to other residents.
The resident went to the hospital for acute catheter care and was not allowed back to the nursing home.

With the assistance of the Ombudsman, the resident appealed the discharge which was reversed. The nursing home was ordered to immediately re-admit the resident, but the nursing home refused. Corporate made it re-admit the resident when penalties started accruing for deficiencies related to resident 1.

Resident 1 was re-admitted with a physician order, "Resident to be on 1:1 for aggressive behaviors" despite no Care Plan discussing the 1:1 monitoring, the behavior that caused it to be used, and how the monitoring would be titrated. He was placed under constant 24/7 staff supervision." If he smoked, spoke on the phone, used the toilet, slept, or had private time with his girlfriend, staff monitored him. Someone followed him everywhere he went and documented all his movements. This made him upset and angry as he felt like being in a prison. He said, "I am not a monkey in a zoo" and "This is an invasion of privacy!"

When the resident refused an X-Ray, a change in bowel regime, and psychiatric evaluation, the medical director told him that their physician-patient relation will be terminated, which could mean discharge.
The resident thought the nursing home was harassing him and retaliating against him for challenging his discharge and winning his fair hearing. The Ombudsman stated that what the nursing home was doing to the resident was considered profiling and that the 1:1 monitoring violates his rights.

Name of Nursing Home	Heritage at Turner Park Health & Rehab / Provider ID: 455733
Address	820 Small Street, Grand Prairie, Texas
Date investigation completed	November 26, 2019
Type of deficiency issued	F550 – Resident Rights / Exercise of Rights F583 – Personal Privacy / Confidentiality of Records
Severity level	Actual harm
Overall Quality Star Rating: 2; Staffing Rating: 1	

Investigation report: No longer available on *Care Compare* website.