FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT #12-030-9007
Sheridan Shores Care and Rehabilitation

Case Summary: The HRA did not substantiate the complaint that the facility did not follow Nursing Home Care Act requirements when it hospitalized the recipient before her hearing on appeal against involuntary discharge, administered forced medication for no adequate reason, and did not allow the recipient to go on 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 Sheridan Shores Care and Rehabilitation (Sheridan Shores). It was alleged that the facility did not follow Nursing Home Care Act requirements when it hospitalized the recipient before her hearing on appeal against involuntary discharge, administered forced medication for no adequate reason, and did not allow the recipient to go on pass for no adequate reason. If substantiated, this would violate the Nursing Home Care Act (210 ILCS 45 et seq.) and facility policy.

Sheridan Shores is a 191-bed skilled nursing and psychiatric rehabilitation facility located in Chicago.

To review this complaint, the HRA conducted a site visit and interviewed the Attorney for Sheridan Shores, the facility Administrator and the Psychosocial Rehabilitation Services Director (PRSD). Relevant facility policies were reviewed, and records were obtained with the consent of the recipient.

FINDINGS

The record indicates that the recipient was admitted to Sheridan Shores on 6/21/11. On 9/27/11 social services progress notes indicate that the recipient had been smoking in her room: "PRSC [Psychosocial Rehabilitation Services Coordinator] notified by 4th floor nurse resident had been smoking in her room. PRSC conducted a room search in [recipient's] room and confiscated all smoking materials. PRSC educated [the recipient] on the dangers of attaining cigarettes, lighters, matches, etc. PRSC continued to explain resident smoking only allowed

during supervised scheduled times. PRSC provided resident with a letter indicating a last warning for her behavior. In the event [the recipient] smokes in an unsupervised area, the resident will be issued an involuntary 30 day discharge/transfer. [The recipient] displayed agitation and denied smoking in her room. PRSC redirected the resident and explained the importance of complying with the facility's policies. SS [social services] will continue to meet with resident and inspect her room as needed to ensure no smoking materials are in her room or on her."

The record indicates that the facility issued 30-minute observation checks of the recipient, then 30-minute room checks, and revised the allowed smoking times for the recipient (for periods at night when the recipient could not sleep and requested smoking). An assessment of the recipient's smoking practices was completed on 9/27/11 and reassessed on 10/26/11.

The record contains the letter of warning issued to the recipient on 9/27/11: "This letter is to serve as a final warning that continued violations of Sheridan Shores' smoking policy, specifically smoking in your room and holding smoking materials on your person or in your room, will result in the facility beginning 30-day Involuntary Transfer and Discharge proceedings against you. Staff has repeatedly educated you regarding both facility policy, as well as the myriad risks this behavior poses to yourself and other residents, yet the violations continue. This comes in spite of your verbal agreement to comply with the policy, and your expressed understanding of the dangers of being in possession of smoking materials, and that your behaviors place others, as well as yourself, at risk. We hope this letter will accomplish what our other interventions could not, and prevent us from having to take drastic action to ensure the safety of all our residents."

The record shows that on 10/01/11 at 9:30 a.m. the recipient was caught smoking in an unauthorized area. Progress Notes indicate that staff considered having the recipient hospitalized for a psychiatric evaluation due to the recipient's increased agitation and continued smoking, however a bed was not readily available. On this day the facility also issued the Notice of Involuntary Transfer or Discharge and Opportunity for Hearing. The reason for the proposed transfer indicates the resident's "welfare and needs cannot be met in this facility, as documented in your clinical record by your physician" and "the safety of individuals in this facility is endangered." The Notice document contains the recipient's rights to appeal the transfer decision. It indicates that if the resident feels she should not leave the facility, she may file a Request for a Hearing with the Illinois Department of Public Health (IDPH) within 10 days after receiving the Notice. It also states that if the recipient requests a hearing, it will be held not later than 10 days after the request and the recipient will not be transferred or discharged during that time. The record shows that the Request for Hearing was completed by the facility and was not completed by the recipient.

Social service progress notes for 10/15/11 state, "PRSC conducted room/body search due to continuous inappropriate smoking behavior. PRSC found cigarettes in the resident's possession. [Recipient] was compliant with allowing PRSC to confiscate smoking materials. PRSC continued to educate the resident on the danger and hazards of keeping smoking materials on her. [The recipient] stated, "Yeah, yeah, I already know the facility's policies. I just don't care because I am a safe smoker…."

The record contains a statement made by the Executive Director that also on 10/26/11 the PRSC had assisted the recipient in contacting IDPH regarding her appeal. The Director indicates in this note that the IDPH representative stated that the recipient's appeal had not been received within the mandated timeframe.

The record shows that on 10/26/11 the recipient again smoked in her room: "PRSC met with [recipient] per resident's request in her room. [Recipient] presented as agitated and verbally aggressive towards PRSC. PRSC observed resident's room smelling like smoke. A room and body search was conducted to ensure resident did not have any smoking materials on her. PRSC found a cigarette on the resident that had been lit. The cigarette contained a strong smell as if it was recently lit. PRSC confiscated the smoking material…." At 9:27 p.m. nursing notes indicate that the recipient was "very aggressive, shouting at the top of her voice, trying to walk over staff and residents with her walker…." An entry made at 8:10 p.m. indicates that the recipient was hospitalized: "Resident transferred to … by two MEDEX paramedics for psyche evaluation per doctor…. All due meds given with no adverse reaction noted prior to leaving. Vitals within normal range. Writer spoke to one of her emergency contacts about her transfer…"

Social Services notes entered by the PRSD the same day state, "PRSD completed resident chart review and [recipient's] Smoking Risk Observation was re-assessed due to inaccurate information noted in previous assessment. [Recipient] was assessed to be an unsafe smoker due to her repeated failure to comply with the facility's smoking policy and procedure…."

The record contains a petition for involuntary admission completed 10/26/11 by the PRSC for the following reason: "[Recipient] is in need of immediate hospitalization for psychiatric evaluation due to an increase in agitation, lack of impulse control, and poor decision making. [Recipient] also exhibited inappropriate and unsafe smoking behaviors and continues to violate the facility's smoking policy. [Recipient] is also verbally aggressive toward staff and peers. [Recipient] is resistant to staff intervention and re-direction. [Recipient] may be a potential threat to others and herself due to the behaviors listed above."

The progress notes indicate that the recipient received injected psychotropic medication on the following dates and for the following reasons:

1. 9/19/11 "res came back from appt agitated. res was asked if the hospital gave any paperwork. She calling nursing staff stupid and started screaming stating to leave her alone. res became verbally abusive to staff and residents. res was ask [sic] to go to her room and calm down. res refuse [sic] and stated she would pulled down her pants in front of staff and residents. res was ask not to do that. res was ask to go to her room again she refuse and cont to scream at staff about asking her about her appt. she stated it isn't your business. res was offered a prn [as needed medication] to calm down. Ativan 2 mg given im [intramuscularly]."

2. 9/29/11 "PRSC met with resident for follow up concerning resident's continuous behavior of smoking in unauthorized areas. [Recipient] presented as alert and agitated when she informed this staff that she had been given a prn and would be sleeping soon…."

3. 10/02/11 "IDT [interdisciplinary team] determined that [recipient] will be issued an Involuntary Transfer and Discharge Notice due to her unsafe smoking behaviors. PRSC served the notice to [the recipient] at the facility and explained the notice, the reasons behind the decision, and the appeals process to [the recipient], who indicated her understanding verbally. [Recipient] was provided a copy of the notice, an appeal form, and a pre-addressed, pre- postage paid envelope should she decide to exercise her right to appeal. After discussing information regarding 30 day with [recipient], she stated, 'Well, I am just gonna appeal it out of spite now. I don't care. I know I have stuff on me and I know I'm a safe smoker. I can smoke upstairs.' A copy was placed in her chart, and additional copies were mailed certified and with a return receipt to the local Ombudsman and IDPH. [Recipient] continues to exhibit increase in aggressive behavior, PRSC and nursing supervisor escorted [recipient] her floor where she received a PRN…."

4. 10/23/11 "Resident was verbally abusive and agitated, calling police every now and then. She was on some residents face yelling on top of her voice, writer tried redirecting her but up to no avail. She was given PRN IM in the left gluteal maximus"

5. 10/24/11 "Resident remains on 30 minutes room check. Resident has been aggressive PRN IM given, no reaction noted…."

6. 10/26/11 "Resident received very aggressive, shouting on top of her voice, trying to walk over staff and resident with her walker, redirect resident by talking to her, and she is now calm, will cont to monitor closely."

The clinical record contains the recipient's signed informed consent for all scheduled and prn medication.

The record contains no indication that the recipient's pass privilege was restricted.

FACILITY REPRESENTATIVES' RESPONSE

Facility staff were interviewed regarding the complaint. They stated that the recipient had been educated about the rules for not smoking in the building and not having smoking materials on her or in her room, however she believed she was a safe smoker and that the rules did not apply to her. They indicated that the facility has smoking periods throughout the day and in the case of this recipient she was given the privilege of smoking at night in case she awoke and could not sleep, however she continued with smoking in the building. Staff stated that some residents may be on oxygen or their medication may cause drowsiness all of which makes smoking extremely dangerous. On 9/27/11 the recipient was issued a final warning regarding the smoking, and when she was caught smoking on 10/01/11, she was given her Notice for Discharge and appeal. Staff stated that the record shows that the recipient was not hospitalized until 10/26/11, so she had ample time in which to file her appeal, and this process was reviewed by both the hospital Ombudsman and IDPH, who all agreed that she had not complied with the stated timeframe.

Staff were asked about forced psychotropic medication. They stated that the recipient never refused prn medication, even if it was administered through injection. The facility administrator stated that the facility never gives forced medication of any kind- if scheduled medication is refused it is not given, and if a recipient's behavior becomes dangerous and they refuse medication, then the police would be called and the recipient would be hospitalized- there is never a reason to force medication.

Staff were asked about the recipient's pass. The administrator stated that the residents have the Community Access Assessment completed within 48 hours of their admission. In this case the recipient was evaluated and she was not ready for complete community access, meaning she required staff accompaniment (she required a walker and exhibited some behavior problems such as exposing herself in public). Staff stated that they never took any privileges away from the recipient- she was never confined in any way and always had someone to accompany her when she wanted to go out in the community. Staff also noted that she had a staff member from another counseling agency who accompanied her on passes, as well as family members.

STATUTORY BASIS

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).

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 Nursing Home Care Act requires that the Notice issued pursuant to an involuntary discharge include the reason for the proposed transfer or discharge, the effective date of the proposed transfer or discharge, and a statement of the right to appeal the transfer. It states, "You have the right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may file a request for a hearing with the Department of Public Health within 10 days after receiving this notice. If you request a hearing, it will be held not later then 10 days after your request, and you generally will not be transferred or discharged during that time…." A hearing request form, together with a postage-paid, pre-addressed envelope to the IDPH, and the name, address, and phone number of the person responsible for the transfer or discharge is to be included with the Notice.

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).

FACILITY POLICY

Sheridan Shores provided the facility policy regarding resident discharge and it complies with all Nursing Home Care Act mandates.

Sheridan Shores provided the facility policy regarding the use of antipsychotic medication. It states that residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. For acute psychiatric situations, antipsychotic medication must meet the following criteria:

a. The acute treatment period is limited to seven days or less;
b Interdisciplinary team must evaluate and document the situation, to identify and address any contributing or underlying causes of the acute psychiatric condition and verify the continuing need for antipsychotic medication; and
c. Pertinent non-pharmacological interventions must be attempted, unless contraindicated, and documented following the resolution of the acute psychiatric situation.

Sheridan Shores provided the facility policy regarding the residents' passes in the community. It states that a Community Access Assessment is completed within 48 hours of the resident's admission. A physician's order must be obtained when placing a resident on restriction for longer than 23 hours, and restriction orders must specify whether or not the resident is allowed to access the community with supervision. The policy states that residents may be placed on a restriction without a physician's order for no more than 23 hours if the resident is exhibiting an unsafe condition that staff feel compromises the resident's ability to safely access the community (such as intoxication, psychotic episode, or medication side effects). If the unsafe condition continues beyond the 23 hours, the doctor must be informed and an order for restriction obtained. If a resident's pass is restricted, the resident must be informed of the reason for the restriction, and they must be informed of the treatment plan interventions necessary for them to regain their community access. The Community Access Assessment is completed annually, and restricted resident's community access must be reviewed at their quarterly care plan conference and as needed.

CONCLUSION

The record shows that the recipient was issued a Notice of Involuntary Transfer or Discharge and Opportunity for Hearing on 10/01/11 along with the required pre-addressed and postage-paid envelope in which to submit it to IDPH. The recipient was then hospitalized, but not until 10/26/11, which was well beyond the required 10 days that she had to submit her request for a hearing. The record also indicates that the recipient was offered, and then accepted her prn medication, even at those times when it was given intramuscularly. And finally, the record does not show that the recipient had her community access restricted, although she required accompaniment. The HRA does not substantiate the complaint that the facility did not follow Nursing Home Care Act requirements when it hospitalized the recipient before her hearing on appeal against involuntary discharge, administered forced medication for no adequate reason, and did not allow the recipient to go on pass for no adequate reason.

SUGGESTION

1. The HRA suggests that the facility indicate in the record each time that injected prn medication is accepted by the recipient so that it is clear that the right to refuse medication has not been denied.
2. When residents have smoking issues/behaviors, address this in resident care plans.