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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT #12-030-9006
Presidential Pavilion

Case Summary: The HRA did not substantiate the complaint that the facility did not follow Code requirements when it hospitalized a resident for no adequate reason and denied him his pass for no adequate reason.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Presidential Pavilion. It was alleged that the facility did not follow requirements when it hospitalized a resident for no adequate reason and denied him his pass for no adequate reason. If substantiated, this would violate the Nursing Home Care Act (210 ILCS 45), the Mental Health and Developmental Disabilities Code (405 ILCS 5), and the Code of Federal Regulation, Requirements for Long Term Care Facilities (42 C.F.R. 483).

Presidential Pavilion is a 328-bed Intermediate and Skilled Nursing Home located in Chicago. Approximately 240 residents have a mental health diagnosis.

To review this complaint, the HRA conducted a site visit and interviewed the Presidential Pavilion Administrative Designee/Nursing Supervisor and the Director of Nursing. Relevant facility policies were reviewed, and records were obtained with the consent of the recipient.

COMPLAINT SUMMARY

The complaint states that on 8/12/11 the resident (a 63 year old man) was outside the Presidential Pavilion building when a gang member assaulted him, tackled him to the ground, kicked him, and stole his money. The event was witnessed by passersby who called the police and they arrested the assailant. The police wanted the recipient to go to the police station but he said he was too upset to go with the police, and he returned inside the building with police where he notified the Presidential Pavilion security staff of the event. The complaint indicates that the recipient approached the Presidential Pavilion on-duty nurse and she stated, "I'm gonna take your pass- you can't take care of yourself." Allegedly, when the recipient screamed that it wasn't his fault that he was assaulted the nurse stated, "You're too much trouble" and had him hospitalized for 8 days for no reason. When his sister called the facility to inquire about the recipient, she was told he was sent to the hospital because he was having breathing problems.

FINDINGS

The record in this case indicates that the recipient was admitted to Presidential Pavilion on 12/21/09 for this period (more than 5 years for previous residencies). His diagnoses include: Asthma, Major Depression, Degenerative Joint Disease, Chronic Obstructive Pulmonary Disease, and Eczema. The HRA received Nurse's Progress Notes for the period of 4/28/11 through 8/12/11 and Social Service Progress Notes from the period of 9/09/11 through 10/20/11. These records indicate that the recipient was cooperative, compliant with medication and generally spent his days away from Presidential Pavilion on pass and his time spent in the facility was generally unremarkable except for the event which took place on 8/12/11.

An entry in the Nurse's Notes for 8/12/11 at 5:00 p.m. states, "Resident severely agitated, paranoid, suspicious, and very hostile towards staff and others. Moody, irritable, non-redirectable, uncooperative, non-compliant with medication. Angry with everyone. Dr. … was called. Gave orders to transfer Resident to …Hospital for psych evaluation." Another entry on the same day at 5:30 p.m. states, "Lifeline Ambulance was called gave Eta 45 mins. No family listed with phone # information given to social services No notify." Another entry on the same day at 6:30 p.m. states, "Lifeline Ambulance present 2 attendant assisted Resident to …Hospital for psych Evaluation. All Deps Notified Meds placed on Hold. Personal belongings placed in storage." The only other mention of the event was made on 9/23/11 by the recipient's social worker: "[Resident] was sent to …Hospital on 8/12/11 for a psych evaluation and returned on 8/20/11 in good condition. He maintains a pass @ the discretion of the supervisor. Res is compliant with group/program, he is med compliant, and receive small cues for grooming. At this time, res. States that he has no plan for discharge. Potential will be reviewed next quarter."

The record contains a Petition for Involuntary Admission completed on 8/12/11 at 5:00 p.m. by the RN on duty at the time of the event. The signs and symptoms of mental illness displayed by the recipient are described as follows: "Resident severely agitated. Paranoid, suspicious, and very hostile toward staff and others. Uncooperative, aggressive verbal and physical. Throwing walking cane around. Resident in need of immediate hospitalization." The petition includes two Licensed Practical Nurses and a Registered Nurse as witnesses, and indicates that the recipient has been given rights information.

The record contains a Victim Information Notice completed by the Police Department. The incident on this form is described as a Strong Arm Robbery and concurs in time and place with the complaint.

FACILITY REPRESENTATIVES' RESPONSE

Facility representatives were interviewed about the complaint. The Nursing Supervisor at the time of the event stated that she had no knowledge of the resident having been assaulted outside the building. She stated that had she known of this event she would have initiated an Incident Report and investigated the event, which she did not. The Nursing Supervisor stated that she reviewed the record for the site visit and she was only aware that the recipient had been hospitalized for a "psych admission" which would not warrant a report or investigation. The

Nursing Supervisor was asked if a resident who has lived at the facility a number of years without any problem is abruptly "uncooperative", "paranoid" and "suspicious" and then subsequently hospitalized, would the situation warrant an investigation and she stated that psychiatric hospitalizations are fairly common at the facility and do not warrant scrutiny. She stated that she was not on duty at the time of this event and was not informed of any situation like this one having occurred- she stated that the site visit was the first time this event had been brought to her attention. She stated that it would have been the responsibility of the Director of Nursing to apprise her of this event if it did happen, and she questioned whether the assault occurred outside the building, noting that she would not be obligated to complete a report if the assault occurred off the premises.

Facility representatives did not know if a report was generated by the Presidential Pavilion building security of the event, but they did not think one was completed.

The Director of Nursing was also interviewed about the complaint. She stated that she did remember that the recipient was assaulted, and she remembered that the police came inside the building. She stated that she did not think the event took place on the facility premises, and thus she did not report it to her supervisor. She stated that the recipient had been sent to the hospital on a petition for involuntary commitment and had remained there for 8 days however she had no information regarding the events which led up to this decision. The Director of Nursing denied that she told the recipient his pass privileges would be curtailed and reminded the HRA that all outside passes are suspended for 10 days after a resident is hospitalized, until the treatment team is certain that the resident has adjusted to their new treatment regimen and is stable. She felt that the recipient may have misinterpreted this to mean that his pass was revoked because of his assault.

STATUTES

The Nursing Home Care Act states that no resident shall be deprived of any rights, benefits or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States "solely on account of his status as a resident of a facility" (210 ILCS 45/2-101). The Act also states that, "Each resident and resident's guardian or other person acting for the resident shall be given a written explanation, prepared by the Office of the State Long Term Care Ombudsman, of all the rights enumerated in Part 1 of this article and Part 4 of Article III" (45/2-211).

Additionally, the Nursing Home Care Act states that every resident "shall be permitted to refuse medical treatment and to know the consequences of such action, unless such refusal would be harmful to the health and safety of others and such harm is documented by a physician in the resident's clinical record" (45/2-104 c).

The Nursing Home Care Act states that a facility may involuntarily transfer or discharge a resident only for one or more of the following reasons:

1. for medical reasons;
2. for the resident's physical safety;

3. for the physical safety of the other residents, staff or visitors;
4. for late payment or nonpayment for the resident's stay (210 ILCS 45/3-401).

Federal regulation also limits the use of transfer and discharge and mandates the documentation of this information in the resident's file:

a) Transfer and discharge--

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--

(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) The safety of individuals in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--

(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. (42 C.F.R. 483.12).

The Mental Health and Developmental Disabilities Code outlines the process whereby a person 18 years of age or older who is subject to involuntary admission and in need of immediate hospitalization may be admitted to a mental health facility (405 ILCS 5/3-600 et seq.). This process requires a detailed statement of the reason for the assertion that the recipient is in need of

involuntary admission, the signs and symptoms of mental illness, and a description of any acts, threats, or behaviors supporting the assertion (3-601).

FACILITY POLICY

Presidential Pavilion provided the facility policy on Refusal of Medication. It states, "With respect to PRN [as needed] medications ordered by the physician, if the resident refuses the PRN, such refusal shall be noted on the MAR. In addition, the Physician shall be notified if the resident manifests behaviors."

Presidential Pavilion provided their policy for Involuntary Admission by Certification which complies with all Mental Health Code requirements for Involuntary admission/Immediate hospitalization, requiring a petition which provides a detailed description of the reason for the assertion that the is in need of involuntary admission, the signs and symptoms of mental illness, and a description of any acts, threats, or behaviors supporting the assertion.

Presidential Pavilion provided the facility policy on Outside Passes. Newly admitted residents are assessed for cognitive status, their degree and severity of mental and/or physical illness, addictive history and present addictive behaviors, community safety skills, ability to follow rules and procedures, and their maintenance of personal grooming and hygiene. The policy states, "Decisions regarding pass privileges, including independent privileges or being accompanied by a responsible individual are at the discretion of administration. As appropriate, pass privileges may be discussed at care plan meetings which the resident is encouraged to attend. The resident is responsible for making staff aware of his/her desire to receive an independent pass privilege." Additionally, "Persons who demonstrate consistent maladaptive and problematic behaviors may not be candidates for independent privileges."

Presidential Pavilion provided the Resident Behavior Contract that the recipient in this case signed upon admission. It states, "I understand that taking my medication as prescribed on a daily basis is necessary to regain my stability, and that failure to do so will immediately warrant a recommendation to a more secure facility. In fact, I promise that while I am a resident of this facility, I will comply with my overall treatment plan as established by me, personally and the health care team. Consequences established for non-compliance with this admission contract will be at the discretion of the Administrator, Physician, and Interdisciplinary Team Members, and ARE VERY LIKELY TO RESULT IN IMMEDIATE TRANSFER FOR ACUTE PSYCHIATRIC CARE" (caps provided).

CONCLUSION

It is difficult to determine from the record what happened to the recipient on 8/12/11. The recipient, who had lived successfully at the facility for numerous years, was on that date described as, "Moody, irritable, non-redirectable, uncooperative, non-compliant with medication. Angry with everyone." The record does not mention that the recipient had been assaulted outside of the building, kicked and then robbed at approximately 2:00 p.m. that day. Although there is documentation that the Police Department arrested the assailant and assisted the recipient

back into Presidential Pavilion, and staff acknowledge that they saw the police return with the recipient into the building, there is no mention of it in the record, and there was no Incident Report or investigation of the event. What is more disturbing to the HRA is that the Presidential Pavilion representatives were unable to discuss anything that happened surrounding the event. It seems by documentation and previous history that the recipient's negative behaviors that day were exacerbated by the lack of attention paid to him after he was attacked. Although we contend that there should have been a documented attempt to help the man cope, the petition nonetheless asserts that he was "very hostile to staff and others…throwing cane around…aggressive physical" which is an observed assertion for his involuntary psychiatric evaluation. The HRA does not substantiate the complaint that Presidential Pavilion hospitalized a resident for no adequate reason.

The clinical record in this case does not show that the recipient's passes were affected by his involuntary hospitalization, and staff report that passes are postponed after hospitalization pending the decision of the treatment team. The HRA does not substantiate that Presidential Pavilion denied the recipient his pass for no adequate reason.

SUGGESTION

1. Attempt to work with residents whose behaviors may be escalating instead of immediately hospitalizing them. All attempts at least restrictive means of counseling and intervention must be documented.

2. The HRA cautions the facility that its Resident Behavior Contract suggests that refusing medication alone warrants an immediate transfer for acute psychiatric care, when in fact residents always have the right to refuse treatment, including medication.