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HUMAN RIGHTS AUTHORITY-PEORIA REGION

REPORT 09-090-9011
TIMBERCREEK REHABILITATION AND HEALTHCARE CENTER

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at Timbercreek Rehabilitation and Healthcare Center in Pekin, a skilled nursing facility that has approximately 125 residents. Complaints alleged the following:

1. The facility failed to allow a resident private visitation with his spouse.
2. The facility interfered with the resident's and his spouse's right to submit grievances regarding care.
3. A staff person was rude and acted inappropriately toward the spouse.

Substantiated findings would violate recipient rights protected by the Nursing Home Care Act (210 ILCS 45) and the Administrative Code for Skilled Nursing Facilities (77 Ill. Admin. Code 300).

The HRA visited the facility where representatives were interviewed. Relevant hospital and program policies were reviewed as were sections of an adult recipient's clinical record upon his written authorization.

COMPLAINT SUMMARY

This complaint states that in September 2008 a resident's spouse visited him at the nursing home and found him upset. The spouse allegedly noticed bruising on the resident's hand and tried to take a picture of it when a nurse came in, asked the spouse to stop taking pictures and leave, and then blocked her path while demanding that she turn over the camera. Other aides reportedly came on the scene and the spouse was allowed to leave with one of them following her. According to the complaint, the spouse fell on her way out and the aides yelled that no one should help her up.

FINDINGS

Timbercreek explained during our visit that they cover privacy and resident rights issues with all residents and families who in turn sign a privacy act and rights statement. In this case the resident's spouse was a frequent visitor at the facility, usually appearing everyday, sometimes more than once per day. There were no restrictions on seeing her husband until she was

observed destroying nursing home property, after which visits were scheduled and limited to an hour each for about a nine-week period. The facility also expected her to let someone know when she was in the facility. The resident was prone to falls and he had an aide with him at all times for prevention. There had been previous incidents with falls and the resident's spouse became upset about his care and started taking pictures of him, other residents and staff. She was advised on several occasions that she could photograph her husband but not other people without their permission.

On the day of the alleged incident, the spouse was concerned about a bruise on the resident's wrist area. An aide told her that a velcro watchband caused the irritation, and the spouse took pictures of the bruise but proceeded to take them of the roommate and a nurse who entered the room as well. She was asked to stop, got upset, left the building and fell in the parking lot. The nurse elaborated that no one touched the spouse or her camera. She walked out with her side-by-side and they sat down briefly in the reception area where she tried talking to her. The spouse stood up, staggered, and eventually fell, telling the nurse to get away from her and that she had no privacy with a one-to-one aide in the room.

Documentation surrounding the incident that was provided to us supported these accounts. There were numerous written statements by various staff members who cited altercations with the resident's family, much of which involved the family taking photographs of the resident wearing a lap buddy, a soft device that fits between arm rests to prevent falling out, and photographs of the facility and other people without appropriate authorization. There was a police report that verified the spouse's previous involvement in property destruction at the facility. Illinois Department of Public Health findings regarding fall incidents were also included; those investigations cited problems with improper nursing care but no problems with abuse, neglect or resident rights issues. One staff member noted her discussion with the spouse about her husband's need for one-on-one assistance to prevent falls. The spouse was described as upset, complaining that the aide was only there to watch her. The staff member explained to her that the aide was not there to watch her; rather, she was assigned to both occupants in the room for safety purposes. As the spouse continued to complain about the lack of privacy, the staff member assured her that during her visits the aide would remain outside the door where she could still see the roommate. The record information did not include a physician's order or other documentation on the need to limit the spouse's visits to pre-scheduled hours as stated. The HRA notes that mot facilities have visitor sign-in sheets that require visitors to acknowledge their presence in the facility.

Regarding the incident in question specifically, we reviewed a nurse's note that stated how the resident put his watch on too tightly and that a red mark appeared underneath. The area was cleaned and covered with gauze, and the resident's physician was notified although there was no additional medical attention necessary. The assigned aide's documentation stated that she observed the spouse taking a picture of the resident's wrist and that she also took a picture of the nurse who came into the room. The nurse asked her to leave and she did. The resident attempted to get up too, and the aide went to help him back into his chair. The nurse wrote that she informed the spouse she could not take pictures of others without permission. The spouse became irate, she screamed and yelled and then left the room, but when she asked her to wait until the charge nurse could speak with her, the spouse started kicking and yelling that they just

wanted her in jail. She ended her notation by stating that she attempted to calm her because she was crying and was extremely unsteady. A third staff member wrote that she was already in the parking lot when the spouse fell. Although she did not see the fall, she tried to help her up but the spouse told her to leave her alone.

We also reviewed the rights material that is shared with residents and their families or representatives. It states that the facility must provide services to keep a resident's physical and mental health at the highest level and that abuse from anyone is prohibited. Medical and personal care are private and facility staff must be respectful of that. No information about a resident or his or her care may be shared without proper authorization. Visits, telephone calls and mail are private. Grievances may be presented to the facility and there must be a prompt response to follow. Grievances may also be presented to outside organizations including the Long Term Care Ombudsman, Protection and Advocacy (Equip for Equality) and the Illinois Department of Public Health--their contact numbers and example steps in addressing grievances are listed. An authorization for documentation and publicity sheet from this resident's chart states that consent is given to use the resident's name and photograph for medical record documentation, room identification, and in newsletters, news releases, or newspaper photos. Camera use within the facility, whether by residents, visitors or staff is not addressed in the materials provided. The HRA found no documented evidence of any formal grievances filed by the family although family dissatisfaction was noted in the resident's record. The HRA also found only one incident report in the resident's record.

CONCLUSION

The Nursing Home Care Act states,

> *Every resident shall be permitted unimpeded, private and uncensored communication of his choice by…visitation. … The administrator shall ensure that residents may have private visits at any reasonable hour unless such visits are not medically advisable for the resident as documented in the resident's clinical record by the resident's physician. … Unimpeded, private and uncensored communication…by visitation may be reasonably restricted by a physician in order to protect the resident or others from harm, harassment or intimidation, provided that the reason for such restriction is placed in the resident's clinical record by the physician….* (210 ILCS 45/2-108).

The Act also prohibits abuse of a resident in any form, including mental abuse (210 ILCS 45/2-107), and the Administrative Code states that facilities must provide necessary care to attain or maintain the highest practicable physical, mental and psychological well-being of the resident (77 Ill. Admin. Code 300.1210).

Finally, under the Act,

> *A resident shall be permitted to present grievances on behalf of himself or others to the administrator…State governmental*

> *agencies or other persons without threat of discharge or reprisal in any form or manner whatsoever. The administrator shall provide all residents or their representatives with the name, address, and telephone number of the appropriate State governmental office where complaints may be lodged.* (210 ILCS 45/2-112).

On the issue in complaint #1, not being allowed private visits, the resident's record is full of documentation showing the need for one-to-one help for his safety. Although there is no proof that privacy was actually assured whenever the spouse visited, documentation suggests that aides were aware of the need for their privacy, and, having to also watch the roommate, would remain on the other side of the room's door. This is <u>not a violation</u> of the resident's right. Visitation was allowed. But, the facility stated that it limited the spouse's visits to pre-scheduled hours for a time after she was involved in destroying property. However necessary it was to apply, there was no corresponding documentation in the materials sent to us that showed physician consultation or approval as required by the Act. The HRA strongly suggests the following:

Instruct all appropriate staff members to consult with physicians and enter physician-written approvals to limit any resident's visits of her/her choice (210 ILCS 45/2-108).

Complaint #2 questions whether the facility interfered with the resident's or his spouse's right to submit grievances regarding his care. The HRA found no documented evidence of a formal grievance having been filed by the resident or his family although the facility was aware of family concerns. Information regarding grievances is addressed in the resident's rights booklet distributed at admission. There is no evidence to conclude that the facility interfered with the right to file grievances; therefore, the HRA <u>does not</u> substantiate a rights violation with regard to grievances. However, the HRA does not discount the concern voiced in the complaint and suggests the following:

Ensure that resident/family grievances and the facility's responses are documented.

Complaint #3 states that a staff person was rude and acted inappropriately toward the spouse, who was a visitor at the facility. Statements from those we interviewed and collaborating record documentation from several of them indicate that the visitor was asked to leave because she was taking pictures of other people and that she was offered help after she fell. The Act prohibits actions that cause mental injury to any resident, and, the Administrative Code calls for care and services that promote a resident's psychological well-being. Although the alleged incident was said to happen to a visitor, not the resident, it could, if occurred, be a source of mental anguish for him. In any case, there is no evidence to suggest that it did, and the resident's right is <u>not violated</u>.

Comment:

The HRA found that there was a general lack of documentation regarding safety concerns related to this resident as well as only one completed incident report. The HRA is also concerned about the right of all facility residents to live in a safe environment. As such, the Authority also suggests that the facility maintain adequate documentation of safety concerns,

including completed incident reports. In addition, when visitors to the facility demonstrate behaviors that are threatening to the safety or rights of residents, the HRA suggests that the facility consider the possibility of pursuing legal intervention (e.g. restraining order) for the protection of all facility residents.