FOR IMMEDIATE RELEASE

REPORT OF FINDINGS 09-040-9004
MIDWAY NEUROLOGICAL REHABILITATION CENTER
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary—– The Authority did not substantiate the complaint as presented; the public record on this case is recorded below.]

INTRODUCTION

The Human Rights Authority (HRA) has completed its investigation into allegations concerning Midway Neurological Rehabilitation Center. This 404-bed skilled care facility is located in Bridgeview. The complaint stated that the staff discussed the resident's confidential information in the presence of other residents. If substantiated, this allegation would violate the Nursing Home Care Act (NHCA) (ILCS 45/2-105), the Centers for Medicare and Medicaid Services, (CMS) Conditions of Participation for Long Term Care Facilities (42 CFR 483.10) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/3).

METHODOLOGY

To pursue the investigation, the Facility's Administrator, the Director of Psychiatric Rehabilitation Services, the Assistant Director of Psychiatric Rehabilitation Services and two Licensed Practical Nurses were interviewed. Portions of the adult resident's record were reviewed with written consent. The facility's grievance procedures were also reviewed.

COMPLAINT STATEMENT

According to the complaint, the nursing staff discussed very loudly an altercation that the resident had with another peer at his outside day training program and other residents overheard them. A male nurse reportedly said that the resident was not going to hit him, "like he hits on females."

FINDINGS
Information from the record, interviews and policy

After reviewing the record, the HRA determined that the resident was transferred to the facility from a behavioral health unit on March 12th, 2008. He was diagnosed with Schizophrenia and reportedly at risk to exhibit some bizarre behaviors. The record contained an incident report dated July 17th written by a staff person at the resident's outside day training program concerning an altercation with a peer. According to the report, the resident and a female peer were arguing, and they were asked to go back in the program's building. Once there, the resident reportedly walked over to the table and started hitting the same peer on her

head and upper body with his fists. The staff pulled the resident off his peer, placed them in separate rooms and sent them back to the nursing facility via separate transportation.

A Psychiatric Rehabilitation Services Counselor wrote that the staff informed her about the altercation on that same day. She noted that she would follow-up with the resident when he returned to the facility. The Social Services Director recorded that the resident was very upset upon returning from his training program. He was given as needed medication as requested, and he was later transferred to a local hospital for a psychiatric evaluation. The same day the resident's care plan was updated to include physical aggression toward peers.

Documentation on October 9th stated that the resident seemed very upset because he believed that the nursing staff were talking about him. He was counseled about his behavior and accepted as needed medication. Another note indicated that a quarterly staffing was held on November 26th, and there were no significant changes in the resident's condition. As before, the resident was counseled about his belief that the nurses were talking about him. The same day the resident's care plan documented diagnoses of Schizophrenia, Paranoid Type with Acute Exacerbation and chronic auditory hallucinations.

The complaint was discussed with the facility's staff. According to the Director of Psychiatric Rehabilitation Services, the resident did not return to the day training program after the July 17th incident because the staff were afraid of him. She said that the resident is on probation for previously assaulting someone in the community, and that the female peer involved in the altercation did not file charges against him. The resident reportedly told the Assistant Director of Psychiatric Rehabilitation Services that the nursing staff were talking about him but provided no other information. The staff person also reported that the resident denies hearing voices.

The two nurses who supposedly discussed the resident's private information around other residents denied the allegation. According to the first nurse, the resident was very paranoid and easily bothered by other residents. He said that he heard about the altercation at the resident's day program. However, he could not remember whether the day program or the facility's staff informed him about the incident. The nurse also denied that he said that the resident was not going to hit him like he does females. The second nurse told the HRA that she was never assigned to provide personal care to the resident, nor aware of the incident at his day program. She would ask residents who are standing nearby the nursing station to leave before sharing information with other staff members. She said that the medicine room on the third floor is used to discuss resident information. The nurse reportedly has received training on privacy standards regarding resident's protected health information during her employment with the facility.

According to the facility's administration, all newly hired staff must complete orientation that includes training on confidentiality and abuse. They also receive training concerning the same issues twice a year. Midway Neurological Rehabilitation Center reportedly does not have a policy regarding residents' rights to confidentiality, but the facility's procedure is to follow the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities.

The facility's grievances policy encourages residents and their families to voice concerns regarding services and staff members. The policy states that any staff person may accept a complaint from a resident or family member and should attempt to resolve the issue. If the complaint is not resolved, the resident or a family member should be directed to the appropriate department head or the Administrator. If they are not available, the staff person should gather as much information as possible about the grievance and complete a complaint form. The policy has procedures for investigating the grievance, informing the complainant and the Administrator about the resolution, and reviewing all grievances at the monthly Quality Assurance Meetings.

CONCLUSION

CMS' Requirements for Long Term Care Facilities Section 483.10 states that,

> (e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

According to Section 45/2-105 of the NHCA, a resident shall be permitted respect and privacy in his medical and personal care program. Every resident's case discussion, consultation, examination and treatment shall be confidential and shall be conducted discreetly, and those persons not directly involved in the resident's care must have his permission to be present.

The Mental Health Confidentiality Act Section 110/3 (a) states that all records and communications shall be confidential and shall not be disclosed except as provided in this Act. This Act protects against the authorized disclosure of information regarding a recipient to other recipients, as well as to those outside of the facility.

For lack of evidence or witnesses, the Authority cannot substantiate the complaint that the staff discussed the resident's confidential information in the presence of other residents. The HRA finds no violations of the Sections or the facility's policy.

SUGGESTIONS

1. All complaints should be brought to the attention of the Administrator regardless of how much information is provided.

2. The facility should discuss this complaint with its staff during a clinical team or Quality Assurance Meeting.