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North Suburban Regional Human Rights Authority
Report of Findings
HRA #08-100-9011
West Chicago Terrace

Case Summary: The facility has a procedure in place to inspect each mattress monthly; the HRA did not find that residents' rights are being violated. The facility had a problem with insect control; the allegation was substantiated. Since the matter had been addressed, no recommendations were made. The HRA concluded that the resident was sent to the hospital for the safety of others; the allegation that he was sent to the hospital for behavioral health services unjustly was unsubstantiated. The HRA found no evidence to substantiate the claim that some of the resident's personal possessions had been thrown away; the allegation was unsubstantiated. The HRA's public record on this case is recorded below.

In October 2007, the North Suburban Regional Human Rights Authority opened an investigation of possible rights violations within West Chicago Terrace. The complaints accepted for investigation are as follows:

1. The facility is "full of bugs" and that some facility-provided items (mattresses) are ripped.
2. A resident was sent to the hospital for behavioral health services unjustly.
3. A resident was being discharged from the facility and some of his personal possessions had been thrown away.

Residents receiving services at West Chicago Terrace are protected by the Nursing Home Care Act (210 ILCS 45/100 et seq.) and the Illinois Administrative Code (77 IL Adm. Code 300).

West Chicago Terrace is a 120-bed, for-profit Intermediate Care facility located in West Chicago, Illinois.

Methods of Investigation

The HRA conducted an on-site visit in January 2007. While at West Chicago Terrace, the HRA discussed the allegation with the facility's Administrator and a few of the facility's Case Workers. The resident whose rights were alleged to have been violated was interviewed by telephone and in person. The HRA reviewed the resident's clinical record with consent. Also reviewed was a posted Illinois Public Health Survey on the facility in question.

Allegation 1: The facility is "full of bugs" and that some facility provided items (mattresses) are ripped.

Findings

As stated, it was reported that the facility had an insect problem and that facility-provided items are in need of repair. At the site visit, the Administrator stated that there was a problem with flies. The facility has since contracted an outside insect control service that dispenses a chemical around the outside dumpsters once a month, and insect control strips were placed inside the facility. The outside service also goes to the facility on an as needed basis. The HRA did not note any insect problems during the visit.

A review of the IDPH survey (8/24/07) noted a "huge influx of flies throughout the facility and that residents complained to the surveyors that this was a daily occurrence." The facility's Plan of Correction stated that the facility had installed five fly traps for fly control and the traps would be serviced monthly. The Plan indicated that the pest control service and the Environmental Services Director would monitor the effectiveness of the traps.

Regarding the allegation about the mattress, the Administrator stated that the Environmental Services Director inspects each residential wing once a week, which results in every mattress being inspected once a month. The mattresses are then replaced as needed. The HRA requested and received copies of the completed Maintenance Quality Assurance Sheets for the month of August 2007, which indicated that mattresses, call lights, window curtains, screens doors and faucets were inspected and replaced/repaired as needed.

Conclusion

Pursuant to the Skilled Nursing and Intermediate Care Facilities Code Section 300.2410, "each resident shall be provided with a separate bed suitable to meet the needs of the resident. Each bed shall be at least 36 inches wide, have a headboard, and be of sturdy construction and in good repair. Each bed shall be provided with satisfactory type springs in good repair and a clean, firm, comfortable mattress of appropriate size for the bed." The HRA realizes that some facility-provided items like mattresses will become damaged by everyday wear-and-tear and, from time to time, by intentional means. The facility has a procedure in place to inspect each mattress monthly. The HRA does not find that residents' rights are being violated.

Pursuant to Section 300.2210 of the Code**,** "Each facility shall maintain the grounds free from refuse, litter, insect and rodent breeding areas." The facility had a problem with insect control; the allegation is substantiated. Since the matter has been addressed, no recommendations are made.

Allegations 2 and 3: A resident was sent to the hospital for behavioral health services unjustly.

A resident was being discharged from the facility and subsequently some of his personal possessions had been thrown away.

Findings

The complaint reported that the resident told facility staff that he did not want to go to the AA (Alcoholics Anonymous) meeting because the meetings are too religious and that he would find some other meeting for substance abuse. It was reported that during this exchange, the resident did not make any homicidal threats, as stated on the petition. The resident learned (while in hospital) that his personal possessions had been placed in storage and that some items (puzzles, books) had been thrown away.

According to the clinical record, the resident was admitted to West Chicago Terrace in May 2006. On August 28, 2007, the resident reported to his Psychiatrist that he would *strangle* the

Administrator if she made him attend the upcoming AA meeting. A petition for involuntary admission was subsequently completed by a nurse, which stated that the resident was "allegedly very aggressive and had homicidal ideations, threatened to choke the Administrator if she told him to go to the AA meeting".

At the site visit, the Administrator stated that she took the resident's threat very seriously because he had been physically aggressive - hitting, attempting to stab - other residents. When asked, it was stated that after the initial incidents of physical aggression, the resident was enrolled in anger management courses but his attendance was sporadic. The Administrator stated that when it was decided that hospitalization was warranted, she knew at that time that he would be discharged. She stated that the recent incident, coupled with the resident's prior physical aggression and constantly breaking rules (smoking in unauthorized locations, alcohol on the premises, etc) cemented the decision. The Administrator stated that she sent the Notice of Involuntary Transfer or Discharge and Opportunity for Hearing document to the hospital, as mandated, so that the resident was advised of his appeal rights. It is noted that HRA personnel met with the resident while he was hospitalized; he had this document and knew he was being discharged from West Chicago Terrace and of his appeal rights.

The Administrator stated that while waiting for the ambulance, she explained to the resident that he was leaving for the hospital and that he would not be returning. She stated that the resident had way too many personal possessions to inventory on the spot as he was a hoarder. She did say that she had thrown away some spoiled food items from his refrigerator. On August 24, 2007, progress notes documented that the resident's room was "again" being searched for suspected incense burning. The note documented that the resident was present during the entire search; it was documented that the Administrator threw away some spoiled food items from his refrigerator.

The Administrator stated that the resident's personal items were packed and sent to a public storage site that the facility rents; they actually had to rent because he had so much stuff. The Administrator recalled that there were about 10 bags and 10 boxes of items. It was stated that when the resident was admitted to another facility, the staff from this facility picked-up the belongings from the public storage site. The Administrator stated that personal items are kept for about six months after a resident is discharged. The chart contained an inventory sheet which indicated that 8 boxes and 6 bags of personal items were sent to public storage. The inventory listed each article retained by the resident (6 belts, 4 coats, 3 wallets, 20 books, etc.).

Conclusion

Pursuant to the Skilled Nursing and Intermediate Care Facilities Code Section 300.3300, a facility may involuntarily transfer or discharge a resident only for 1) medical reasons 2) the resident's physical safety 3) the physical safety of other residents, the facility staff or facility visitor 4) either late payment or nonpayment for the resident's stay, except as prohibited by Title XVIII and XIX of the Federal Social Security Act. The HRA concludes that the resident was sent to the hospital for the safety of others; the allegation that he was sent to the hospital for behavioral health services unjustly is unsubstantiated.

Pursuant to Section 300.1830 of the Code**,** "the facility shall maintain a record of any resident's belongings, including money, valuables and personal property, accepted by the facility for safekeeping. This record shall be initiated at the time of admission and shall be updated on an ongoing basis and made part of the resident's record." The HRA found no evidence to substantiate the claim that some of the resident's personal possessions had been thrown away; the allegation is unsubstantiated.