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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 13-030-9007
Cedar Point Rehabilitation and Nursing Center

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Cedar Point Rehabilitation and Nursing Center (Cedar Point). It was alleged that the facility did not follow Nursing Home Care Act requirements when it did not investigate the injury of one of the facility residents. If substantiated, this would violate the Nursing Home Care Act (210 ILCS 45), the Illinois Probate Act (755 ILCS) and the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30).

Cedar Point is a 600-bed rehabilitation and nursing facility located in Cicero, IL.

To review these complaints, the HRA conducted a site visit and interviewed the Administrator, the Director of Nursing, the Assistant Director of Nursing, and a Staff Registered Nurse. Program policies were reviewed as were the adult recipient's records upon written request, as well as the guardian's Letter of Office.

COMPLAINT SUMMARY

The complaint indicates that on Tuesday, December 11, 2012 the resident's guardian received a phone call from the nurse on duty who reported that her sister had fallen out of bed and was sent to the hospital with injuries. When the guardian asked what had happened the nurse did not know what had happened or how long the resident had been on the floor. The resident cannot walk and has difficulty moving, so the guardian requested, but did not receive, results from the subsequent investigation by the facility on how the accident happened. The resident has had an aneurism in the past which placed her in a coma so the guardian is very careful of any blows to her sister's head. To date, the guardian has not received any report of the investigation or any follow-up to the incident. The guardian filed a complaint with the Illinois Department of Public Health, who also investigated the incident which resulted in no findings.

FINDINGS

The HRA requested all nursing/social/psychiatric progress notes as well as any related incident reports or investigations regarding the resident's fall. The HRA received four pages of notes from the record. The Nursing Notes for 12/11/12 at 8:00 a.m. state, "While doing rounds, [resident] was noted on the floor. She stated that she hit her head. [Resident] was left on the floor with her head and neck supported. A head to toe assessment was completed, and …[vital signs given]. The family and Dr… were made aware, and orders to send her to [hospital]. Med Ex's ETA is thirty minutes and report called to [hospital ER Nurse]." The next entry made at 8:55 a.m. indicates that the resident left the facility in no apparent distress. At 6:01 p.m. another nursing note is entered. It states, "[Resident] returned from [hospital] with orders for Levequin 500 milligrams per gastric tube daily for five days. Urinary tract infection. [Vitals given]. …remains in no apparent distress." An entry made at 6:27 p.m states, "…Resident returned from [hospital] with no injury from fall. Resident in bed resting no further attempts to get out of bed. Resident bed in low position, wedge cushion in place. Will continue to monitor."

At the site visit for this case the HRA requested and received the Incident Report packet for this event. The Incident Report indicates that the event is a resident's fall with no injury and it is initiated on 12/11/12 with a revision date of 3/21/13. The Nursing Description states, "During rounds [resident] was noted on the floor of her room." The Resident Description states, "[Resident] stated that she was trying to go home." The report indicates that the resident suffered no injuries and that she was not taken to the hospital. On page two of the report it states that the resident is "alert" and her mobility is described as "Ambulatory without staff assistance." It also indicates Mental Status, Predisposing Environmental Factors, Predisposing Physiological Factors, and Predisposing Situational Factors, however several of these categories are not completed. The packet also contains the Staff Immediate Post Incident Statement form completed by the Charge Nurse and it indicates that the event was not witnessed and that the resident hit her head and was examined, her guardian and physician were notified, and that she was sent to an ER. The packet also contains a Fall Occurrence Investigation form and an amended Care Plan to address falls. The packet does not indicate which staff members were interviewed about the event, when they were interviewed, or what their statements were regarding the event.

Facility Representatives' Response

The HRA interviewed staff regarding the complaint. They indicated that the recipient is unable to ambulate on her own without staff assistance. One of the resident's arms is contracted and she is fed through a gastric tube. Staff indicated that the resident is unable to follow a conversation, however she is able to answer some questions, and generally responds to people's energy level, even singing at times to her favorite music. Although she is not able to sit upright, the resident can move her legs somewhat, and she could have swung her legs enough that they moved off the bed, thus pulling her to the floor. Staff indicated that side rails are considered restraints and are not used except as "enablers", or to allow residents to position, elevate or get out of bed. Staff indicated that after the event the resident vocalized that she was trying to go home at the time of the fall. Immediately upon finding the resident on the floor an assessment was conducted by the nursing staff and although there was no apparent injury, the resident was sent to a hospital for evaluation. The hospital visit confirmed that there was no injury and the

resident returned to the facility without follow-up for anything related to the fall. Facility staff were asked if the incident was reported to the Illinois Department of Public Health (IDPH) and they stated that the incident was not deemed a reportable incident because it did not result in injuries. The resident was sent to the hospital for evaluation and returned immediately. The staff members indicated that facility staff would only report incidents that incur injuries or where hospitalization is needed. They also reported that the guardian reported the incident to IDPH (this was confirmed by the HRA) and that representatives came to the facility and questioned staff, however there was no finding of deficiency.

Staff were interviewed regarding the investigation of the event. The floor supervisor stated that she completes the follow-up for all incidents and she indicated that whenever something happens or something is brought to staff attention, it is investigated. An Incident Report is initiated immediately, and for falls specifically, a checklist reminds staff of all the considerations for causes of the fall and a Care Plan is developed for preventing falls going forward, which was done in this case. Staff indicated that training is provided for reporting and handling falls and this training is offered when staff are first hired and then two to three times yearly. Although staff indicated that they called the resident's guardian immediately after the incident, there is no indication that she was contacted with the results of the staff investigation. Staff stated that it is not the practice or policy of Long Term Care Facilities to notify family of the results from each incident investigation if there are no significant injuries or negative outcomes. This would be discussed in the Care Plan conference that is held at the facility with the interdisciplinary team in conjunction with the resident and his/her family. Staff also indicated that if the guardian wants the Incident Report packet, she would have to request the record in writing and the facility would provide it.

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 Nursing Home Care Act defines "Neglect" as, "A facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident" (210 ILCS 45/1-117).

The Nursing Home Care Act defines restraint as "any manual method or physical or mechanical device, material, or equipment attached to or adjacent to a resident's body that the resident cannot remove easily and restricts freedom of movement or normal access to one's body. Devices used for positioning, including but not limited to bed rails, gait belts, and cushions, shall not be considered to be restraints…" (210 ILCS 45/2-106).

The Abused and Neglected Long Term Care Facility Residents Reporting Act mandates that any employee of a long term care facility that has reasonable cause to believe any resident with whom they have direct contact has been subjected to abuse or neglect "shall immediately

report or cause a report to be made to the Illinois Department of Public Health", and anyone required under the Act to report abuse or neglect who fails to do so is guilty of a Class A misdemeanor. The Act states:

"All reports of suspected abuse or neglect …shall be made immediately by telephone to the Department's central register …or in person or by telephone through the nearest Department office. No long term care facility administrator, agent, or employee, or any other person shall screen reports or otherwise withhold any reports from the Department, and no long term care facility…shall establish any rules, criteria, standards or guidelines to the contrary.

….The report required by this Act shall include the name of the resident, the name and address of the nursing home at which the resident resides; the resident's age; the nature of the resident's condition including any evidence of previous injuries or disabilities, and any other information that the reporter believes might be helpful in establishing the cause of such abuse or neglect and the identity of the person believed to have caused such abuse or neglect."

The Illinois Probate Act of 1975 defines the duties of the guardian:

"To the extent ordered by the court and under the direction of the court, the guardian of the person shall have custody of the ward and the ward's minor and adult dependent children; shall procure for them and shall make provision for their support, care, comfort, health, education and maintenance, and professional services as are appropriate….The guardian shall assist the ward in the development of maximum self-reliance and independence." (755 ILCS 5/11a-17a).

Also, the Probate Act gives direction to providers to rely on guardian decision making:

"Every health care provider…has the right to rely on any decision or direction made by the guardian….to the same extent and with the same effect as though the decision or direction had been made or given by the ward." (755 ILCS 5/11a-23).

The Nursing Home Care Act states that "Every resident, resident's guardian, or parent if the resident is a minor shall be permitted to inspect and copy all his clinical and other records concerning his care and maintenance kept by the facility or by his physician. The facility may charge a reasonable fee for duplication of a record" (210 ILCS 45/2-104 d).

HOSPITAL POLICY

Cedar Point provided their policy and procedure for responding to falls. It addresses falls "Observed or unobserved and reported by staff member. Licensed nurse should conduct assessment immediately, including events leading up to the fall to determine when possible [sic] and causative factors." The procedure requires immediate assessment of the resident's overall condition, respiratory difficulties, bleeding and fractures as well as immediate notification of an ambulance, the resident's physician, and family.

Cedar Point provided their policy and procedure for Accident/Incident Reporting. It states that an accident is "an unexpected, unintended event that can cause a resident bodily

harm." An incident is "an event out of the ordinary which happens to or involves a resident. This may include but is not limited to medication errors, drug reactions, and all situations requiring the emergency services of a physician, hospital, police, or fire department." The policy indicates that when accidents/incidents occur the nurse in charge shall immediately respond and provide immediate nursing intervention, including arranging for emergency services. After the immediate situation is resolved the nursing supervisor is notified and an accident/incident form is completed. At this time the resident's family is notified along with the attending physician. Additionally, the policy states that "Accidents or incidents requiring the intervention of the police or fire department, or the services of a physician or hospital emergency room must be reported to IDPH within 24 hours and a written follow up within seven days by mail or fax." The facility is mandated to notify IDPH of any incident or accident which has or is likely to have a significant effect on the health, safety or welfare of a resident or residents. Also, the facility must maintain a file of all written reports of serious accidents or incidents involving residents.

CONCLUSION

The record in this case indicates that facility staff initiated a preliminary assessment of the resident's fall on the day that it occurred. Staff determined that the resident required an evaluation in an emergency department and she was assessed and returned to the facility without injury. It is not clear where the investigation proceeded from that point. There is no record of the staff persons who were interviewed regarding the event, when they were interviewed, or what their assessments were of the situation. When the HRA asked about the use of bed rails for the resident, a simple remedy for the threat of falling from the bed, the staff indicated that bed rails are not used because they are considered restraints, which the Nursing Home Care Act specifically indicates are not restraints. Additionally, although the event clearly meets the reporting requirement of the facility's own policy on incidents and accidents, including services of an emergency room, it was not reported to the IDPH within 24 hours.

The Probate Act gives guardians the right to make provisions for their ward's care, comfort, health and maintenance to such an extent that health care providers are directed to rely on the decisions and directions of the guardian to the same extent and with the same affect as though the decisions were made or given by the ward. The guardian in this case requested information from the facility investigation to make determinations regarding the resident's fall because she did not understand how her sister could have fallen when she cannot move herself out of bed (such as why the bed rails were not up and whether they need to be going forward). She was not given this information at any point and thus has not been able to assess how the accident occurred or how to prevent it in the future. Her concern was great enough to cause her to contact the IDPH, which should have indicated to staff the seriousness of her inquiry. At the time of this writing the guardian has not received the results of the staff investigation, and this deprives the resident of very valuable and perhaps life-saving advocacy. Although the Act provides all record access to guardians without stipulation of it having to be in writing, the facility could have simply asked for the guardian's signature at the time she made the request.

The HRA substantiates the complaint that the facility did not follow Nursing Home Care Act requirements when it did not investigate the injury of one of the facility residents.

RECOMMENDATION

1. Train staff in the Abused and Neglected Long Term Care Facility Residents Reporting Act guidelines for the reporting of any incident where staff "has reasonable cause to believe that a resident with whom they have direct contact has been subjected to abuse or neglect."

2. Train staff in the facility policy that states that "All accidents or incidents requiring the intervention of the police or fire department, or the services of a physician or hospital emergency room must be reported to IDPH within 24 hours and a written follow up within seven days by mail or fax." Also, train staff in the facility policy which mandates that staff notify IDPH of any incident or accident which has or is likely to have a significant effect on the health, safety or welfare of a resident or residents.

3. Train staff to make every effort to provide guardians with the information they request in order for them to provide for their ward's care, comfort, health and maintenance, especially regarding unusual events. Train staff in the rights of guardians.

SUGGESTIONS

1. The Incident Report states that the resident was not taken to the hospital and also that she was "Ambulatory without staff assistance" and both statements are inaccurate. Please remind staff that all documentation is important but especially investigations of incidents where residents could sustain injury and ensure that this information is recorded as accurately as possible.