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REPORT OF FINDINGS
HEATHER HEALTH CARE CENTER— 10-040-9005
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary— The Authority made corrective recommendations regarding one of three allegations. The public record on this case is recorded below; the provider did not request that its response be included as part of the public record.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA), the investigative division of the Illinois Guardianship & Advocacy Commission has completed its investigation into allegations concerning Heather Health Care Center. The complaints investigated were as follows:

1. The staff opened a resident's mail without his written consent.
2. A staff person entered the resident's room without knocking.
3. Residents are only allowed to leave the locked unit at certain times.

If substantiated, these allegations would be violations of the Nursing Home Care Act (NHCA) (210 ILCS 45/2 et seq.), the Illinois Administrative Code (77 Ill. Admin. Code Part 300 et seq.) and the Centers for Medicare and Medicaid Services, Department of Health and Human Services' (CMS) Requirements for Long Term Care Facilities (42 C.F.R. 483.10 [i] [1]).

Heather Health Care Center provides 24-hour skilled nursing care and offers a range of programs including rehabilitation services. The 173-bed facility located in Harvey reportedly has about 120 residents, and many of them have been diagnosed with a mental illness.

METHODOLOGY

To pursue the investigation, a site visit was conducted on January 21st, 2010. The Facility Administrator, the Officer Manager, a Licensed Practical Nurse and a Psychiatric Rehabilitation Services Counselor were interviewed. The resident's record was reviewed with his written consent. Some of the facility's residents were interviewed concerning the second and third complaint. The facility policies were reviewed. An Illinois Department of Public Health Report that was not part of the record was reviewed.

FINDINGS

COMPLAINTS # 1 and 2: Privacy

According to the complaint, a staff person opened the resident's mail that contained a refund check from a physician's office without his permission. It was reported that a nurse entered the resident's room twice without knocking. The nurse was asked to knock on the resident's room door after the first incident, but he entered the room without knocking on the following day. A written grievance was filed with the facility, but the privacy issue was never discussed with the nurse because the completed complaint form allegedly disappeared.

Information from record, interviews and program policies

According to the record, the resident was admitted to the facility on February 26th, 2009, and he was able to clearly make his needs known. He was diagnosed with Major Depression and many physical problems. A form entitled, "Authorization to Open and Inspect Mail" was signed by the resident on the admission day. The form specifically stated that the consent only covered the resident's "business mail." The resident's "Care Plan" developed on March 7th included goal objectives concerning depression and social interaction. Subsequently, objectives regarding suicidal ideations, compliancy with treatment, and repetitive non-health related complaints such as relationship issues were added to his plan. Progress notes indicated that the resident was sometimes non-compliant with treatment and stayed in his room most of the time.

With respect to the complaint, there was no documentation concerning the lack of privacy in written communications found in record. But, nursing entries detailed that the resident was verbally abusive and aggressive toward the staff and provided information about the second allegation mentioned in the complaint. On July 8th 2009 at 9:30 p.m. a nurse wrote that the resident was very agitated because he wanted "Norco" but the medication was not due. On that next night the resident tried to start a fight with the same nurse "because of narcotics." On July 10th, at 5:30 a.m. a different nurse documented that the resident refused to have his blood sugar checked. Then, at 10:30 p.m. the resident was verbally aggressive toward the nurse who wrote the 5:30 a.m. note and alleged that the nurse had entered his room without knocking. The nurse told the resident that he would "knock a little harder in the [near] future." However, the resident was not satisfied with the nurse's response, and social services were notified. At 11:30 p.m. the resident called 911, and alleged that his rights had been violated. When the police responded to the resident's call, the nurse explained the precipitating incident, and they left the facility. His physician was called about fifteen minutes later because of threatening behavior. He was transported to a local emergency room for a mental health evaluation and discharged back to the facility post-hospitalization.

On August 27th, the resident was hospitalized for medical reasons, and upon return to the facility on September 2nd, he was placed on the 2nd floor that has an isolation room. On that next day the resident started yelling when the nurse asked about his hospital discharge papers. It was recorded that he told the nurse to not come in his room again. On that same day a nursing assistant wrote that the resident's room door was closed, and he just stared at the ceiling when she offered breakfast. On September 6th, the resident slammed the door and told staff members "to get the [expletive] out" when they came to provide care. The investigation team noticed three

completed grievance forms in the record, but they were not related to the privacy complaint issues.

In response to the first complaint, the HRA was informed that the facility's Office Manager and clerical personnel are responsible for opening the mail when delivered by the United States Postal Service. The Director of Admissions usually opens mail from the Illinois Department of Healthcare and Family Services, the Social Security Administration and Medicare if authorized by the resident or authorized representative. The Office Manager opens correspondences from physicians, but this does not include checks. Residents' mail is delivered to them by the facility's security personnel. They did not remember the resident filing a complaint about his personal mail being opened by the staff. The facility's residents who were interviewed told the investigation team that mail was not a problem.

According to the Facility Administrator, the staff are directed to knock on residents' room doors before entering at all times. The PRSC reported that the staff are informed about residents' rights including the right to privacy. He said that residents should first contact the facility's social services department when they want to file a complaint with the facility. Residents are informed to put their grievances in writing, and there must be follow-up within 24 hours after a concern form is completed. Although the nursing note stated that social services were notified, the PRSC said that the resident never mentioned the allegation to him.

The nurse involved in the second complaint reportedly was working the night shift on the alleged incident day. He explained that nurses are required to check on residents every two hours. He denied entering the resident's room without knocking. The nurse told the resident that he had knocked (not too hard) before entering his room. The nurse reportedly was interviewed by a representative from the Illinois Department of Public Health (IDPH) concerning the alleged incident. However, the Department's complaint determination report, dated September 4th, 2009, indicated that the nurse was interviewed because of abuse allegations involving the resident in question, and there were no deficiencies found against the facility. According to the report, the resident denied that he refused to have his blood sugar checked as recorded by the nurse involved in the complaint on July 10th.

According to Heather Health Care Center's mail policy, residents have the right to private communication with persons of choice. They may send and receive personal mail unopened unless otherwise indicated by the attending physician and documented in the resident's medical record. It states that residents' mail will be opened upon their requests. Mail will be delivered to them within 24-hours of arrival including Saturday. And, outgoing mail will be delivered to the postal services within 24-hours, except on weekends and holidays.

The facility's "Concern Log" policy states that all concerns or missing items should be reported on the concern form. The Administrator or designee will conduct an investigation, and the complainant will be notified of the outcome within one calendar week. All completed concern forms will maintained by the Administrator.

Heather Health Care Center reportedly does not have a nursing policy concerning routine checks on residents. The facility provided attendance sheets documenting that staff were trained on residents' rights in January and June 2009.

CONCLUSION

According to the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities and Section 45/2-108 (a) of the NHCA, every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or visitation. The Administrator shall ensure that correspondence is conveniently received and mailed. And, Section 45/2-108 (c) of the NHCA states that the facility personnel shall knock, except in an emergency, before entering any resident's room.

Section 483.10 (i) (1) of CMS' Requirements for Long Term Care Facilities guarantees residents the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.

The Authority cannot substantiate that the staff opened the resident's personal mail without his written consent. The complaint that a staff person entered the resident's room without knocking is also unsubstantiated. The HRA does not discredit the allegations, but we found no clear evidence to substantiate them. The record lacked documentation concerning the lack of privacy in written communications. The nurse involved in the second complaint denied the allegation. Progress notes do not clearly indicate whether permission was given to enter the resident's room on September 3rd and the 6th. Additionally, there was no evidence that a grievance was filed with the facility concerning the allegations. The Authority finds no violations of Section 45/2-108 of the NHCA, Section 483.10 (i) (1) of CMS' Requirements for Long Term Care Facilities or the facility's policies.

SUGGESTIONS

1. Heather Health Care should review this complaint with its staff to ensure that residents' right to privacy is respected.

2. Be sure that permission is given before entering residents' rooms unless there is an emergency.

COMPLAINT # 3: Confinement

According to the complaint, residents cannot leave the unit because it is locked. They are only allowed off the unit at certain times, for example during therapy groups.

Information from interviews and program policies

In response to the complaint, the Facility Administrator and the PRSC explained that the facility is divided into three separate units. They said that residents on the second unit need more assistance than other residents. The facility has a visiting policy that allows residents to leave their units during certain hours, and they are monitored by staff. The visiting policy is reportedly explained to residents at intake. According to the Administrator, the policy was implemented

about three years ago as a safety measure. The doors on the 2nd and 3rd units have an alarm system. Residents can turn the alarm off by turning the door knob; a staff person punches in a code and escorts them off the unit. Another staff person said that the doors can be opened by pushing on them for fifteen seconds.

The consensus of the residents interviewed was that they could not leave their units until visiting hours, and that the staff would make them go back to their units, if they exercised their will to leave them. One resident said that residents would receive a written warning, if they did leave their units. One resident said that the staff would stop her from leaving the unit. Several residents said that they have never tried to leave the unit outside of visiting hours. While touring one of the units, the HRA tried to open two doors by pushing on them, but we were unsuccessful. A male staff person had to push the doors opened for the investigation team; the alarms went off and several staff members quickly responded to them.

Heather Health Care Center's "Resident/Visiting Policy" states that the facility is divided into three units: the first unit services skilled and intermediate residents, the second unit is for severely mentally ill residents, and the third unit consists of higher functioning mentally ill residents. Each unit has a dining room, a nursing station, telephone access, television area, activity programming and accessibility to smoking. Residents are encouraged to remain on their assigned unit until visiting hours, which has been scheduled from 10:00 a.m. to 11:00 a.m., 2:00 p.m. to 3:00 p.m. and 6:00 p.m. to 7:00 p.m. According to the policy, the designated hours will provide residents with an opportunity to visit with peers, to attend groups and activities on other units, etc. Residents are permitted to leave their units during visiting hours, and the staff are encouraged to provide increased supervision.

The HRA requested a policy concerning behavioral management, but we did not receive it.

CONCLUSION

According to Section 45/2-104 (a) of the NHCA and Section 300.4040 (c) (3) of the Illinois Administrative Code, every resident shall be permitted to participate in the planning of his total care and medication treatment to the extent that his condition permits.

Section 45/2-104 (c) states that,

> Every resident shall be permitted to refuse medical treatment … unless such refusal would be harmful to the health and safety of other and such harm is documented by a physician in the resident's clinical record.

Under Section 45/2-106 (b),

> Neither restraints nor confinements shall be used for punishment or staff convenience. No restraints or confinement shall be employed

> except as ordered by a physician who documents the need for such restraints or confinement in the resident's clinical record.

According to CMS' Requirements for Long Term Care Facilities Section 483.25,

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

According to Section 300.4030 (f) of the Illinois Administrative Code requirements for facilities providing services to persons with serious mental illness,

> Whenever possible, residents shall be offered some choice among rehabilitation interventions that will address specific Individualized Treatment Plan objectives using techniques suited to individual needs.

Pursuant to Section 300.4040 (b) of the Illinois Administrative Code, the psychiatric rehabilitation services programs in the facility shall be designed to improve or maintain the resident's level of functioning and independence.

Based on the HRA observation and interviews, residents are restricted to their units, except during visiting hours which occur three times a day. The facility's visiting policy seems to be a blanket requirement based on the HRA's observation. The practice, as observed by the HRA and as reported by many residents, does not provide for resident autonomy, individualized needs, and total care planning.

Heather Health Care Center is strongly reminded that residents have the right to refuse any treatment modes or visitation hours as outlined in the facility's policy under Section 45/2-104 (c). They also have a right to receive services without confinement and individually documented needs are required for confinement under Section 45/2-106 (b). Under the observed policy and practice, the Authority finds violations of the above Sections.

The Authority understands that the facility is responsible for the safety of each resident, but the visiting policy should be determined on individualized bases.

RECOMMENDATIONS

1. Heather Health Care Center shall follow the above Sections by making the visiting policy autonomous to residents, based on individualized needs and their participation in total care planning.

2. The facility shall revise its Resident Visiting policy to reflect residents' autonomy in this practice.