FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
WOODSIDE EXTENDED CARE- 13-040-9002
HUMAN RIGHTS AUTHORITY- South Suburban Region

[Case Summary— The Authority made corrective recommendations regarding the allegation that were accepted by the service provider. The public record on this case is recorded below; the provider did not request that its response included as part of the public record.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission opened this investigation concerning Woodside Extended Care in August 2012. The complaint stated that the resident's guardian was not properly notified that the individual had been physically abused by a staff person. If substantiated, this allegation would violate the Nursing Home Care Act (NHCA) (210 ILCS 45/2-107), the Illinois Administrative Code for Skilled Nursing and Intermediate Care Facilities (77 Ill. Admin. Code Part 300), the Code of Federal Regulations, Requirements for Long Term Care Facilities (42 C.F.R 483.13) and the Illinois Probate Act (755 ILCS 5/11).

The 112-bed skilled and intermediate care facility located in Chicago Heights did not have any available beds when the complaint was discussed with the facility staff.

METHODOLOGY

To pursue the investigation, the Facility Administrator, the Director of Nursing and two Certified Nursing Assistants were interviewed. The complaint was discussed with the resident's guardian and sections of the resident's record were reviewed with written consent. The resident was observed at the facility. Relevant facility policies were also reviewed.

COMPLAINT STATEMENT

The complaint stated that the resident was physically attacked by a staff person and sustained an injury to her left eye. It was reported that the guardian learned about the alleged abuse from the resident during an unannounced visit to the facility on July 27th, 2012, five days after alleged the incident.

FINIDING

<u>Information from the record, interviews and program policy</u>

The HRA determined that the resident was admitted to the facility in 2012 and uses a wheelchair to ambulate. An Incident Report, completed on July 24th, 2012 at 9:45 a.m., documented that an unidentified Certified Nursing Assistant informed a nurse that the resident had a "mark" on her face. The nurse noted a bluish bruise on the resident's left cheek upon examination and that she did not complain of pain. An ice pack was applied to her cheek minutes later. The Facility Administrator, the Director of Nursing and the resident's physician were notified. Her physician gave no new orders. On that same day at 10:00 a.m., a nursing note stated that the resident became agitated when she was questioned about the bruise on her cheek. It was recorded that the resident was monitored and that her cheek was still bluish in color on that next day. As before, she reportedly did not complain of pain or show signs of distress.

A Preliminary 24-hour Incident Investigation Report, completed by the Facility Administrator, indicated that the Illinois Department of Public Health (IDPH) was informed about possible abuse under the reporting laws. A confirmation fax sheet attached to the report indicated that the IDPH was notified on July 25th. According to the report, the resident had a "small" bruise, and she said that a staff person had mistreated her. The report documented that the alleged incident had occurred in the resident's room on July 24th. The staff person, who was accused of abusing the resident, was suspended pending the outcome of the facility's investigation. According to the report, the resident's guardian was notified by phone about the allegation, and she would be informed about the results of the investigation. However, the complaint stated that the guardian learned about the incident from the resident during an unannounced visit to the facility on July 27th.

Written statements from five Certified Nursing Assistants (CNA's) reflected that they were questioned about the resident's injury and that the incident had occurred on the evening of July 23rd. Three of the handwritten statements were dated July 24th and two of them were dated the 25th. The first CNA wrote that the resident had refused to go to bed around 8:30 p.m. on the 23rd and was incontinent of urine. She was informed that she needed to go to bed and was placed in her room. Once there, the resident reportedly started calling the CNA derogatory names and told the staff person to leave her alone. She was informed that "she had to get in the bed because she had been up all day." She reportedly started hitting and kicking the staff person who was trying to transfer her to the bed with a sling. She also hit the CNA with a coffee cup and began hitting herself when the staff person moved out of her reach. The staff person wrote that she saw the third, fourth and fifth CNA coming toward the resident's room when she went to get help. The resident told the staff to leave her the [expletive] alone upon entering her room and called them inappropriate names. She was redirected but continued hitting and spitting on the staff. The resident was transferred to the bed, her clothing was changed, and the staff left the room.

The second CNA wrote that the resident was screaming in her room on July 23rd around 10:30 p.m. until 11:00 p.m. There was no indication that the staff person had checked on the resident or was involved in the incident. The third CNA wrote that she heard a lot of noise coming from the resident's room and went to see what was happening. The staff person noticed blood on the resident's chin upon entering her room and that she was "swinging" a pen. She tried to help the first CNA to transfer the resident to the bed but was not successful and the fourth and fifth CNA came to help them. She explained that the first and fifth CNA used the arm-to-arm

method to lift the resident; she pulled down the individual's pants and the fourth CNA stood on the opposite side to prevent her from falling out of the bed. The staff reportedly left the resident's room after they placed her in the bed. The fourth CNA wrote that she noticed blood on the resident's chin and scratches on her chest upon entering her room. She described the resident as being combative because she was profane and spitting. Her account of how the resident was transferred to her bed was the same as the third CNA's report. The fifth CNA wrote that she only assisted with transferring the resident to her bed and that she was in the room no longer than ten minutes. We noticed that she does not mention any observation of blood or bruises on the resident.

A "Final Incident Investigation Report" form stated that the resident had refused to go to bed when the first CNA took to her room. The staff person went to get help because the resident started yelling and hitting her. It was documented that three additional staff members noticed blood on the resident's chin when they entered her room to assist with putting her in bed. According to the investigation report, the first CNA was terminated based on the facility's investigation. The report was signed by the Facility Administrator and a copy was faxed to the IDPH on the 27th.

When the complaint was discussed with the facility administration, the resident was described as being alert; she is sometimes psychotic and paralyzed on one side of her body. The Facility Administrator explained that the procedures for managing combative residents are as follows: 1) the resident should be given time to calm down, 2) another staff person might be used to diffuse the situation, and, 3) as needed medication might be administered. The HRA was informed that the CNAs are responsible for completing the daily living checklist form, but they do not write in residents' charts. We were told that they are required to report possible abuse and neglect to the nursing staff. And, the nurse should document the allegation in the resident's chart and complete other appropriate forms. The facility administration could not recall the CNA who reported the resident's injury on the 24th.

The fourth CNA said that she believes that she reported the blood on the resident's chin and scratches on her chest to the nursing staff. She also said that she might have forgotten to report the incident. She said that the facility administration did not talk to her about reporting resident's injuries but recanted her assertion. She reported that she was inserviced on abuse and neglect a few months prior to the HRA's visit in February 2013. Upon questioning, the fifth CNA denied seeing blood or bruises on the resident on the evening of July 23rd. She said that the facility administration asked about her involvement in the incident. But, she was not asked about her observations. According to the staff person, she was not responsible for informing the nursing staff that the resident was upset on the incident night. She said that the first CNA should have reported the resident's behavior to her supervisor on that same evening. The HRA could not interview the first, second and third CNA because they are no longer at the facility.

A letter, dated September 13th, 2012, from the Facility Administrator stated that she had met with the guardian two days after the incident. The guardian was reportedly informed that she had not been notified because of a mix-up and that the incident was under investigation. She was later informed about the investigation outcome by phone. At the site visit, the Facility Administrator said that she might have met with the guardian on the 24th or the 25th. The

guardian reportedly asked why she had not been promptly notified. She told the guardian that she was in the process of investigating the incident and that the nursing staff usually notifies the guardian if a resident is hospitalized. She acknowledged that the guardian was not timely notified about the incident. She said that the first CNA had worked at the facility for about three months prior to the incident. She reportedly was terminated because the Facility Administrator could not prove that the resident's bruise was caused by accidental means.

The guardian told the HRA that she first learned about the incident from the resident during an unannounced visit to the facility on July 27th, 2012. On that same day, the Facility Administrator reportedly told the guardian that an internal investigation was being done. She was subsequently informed that the CNA had been fired and that she is not eligible to be rehired. Also, she reported that the Facility Administrator had agreed to retrain the staff on reporting possible abuse and neglect. When asked about staff training on abuse and neglect, the facility provided documentation that staff were retrained on November 26th and December 4th, 2012.

The facility's "Accident/Incident Investigation" policy states that the Administrator, the Director of Nursing or designee shall investigate all accidents and incidents. It states that all persons involved in the incident shall be interviewed. If the incident results in an injury, the staff is required to document in the resident's record the following information: 1) the nature of injury, 2) point of injury, 3) interventions provided, and, 4) the need for further interventions if applicable. There was no mention about notifying the guardian or family member.

The facility's policy regarding abuse, neglect or other mistreatment of residents clearly states that such action is unlawful and prohibited. The staff are directed to immediately report inappropriate or harmful acts involving a resident to the Facility Administrator upon becoming aware of them. According to the policy, the facility will conduct a prompt investigation into all reported allegations. The identity of the employee who reported the misconduct and the substance of the report will be kept confidential to the extent reasonably possible. Such matters will be disclosed during the investigation only on "a need to know" basis. The policy further states that a staff person accused of mistreating a resident will be suspended or reassigned pending the outcome of the investigation. It states that employees are subject to disciplinary action, including immediate discharge for the following reasons: 1) engaging in conduct prohibited by this policy, 2) failure to make any report required by this policy, 3) failure to promptly and fully submit to, and comply with, any related investigation by the facility or any government or law enforcement agency, and, 4) interference with, evasion or refusal to submit to, any related search requested by the facility.

CONCLUSION

Sections 45/2-107 of the NHCA and Illinois Administrative Code 300.3240 state that an owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. According to Section 45/1-103, abuse is defined as any physical or mental injury or sexual assault inflicted on a resident other than by accidental means in a facility.

The Illinois Administrative Code Section 300.3240 (b) states that a facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.

> (c) A facility administrator who becomes aware of abuse or neglect shall immediately report the matter by phone and in writing to the resident's representative.

According to the Illinois Administrative Code 300.690,

> (a) The facility shall notify the Department 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. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department.
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> (1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident....
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> (2) A narrative summary of each accident or incident occurrence shall be sent to the Department within seven days of the occurrence.

The C.F.R.'s Requirements for Long Term Care Facilities Section 483.13 state,

> (c) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents….
>
> (c) (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).
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> (c)(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in process.
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> (c)(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State Law within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

The Illinois Probate Act Section 5/11a-17 states that the personal guardian shall make provisions for the ward's support, care, comfort, health, education and maintenance.

The Authority substantiates the complaint stating that the resident's guardian was not properly notified that the individual had been physically abused by a staff person. An incident report documented that a CNA first reported the resident's injury to a nurse on July 24th, 2012. A small bruise on her left cheek was visible upon examination. The resident reportedly told the Facility Administrator that she had been mistreated by a staff person. The facility started an investigation into her injuries on that same day. Staff members who provided direct care or those who might have had contact with the resident were interviewed. The facility determined through its investigation that the incident had actually occurred on July 23rd and that the third and fourth CNA had observed blood and/or bruises on the resident on the incident night. However, they did not report the incident as required by law and program policy. The HRA finds the fifth CNA's assertion that she did not see blood or bruises on the resident during the incident difficult to believe because written statements from two other staff members clearly document that her injury was visible. She also said that she was not responsible for notifying the nursing staff that the resident was very upset on the incident night. The Facility Administrator acknowledged that the guardian was not promptly notified about the incident that involved an injury. This violates the Illinois Administrative Code Section 300.3240 (b) (c).

A report indicated that the IDPH was notified about the incident on July 25th, within the 24-hour timeframe required by the rule. The first CNA, who was named as the abuser, was suspended during the facility's investigation. A final incident report indicated that the results of the facility's investigation were faxed to the Department on July 27th. And, the resident's guardian, physician and the licensing agency were notified that the first CNA was terminated based on the facility's investigation. This complies with the Illinois Administrative Code 300.690 and the C.F.R.'s Section 483.13 (c) (3) (4).

RECOMMENDATIONS

1. Ensure that the resident's guardian or representative is immediately notified pursuant to the Illinois Administrative Code Section 300.3240 (c).

2. The facility shall revise its policy to include procedures for notifying the guardian or family member.

SUGGESTIONS

1. The facility should document in the residents' records the date when guardian notification is given.

2. The fifth CNA was rude and uncooperative when she was questioned by the HRA. Woodside Extended Care administration should review its policy that direct staff to fully comply with all government or law enforcement agencies authorized to investigate complaints involving the facility with the CNA in question.

COMMENT

Although the facility violates the Illinois Administrative Code Section 300.3240 (b), the Authority makes no recommendations because attendance sheets provided to the HRA indicated that the staff have been retrained on abuse and neglect.