FOR IMMEDIATE RELEASE

North Suburban Regional Human Rights Authority
Report of Findings
HRA #09-100-9009
Glen Lake Terrace

Case Summary: the HRA did not substantiate the allegations presented. The HRA's public record on this case is recorded below.

In August 2008, the North Suburban Regional Human Rights Authority opened an investigation of possible rights violations within Glen Lake Terrace. The complaints accepted for investigation are as follows:

>staff members are too busy doing paperwork to deal with the residents
>the food is not balanced - too much sugar and not enough fresh fruit
>a resident has been unable to get a grounds pass
>a resident does not know what to do to get discharged
>a resident has not received a copy of the facility's rules
>the facility does not provide any structured activities

Residents receiving services at Glen Lake 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).

Glen Lake Terrace is a 210 skilled-bed nursing home located in Waukegan, Illinois. Many of its residents have mental illness or Alzheimer's disease.

Methods of Investigation

The HRA conducted an on-site visit in September 2008. While at the facility, the HRA discussed the allegations with the resident whose rights were alleged to have been violated, the facility Administrator, the Director of Social Work, and the resident's Social Worker. The HRA requested and reviewed facility polices specific to the allegation and reviewed portions of the resident's clinical record, with written consent.

Information obtained from the interview with the resident

The HRA met with the resident in her room. The resident stated that she had been admitted in June 2008, and stated that she had one care-plan meeting in July. She offered that she did not know her legal status, i.e., whether she has a guardian or who might have her power of attorney. She stated that she could not get a grounds pass; however, she stated that she needed to follow her care-plan before the physician would authorize the pass. When asked why she wanted the pass and what she would do if she received one, she said that she did not know. She did admit to going on supervised group trips, the last one being three days before the site visit. She stated that she went to Wal-Mart and the Dollar Store.

When questioned about her discharge plan, the resident was able to state what she needed to do for discharge, in that she would need to find a place to live, by making phones calls and that she

needed to be able to take care of herself without help. The resident stated that there was nothing to do, that the residents "just walked around or watched TV," and that the rock music that played constantly over the ceiling speaker just outside of her room drove her "crazy".

The HRA observed that there were two oranges on a bureau in her room. She said that she knew we would see those and she had wanted to hide them, but forgot. The HRA had also observed a notice posted outside of the elevator on the first floor inviting residents to attend a food committee meeting with the nutritionist. The meetings were scheduled for twice a month. When asked if she attended these meetings, she said that she had, but it did not do any good and that the food was still unhealthy.

Information obtained from the clinical record

The resident is a 56-year-old female who has a history of paranoid schizophrenia and alcohol abuse; she had displayed assaultive behavior that indicated a high risk for serious injury to others. She was admitted through the Emergency Department of a nearby hospital on June 4, 2008.

Allegation: staff members are too busy doing paperwork to deal with the residents.

Findings

The HRA was advised that staff members are trained and in-serviced that working with the residents and meeting the residents' needs comes first and foremost. It was offered that paperwork will always exist especially with the added documentation that the IDPH (Illinois Department of Public Health) put onto facilities. The facility has a Social Service Department of four Social Workers and three Social Services Technicians. In addition, the facility employs 200 employees for a census of 210 residents. The Administrator offered that she personally speaks to each resident daily during her rounds and her office staff sees approximately 30-40 residents a day just to talk. It was offered that when a resident, family or visitor has a complaint or grievance, a form is filled out by the person receiving the complaint/grievance and then this form is given to the Administrator. The Administrator then investigates the matter.

Conclusion

Pursuant to the Nursing Home Care Act, Section 2-107, "An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident." "Neglect" means a failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition.

The HRA acknowledges that the resident might perceive that staff members do paperwork instead of assisting with the residents, but no evidence was found to support the claim; the allegation is unsubstantiated.

Allegation: The food is not balanced - too much sugar and not enough fresh fruit.

Findings

A review of the resident's record showed a June 18, 2008 nutrition progress note which documented that the resident met with the Dietary Supervisor Chef regarding her food preferences and that the meals lacked variety. The Chef explained to the resident that the kitchen follows a four week menu cycle. The resident requested more vegetables and more fresh fruit and it was noted that this was added to her tray card. On June 30, 2008, it was documented that the resident is "again complaining" that she is not receiving enough vegetables and fruits. It was explained that apples and oranges are usually available and other fresh fruits are ordered according to the menu cycle. The

resident also requested that salad be offered more; the resident was advised that on the daily substitution list, a Julienne salad and a fruit plate are served three times a week.

The HRA was told that the facility has a registered dietician that comes to the facility three times a week; they also have a full-time nutritionist on staff. The HRA received a copy of the menu plan and spread sheet; the facility provides a 4-week menu cycle. It was noted that grapes, watermelon, fruit salad and melon cubes were listed as food items as were fresh vegetables.

Conclusion

Pursuant to the Illinois Administrative Code Section 300.2050, "Each resident shall be served food to meet the resident's needs and to meet physician's orders. The facility shall use this Section to plan menus and purchase food in accordance with the… Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences."

Based on the information obtained, the allegation that the food is not balanced is unsubstantiated.

Allegation: A resident has been unable to get a grounds pass.

Findings

The Administrator offered that the facility admits various types of residents with various diagnoses (medical, psychiatric). Resident passes are given by the physician through a doctor's order along with the facility policy of a14-day facility in-house stay prior to obtaining a pass. The 14-day period is so that the physician, psychiatrist and staff can evaluate the resident in the area of safety and provide an adjustment period for the resident. It was stated that the resident has not yet earned a pass, but she does go on outings.

The chart contained a Skills Assessment - Level of Functioning document that asks if the resident is "sufficiently alert, oriented, coherent and knowledgeable allowing him/her to be considered for independent outside pass privileges". It was documented that she did not meet this criterion. The Assessment was dated June 25, 2008. The chart reviewed did not show that the resident has requested a pass.

The Facility Policy regarding resident community pass states that "It is the goal of the facility to plan a safe access to the community or to a more independent setting for a specified duration of time for all residents with a physician's order for a Community Pass. An order for a Community Pass to home, the community, or a more independent setting must be initiated and approved by the individual's personal physician or psychiatrist. The resident's doctor must order the Community Pass for the resident prior to any action by Social Services or any other department. All Community Passes are subject to the guidelines and restrictions."

Conclusion

Pursuant to the Illinois Administrative Code, Section 300.610, "The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These written policies shall include, at a minimum the following provisions: Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service."

The facility must ensure that a resident is alert, oriented, coherent and knowledgeable regarding a community pass. It was stated that she is not yet safe for a pass; the allegation is unsubstantiated.

Allegation: A resident does not know what to do to get discharged.

Findings

The HRA was told that when residents are admitted to the facility, a care plan meeting is provided within the first 14 days of admission or sooner, or upon the request from family/resident. It was offered that the meeting might be sooner depending on if the resident is admitted for short-term therapy, respite care, etc. The Social Service Department begins discharge planning, if applicable, upon admission. The chart contained an Admission Orientation Information document that indicated that at the time of admission, the resident's Bill of Rights were explained to her, including all rights and privileges as a citizen of the United States (i.e. the right to vote, confidentially/private treatment, care with respect and dignity, freedom from restraints, freedom from abuse or neglect) and the resident's responsibilities concerning the resident's care. It was also noted that the resident received orientation and an introduction to the facility program and services. The Residents' Rights packet contains numbers (Long Term Care Ombudsman, Equip for Equality, Illinois Department of Public Health) to present grievances. When asked, the resident stated that she had received the Residents' Rights packet.

The policy regarding Discharge Planning states that it is the goal of the facility to plan a safe and effective discharge to home, the community, or a more independent setting for all residents. A physician's discharge order/discharge to home, the community, or a more independent setting must be initiated and approved by the individual's personal physician. The resident's doctor must order the discharge for the resident prior to any action by Social Services or any other department.

Conclusion

Pursuant to the Illinois Administrative Code, Section 300.630, "Before a person is admitted to a facility, or at the expiration of the period of previous contract, or when the source of payment for the resident's care changes from private to public funds or from public to private funds, a written contract shall be executed between a licensee and the following in order of priority; the person. The contract shall provide that if the resident is compelled by a change in physical or mental health to leave the facility, the contract and all obligations under it shall terminate on seven days notice. No prior notice of termination of the contract shall be required, however, in the case of a resident's death. The contract shall also provide that in all other situations, a resident may terminate the contract and all obligations under it with 30 days notice. All charges shall be prorated as of the date on which the contract terminates, and, if any payments have been made in advance, the excess shall be refunded to the resident."

In discussing this allegation with the resident, she was able to say what she needed to do to work toward discharge and she had resident rights and grievance contact information; the allegation is unsubstantiated

Allegation: A resident has not received a copy of the facility rules.

Findings

The HRA was advised that the facility does not have "rules" that would be given out. Upon admission the facility provides each resident with a copy of the resident rights. Other rules that might be established within the facility are posted. Examples are: meal substitute requests are posted by the menu board, and the facility hours are posted. It was also stated that the facility has a concierge program. Upon admission, a concierge takes the new resident to his/her room and assists

with unpacking, taking inventory for the chart, and giving the resident a tour. This person is also available to answer questions that arise.

Conclusion

Neither the Nursing Home Care Act nor the Illinois Administrative Code mandate that "rules" are provided; the HRA observed posted rules throughout the facility; the allegation is unsubstantiated.

Allegation: The facility does not provide any structured activities.

Findings

The HRA was advised that the facility Activity Department consists of: 1 full time activity director; 4 full time activity aides (1 per unit); 2 full time activity staff members that do 1:1 visits and interventions; and 1 part time activity aide. Activities are scheduled 7 days per week and the facility provides 2-3 off-site outings per week. Each floor has individual activities and residents are able to attend activities on other units if they are interested. It was further stated that the facility has a children's in-house daycare center and intergeneration programming also occurs weekly. The activity calendar is enlarged and posted on each unit and there is a calendar posted in each resident room and in the dining room. Residents are also provided an outside workshop program which they can attend and the program's social worker and a physician run groups and job assistance training. The HRA reviewed monthly activity calendars which showed activities such as: current events, bingo, exercises, dice bowling, ice cream social, etc.

According to the resident's record, on September 10th the Social Worker spoke to the resident about attending an out-patient psychiatric care program at a nearby hospital. The resident agreed to attend the program, but was concerned that it might interfere with the activities offered off-site. The Social Worker advised the resident that she would try to work it out so that the resident could attend both the program and the activities. At the site visit, it was stated that the resident refuses to participate in any mental health programs or groups and she did not want to attend the workshop. A review of the Outings List showed that the resident goes off-site with staff members at least once a week to shop or go to a restaurant.

The chart contained an Activity Needs Assessment, completed on June 13, which documented that the evaluator had difficulty getting the resident to answer the questions and when she did answer, she was vague. However, the assessment showed what the resident was and was not interested in. The Care Plan showed that the resident was to choose and actively participate in two activities per week. It was documented (6/25/08) that the resident has gone on a few activities and she has a hard time making up her mind and staying on task. It was noted that she observes the art class and when asked to join in - "off she goes."

Conclusion

Pursuant to the Illinois Administrative Code, Section 300.1410, "The facility shall provide an ongoing program of activities to meet the interests and preferences and the physical, mental and psychosocial well-being of each resident, in accordance with the resident's comprehensive assessment. The activities shall be coordinated with other services and programs to make use of both community and facility resources and to benefit the residents."

Based on the information obtained, the allegation that the facility does not provide structured activities is unsubstantiated.