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North Suburban Regional Human Rights Authority
Report of Findings
HRA #10-100-9014
Skokie Meadows Nursing Center

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

Introduction

In April 2010, the North Suburban Regional Human Rights Authority opened an investigation of possible rights violations within Skokie Meadows Nursing Center. The complaint accepted for investigation was that the facility was without some personal hygiene products for about a week; upon suspected theft, a resident was told that he could not contact the police and a Social Worker is verbally abusive to the residents. Residents receiving services at Skokie Meadows Nursing Center are protected by the Nursing Home Care Act (210 ILCS 45/100 et seq.).

Background

Skokie Meadows is a 108-bed intermediate care facility that serves individuals with chronic mental illnesses.

Investigative Methodology

The HRA conducted an on-site visit in May 2010. At the visit, the HRA discussed the allegations with the facility's Administrator and the Director of Social Services/Program Coordinator. The HRA requested and reviewed (portions) of the clinical record of the resident whose rights were alleged violated, with written consent. Also reviewed were facility policies specific to the allegations. The HRA acknowledges the full cooperation of facility personnel.

Findings

The clinical record revealed data on a male resident admitted to Skokie Meadows in September 2009 with a diagnosis of Mental Illness, Major Depression, Anxiety Disorder and a History of Bipolar Disorder. It was noted that the resident has had multiple psychiatric hospitalizations and that he had most recently lived in another nursing home center.

Regarding the allegation that the facility was without personal hygiene products, the Administrator advised the HRA that the residents' bathrooms have hand-washing dispensers available; there was one day when the dispensers were emptied by some residents who then used that soap to add to the laundry washing machines. It was explained that the washing machines automatically dispense the detergent, which is low suds. The residents believe that if there are no suds, then there is no soap and the clothes are not getting cleaned. When it was discovered that soap was being removed from the dispensers, 36 bottles of antibacterial hand soap dispensers were purchased from a nearby grocery store and placed in each bathroom. The following day, the bathroom dispensers were refilled with foam-type soap, which cannot be used in the washing machines. The HRA toured the washing machine area and was shown how the soap is dispensed

automatically into the machines, and how soap can be added manually. Also noted was the foam-type soap in the resident bathrooms. The Administrator stated that the actual length of time when the residents were without soap amounted to hours not days.

Regarding the theft assertion, the record showed that after returning to the facility from an off-campus pass, the resident reported to social service staff members that other staff members had conducted a room search and had removed some items (an envelope contained with papers, a "bunch" of papers that were on top of his dresser, a family photo, business cards, and deodorant). The resident was told that staff members would not have conducted a room search unless there had been suspected contraband and no contraband was suspected, thus a room search had not been completed. The resident also reported to nursing staff that these items were missing, claiming that his roommate threw away the items. Nursing documentation showed that the resident called the police and an officer came to the facility and interviewed the resident and his roommate.

Social Service notes document that the Social Worker and the Director of Nursing met with the resident about the missing items; the resident was told that an internal investigation was conducted and no items were found. The resident was reminded of facility policy, in that important papers should be locked in a secure area for safe keeping. The resident was also reminded that calling the police was inappropriate and unnecessary. Subsequently, a new care plan goal was developed for the resident which stated that the "resident had displayed socially, inappropriate and maladaptive behavior related to a need for immediate gratification and a poor ability to deal with anger and frustration. Recently these symptoms were manifested by making unnecessary phone calls to the Skokie Police Department. The resident accused his roommate of stealing his belongings and throwing things away without proof and when facility staff did not call the police he took it upon himself to call them and demand his roommate be arrested". The Plan stated that staff members were to educate the resident about the role and purpose of the EMS (Emergency Medical Services) specifically its use for persons with serious injuries and life or death situations and to educate the resident about applicable penalties that may be imposed by the city or municipality for abusing the emergency system by making false or bogus complaints exaggerating one's condition and intentionally misleading emergency personnel.

At the site visit, it was reported that (as noted above), the resident did contact the police department and that they responded to the call. It was stated that the police department is very familiar with the residents since calls are frequently made to them. It was stated that typically when a call is made, the police will contact the facility about the call before an officer is sent to the site. It was also stated that the facility has two pay telephones for personal use and that the resident identified in this investigation has a cellular telephone. The facility does not and cannot prevent a resident from contacting the police, but the residents are educated about the appropriate means for police involvement. It was also offered that there was a strong suspicion that the theft of the papers may not have occurred, but may have been a manipulation or “story” for the resident's lawyer, who was assisting the resident with a disability claim. The Administrator stated that she had offered to get the resident copies of the needed materials if the resident provided the sources and signed a release-which he did not. While touring the facility, the HRA noted that the rooms contained one dresser drawer that could be locked.

The facility's House Rules and Behavioral Expectations document (given to each resident upon admission) states that the facility is not responsible for valuables. Residents are encouraged not to keep any valuables in the facility. It is the resident's responsibility to request a lock for personal items.

In addressing the abuse assertion, the Director of Social Services explained that this resident was very demanding, hyperverbal, and intrusive. He wanted immediate resolutions to his concerns and would not take no for an answer. It was stated that he would (for example) often enter the

Director's office and not leave until the door was closed while the resident remained on the other side of the door. The Director stated (and the record confirms) that when the resident would be made to leave an office in such a manner, the resident would remain on the opposite side of the door claiming abusive behavior by the Director. The Director believed that the resident interpreted the advice and limit-setting by himself as abusive; there were no reportable incidents.

The facility's Abuse Prevention Policy states that each resident has the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This will be done by conducting pre-employment screening of employees, orienting and training employees on how to deal with stress and difficult situations and how to recognize and report occurrences of mistreatment, neglect and abuse; establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; identifying occurrences and patterns of potential mistreatment; immediately protecting residents involved in identified reports of possible abuse; implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively and making the necessary changes to prevent future occurrences; and filing accurate and timely investigative reports.

The HRA requested and met with the President of the Resident Council. This gentleman, who has lived at the facility for about 2 ½ years and has been President of the Council for about two years, stated that staff members are respectful of the residents. He stated that theft can be a problem and residents know to report all problems to the staff. He stated that unfortunately, the thief must be caught red-handed and often this is difficult. He stated that the residents call the police frequently and the police are exasperated with the number of calls - he stated that "The police know us very well; it's always the same officers."

Conclusion

Pursuant to the Nursing Home Care Act (210 ILCS) Section 2-108, "Every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or visitation." Section 2-107 states that, "An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident." Section 2-103 states that "A resident shall be permitted to retain and use or wear his personal property in his immediate living quarters, unless deemed medically inappropriate by a physician and so documented in the resident's clinical record. If clothing is provided to the resident by the facility, it shall be of a proper fit. The facility shall provide adequate storage space for the personal property of the resident. The facility shall provide a means of safeguarding small items of value for its residents in their rooms or in any other part of the facility so long as the residents have daily access to such valuables. The facility shall make reasonable efforts to prevent loss and theft of residents' property. Those efforts shall be appropriate to the particular facility and may include, but are not limited to, staff training and monitoring, labeling property, and frequent property inventories. The facility shall develop procedures for investigating complaints concerning theft of residents' property and shall promptly investigate all such complaints."

Based on the written and verbal information obtained, the Authority finds no violations of the above cited Sections of the Nursing Home Care Act.