FOR IMMEDIATE RELEASE

North Suburban Regional Human Rights Authority
Report of Findings
HRA #08-100-9010
Bethesda Lutheran Home

Case Summary: The HRA did not substantiate the allegation that a resident had not received timely, competent health care regarding his pressure sores and respiratory problems. The HRA concluded that the Guardian is being notified of unusual circumstances in a timely manner. The HRA found no evidence to support the claim that shampoo was left in a resident's hair. Staff members are trained to handle residents with severe behavior problems. The HRA's public record on this case is recorded below; the provider's response immediately follows the report.

In October 2007, the North Suburban Regional Human Rights Authority opened an investigation of possible rights violations within Bethesda Lutheran Home (hereafter named Bethesda). A complaint was received that reported the following: 1) a resident has not received timely, competent health care regarding his pressure sores and respiratory problems. 2) The Guardian is not notified of injuries in a timely manner. 3) A resident's activities of daily living (ADL) care has been neglectful - shampoo has been left in his hair. 4) Staff members are not trained to handle residents with severe behavior problems. If found substantiated, the allegations would violate the Intermediate Care for the Developmentally Disabled Facilities Code (77 Ill. Admin. Code 350) and the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Background

Bethesda supports people with developmental disabilities either in their own homes or in Bethesda-owned facilities. Support programs vary and are based on each person's needs. Bethesda offers the following Types of Support to people with developmental disabilities: case management, community living, day services, home and community-based services, intermediate care facilities, and mental health clinics. The focus of this investigation was a 45-bed Intermediate Care Facility located in Aurora. It has 24-hour nursing personnel (one nurse on duty each shift), two QMRPs (Qualified Mental Retardation Professionals) and direct-care support professionals.

Methodology

To pursue this investigation the HRA, with written consent, requested portions of the clinical data for the resident whose rights were allegedly violated; the material was received and reviewed. Also requested were the following policies: medical treatment/consultation, treatment planning, guardian notification and employee education/instruction. The HRA was informed the facility did not have the requested polices because the policies were not regulated/mandated policies. A site visit was conducted at which time the allegations were discussed with the Director of the

residential site and the Director of Nursing (DON). The complainant was interviewed via telephone.

Allegation: A resident has not received timely, competent health care regarding his pressure sores and respiratory problems.

Findings

The resident identified in this case is a 48-year-old male with a diagnoses of severe mental retardation, Down's syndrome, adjustment disorder with anxiety, osteoporosis and seborrheic dermatitis. He began living at Bethesda in 2005; the resident's sister became his guardian also in 2005.

According to resident's Annual Treatment Plan (dated February 2007), a skin breakdown assessment was completed on the resident in February 2007; the score was 33, which is in the moderate risk category. On August 12, 2007, nursing notes documented that the resident's body showed no open areas. On August 15th, it was noted that the buttock skin was raw with some bleeding. The injured area was noted to be 2" x 4"; treatment cream was applied. The nursing notes showed that from the onset of the observed wound, daily care was provided to the site. On August 25th, chart documentation indicated that the resident's sister requested that the resident be seen by a doctor about the skin breakdown on the buttock. The request was approved and the resident was seen by the physician. The physician ordered DuoDERM (a skin dressing for the treatment of leg ulcers or areas of the skin which are healing slowly) and for the resident to be seen by the wound care nurse. On August 27th, the Wound Care on Wheels specialist assessed the resident and treatment orders were obtained. The orders were to:

1. Clean the area QD-QOD (daily -every other day).
2. Apply Hydrocolloid (a Sterile wound dressings which consist of a hydrocolloid adhesive with an outer clear adhesive cover film impermeable to liquids, bacteria and viruses)to the perineal floor (pelvic floor is composed of muscle fibers of the levator ani, the coccygeus, and associated connective tissue which span the area underneath the pelvis).
3. Apply Calmoseptine Ointment twice daily (this ointment is a moisture barrier ointment that contains calamine, zinc oxide, menthol, and lanolin. Originally designed to treat diaper rash, Calmoseptine Ointment has successfully been used to treat incontinence sites, feeding tube site leakage, wound drainage, minor cuts and scrapes, minor burns, fecal or vaginal fistulas).

On September 28th, the Physician documented that the decubitus ulcer was healing with no drainage. It is noted that the resident wears disposable briefs at all times due to incontinence.

At the site visit, it was stated that the facility has three physicians that attend to the residents. The physicians go to the site once a month or every other month unless contacted by nursing to see a resident(s) sooner than the scheduled visit. The DON stated that in August 2007, the resident developed pneumonia and antibiotic medication was ordered. It was stated that the antibiotic caused the resident to have loose stools, which lead to a decubitus. When the decubitus was noted, treatment began and the DON noted that the decubitus progressed rapidly despite constant treatment. It was stated that the facility utilizes outside wound care specialists; they come to the facility, assess the wound and offer recommendations regarding treatment. The specialists were obtained for this resident. When asked about a policy regarding wound care, the DON stated that there is no formal protocol on wound care, but the procedure consists of good nursing practice.

Regarding the respiratory problems, the chart showed that on July 14th the resident was admitted to a medical hospital due to a prolonged seizure. Emergency room work-ups showed that the resident had left lower pneumonia. While in the hospital, he received a pulmonary consultation

to be assessed for the use of noninvasive positive pressure ventilation. The consultation reported that a CPAP or BiPAP (Continuous Positive Airway Pressure or Bi-level Positive Airway Pressure-breathing apparatuses that help people get more air into their lungs) was contraindicated. It was documented that the family decided that the resident would receive only supportive care and they declined any life support or any noninvasive positive pressure ventilation. The DON stated that the complaints of the respiratory problems stemmed from the hospitalization. The HRA found nothing in the progress notes that the staff reported any respiratory problems or noted any respiratory problems.

Conclusion

Pursuant to Section 5/2-112 of the Mental Health and Developmental Disabilities Code, every recipient of services shall be free from abuse and neglect. Based on the information obtained, the HRA does not substantiate the allegation that a resident has not received timely, competent health care regarding his pressure sores and respiratory problems. However, we note that the Wound Care specialist was not called until the resident's guardian had requested that a physician see the resident.

Pursuant to Section 350.620 of Intermediate Care for the Developmentally Disabled Facilities Code, the facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. The HRA finds the facility in violation of Section 350.620.

Pursuant to Section 350.1220 of the Intermediate Care for the Developmentally Disabled Facilities Code, "The facility shall have a written program of medical services that reflects the philosophy of care provided, the policies relating to this, and the procedures for implementation of the services. The program shall include the health services provided by the facility and the arrangements to effect a transfer to other facilities as promptly as needed. The written program of medical services shall be followed in the operation of the facility." The HRA finds the facility in violation of Section 350.1220.

Recommendation

The facility must develop (or be aware of) written policies and procedures to govern the services which it provides and to guide its staff in providing those services.

Allegation: The Guardian is not notified of injuries in a timely manner.

Findings

The complaint reported that the resident had sustained an injury to his forehead and the guardian was not notified of this injury.

According to the clinical record, on June 29, 2007, nursing notes documented a superficial scratch on the resident forehead, and there was no active bleeding. It was noted that the resident had a small amount of blood under his right little finger nail and the nail was rigged when assessed; the nail was clipped for a smooth edge. The injury was monitored for the next few days and it was noted to be healing on July 3, 20007. The notes do not indicate that the Guardian was notified. The chart indicated that the Guardian was notified when the resident went into the hospital.

At the site visit, facility personnel stated that guardians are notified of every incident that would be reportable to the Illinois Department of Public Health. It was stated that a guardian would not be notified every time a resident had a seizure; if for example, that resident had a history of having multiple seizures. Should a resident have a seizure without this medical history, the guardian would be definitely be notified. A guardian would not be notified if a resident had a minor injury such as a scratch. But again, any major injury or a change in the resident's medical status would be reported to the guardian. When asked if there was a policy about guardian notification, it was stated that the agency might have one in the master computer files, but one was not known or readily available.

Conclusion

Pursuant to Section 350.3210 of the Intermediate Care for the Developmentally Disabled Facilities Code, the facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise. Based on the information obtained, the HRA concludes that the Guardian is being notified of unusual circumstances in a timely manner; the allegation is unsubstantiated.

Suggestion

Best practice dictates that a policy is developed that addresses guardianship notification. Also, best practice dictates that the Guardian be given the choice of whether they wish to be notified of incidents that would not be reportable to the Illinois Department of Public Health.

Allegation: A resident's ADL care has been neglectful - shampoo has been left in his hair.

Findings

It was stated that hygiene care is given on daily basis and showers are given nightly. When asked how showers are monitored (to ensure that staff are doing this job duty), the DON stated that she, as well as the QMRPs work during the evening hours and observe that showers are being completed. It was stated that no staff member would intentionally leave soap on any kind on a resident.

Conclusion

Pursuant to Section 5/2-112 of the Mental Health and Developmental Disabilities Code, every recipient of services shall be free from abuse and neglect. The HRA cannot discount the claim that the resident had shampoo life in this hair; however, the HRA found no evidence to support the claim; the allegation is unsubstantiated.

Suggestion

The facility should require that staff document when a resident's ADLs are completed.

Allegation: Staff members are not trained to handle residents with severe behavior problems.

Findings

At the site visit, it was stated that this has been a concern of this resident's Guardian, and it has been addressed many times with the Guardian. It was stated that the home has two residents who like to approach visitors and touch them. It was stated that they do not touch in an aggressive manner, but at times the touch might be inappropriate -for example - pulling a shirt sleeve. It was stated that this is simply the manner in which these two residents greet visitors. It was explained that the Guardian has threatened to call police on the two residents to file assault charges. The Administrator stated that he has met with the Guardian to address the matter and the Guardian has asked that the residents be discharged; the Guardian was advised that this would not happen. The Administrator also stated that he had the facility minister talk to the Guardian about this matter.

Regarding staff training, it was explained that staff members receive training at orientation and periodic in-service trainings. It was stated that some residents have behavior plans and a behavioral specialist educates the staff members on how to run the plans. When asked, staff could not recall if the residents in question were on a behavior plan.

The facility provided the HRA with the materials used for the training mentioned above, called Behavior Prevention and Intervention. A completed signature sheet for the last annual training (6/27/07) was also provided. It was offered that new hire orientation sign-in sheets are completed as the classes occur.

Conclusion

Pursuant to Section 350.670 of the Intermediate Care for the Developmentally Disabled Facilities Code, all facility employees who deal directly with residents shall be trained on the individual requirements and behavioral issues of residents who may come under their care, to ensure the safety and dignity of each client. The employees' training and competency shall be documented. Given the situation as described by facility personnel regarding the two residents who approach visitors, the HRA concludes that resident rights are not being violated.

The HRA reviewed the Illinois Department of Public Health website and no inspections regarding similar issues were published.

RESPONSE

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

Julie Sass
Guardianship and Advocacy Commission
North Suburban Regional Office
9611 Harrison Street, W-300
Des Plaines, IL 60016-1565

Re: HRA#08-100-9010

Dear Ms. Sass
Per our phone conversation on 4-10-08, you will find the answers to your recommendations and suggestions.

Allegation:
A resident has not received timely competent health care regarding his pressure sores and respiratory problems

Your recommendations:
They facility must develop (or be aware of) written policies and procedures to govern the services in which it provides and guide its staff to providing those services.

Bethesda Lutheran Homes response:
Please see exhibit A & B:
Exhibit A: policy on admission/discharge agreement addendum covered and non-covered services.
Exhibit B: Policy on change of condition

Allegation:
The guardian is not notified of injuries in a timely manner

Your suggestion:
Best practice dictates that a policy is developed that address guardianship notification. Also, best practice dictates that the guardian be given the choice of whether or not they wish to notify incidents that would or would not be reportable to the department of public health.

Bethesda Lutheran Homes response:
Please see exhibit C:
Exhibit C: policy on incident reporting

Allegation:
An individual's ADL care has been neglectful- shampoo left in his hair

Your suggestion:
The facility should require that staff document when the residents ADL's are completed.

Bethesda Lutheran Homes response:
Please see exhibit D:
Exhibit D: Our from to indicate when employees of Bethesda are completing individuals ADL's.

If you have any questions I stand ready to assist

Sincerely,

Gary Anderson Director of operations
Greg Roessler Area Director