FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
CRESTWOOD TERRACE NURSING CENTER— 13-040-9008
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary— The Authority did not substantiate the complaint issues below. The public record on this case is recorded below; the provider did not provide a response to the report.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA) has completed its investigation into allegations concerning Crestwood Terrace Nursing Center. The complaint alleged the following: 1) a resident is being forced to take medication in the absence of an emergency, 2) the facility has not protected the resident from her roommate or moved the roommate to a different room as requested, 3) the staff enter the resident's room without knocking, and, 4) the staff opened the resident's mail twice without her written consent.

If substantiated, these allegations would be violations of the Nursing Home Care Act (NHCA) (210 ILCS 45/2 et seq.), the Illinois Administrative Code (77 Ill. Admin. Code Part 300 et seq.), the Mental Health and Developmental Disabilities Code (405 ILC 5/2-107 [a]) and the Centers for Medicare and Medicaid Services, Department of Health and Human Services' (CMS) Requirements for Long Term Care Facilities (42 C.F.R. 483.10 [i] [1]).

Crestwood Terrace Nursing Center is a 126-bed intermediate care facility located in Crestwood. The facility had five available beds when the complaint was discussed with the facility staff in June 2013. The majority of facility's residents have been diagnosed with a mental illness.

METHODOLOGY

To pursue the investigation, the Facility Administrator, the Acting Director of Nursing and the Director of Psychiatric Rehabilitation Services were interviewed. The complaint was discussed with the resident. Sections of the resident's record were reviewed with written consent. Some of the facility's residents were interviewed concerning the third and fourth complaint. Relevant policies were also reviewed.

FINDINGS

COMPLAINTS # 1 and 2

The complaint alleged that the resident is being forced to take medication in the absence of an emergency. She reportedly is told that she will be transported to the hospital if she does not accept medication. The complaint stated that the resident was sent to the hospital four times in two weeks and was admitted to a psychiatric unit during one of these visits. She reportedly had refused medication leading up to three of the hospital's visits and was upset about pain medication leading up to one of them.

Information from record, interviews and program policies

According to the resident's record, she was admitted to the facility in July 2012 and she was able to make her needs known. She was diagnosed with Schizoaffective Disorder, Depression, Anxiety, Asthma, Diabetes, Rheumatoid Arthritis, and other physical problems. Her care plan developed on July 25th, 2012 included goal objectives concerning depression, compliancy with treatment, social interaction and hygiene. Medication Administration Records (MARs) indicated that Haldol 5mg and Ativan 1 mg four times daily, Metformin 500 mg and Glipizide 5mg twice daily, Levothyroxin 25 mg, Furosemide 20 mg, Lisinopril 10 mg, Digoxin 0.125 mg, Oxybutynin 5 mg, Metoprolol 25 mg, Pantoprazole 40 mg once in the morning, Paroxetine 30 mg, Simvastatin 40 mg, Donepezil 10 mg nightly, Haldol 5 mg Intramuscular (IM) every four hours and Cogentin 2mg every eight hours, and other as needed medication (PRN) such as Vicodin and Norco were administered between January 7th through July 6th, 2013 with some exceptions. The HRA found no clear indication during the record review that medication was administered over the resident's objections or that the resident provided informed consent for any medication. We also did not find any physician's orders for emergency medication.

Corresponding progress notes indicated that the resident was sometimes non-compliant with medication and that she complained of having problems with her roommate. On the January 24th, 2013, the resident was reportedly hallucinating, belligerent and noncompliant with medication. She was transported to a hospital for an evaluation and returned to the facility on that same day. The next day, she was seen by the facility's physician who ordered that the resident should be sent back to the same hospital for another evaluation. Again, she was not hospitalized and was returned to the facility. On January 30th, the resident was admitted to a behavioral health unit after she was sent back to the hospital for a third time. She was discharged back to the facility on February 8th, and she refused all medication except for Norco on that next day.

On March 19th, the Director of Nursing recorded that the resident had refused several medications many times. She reportedly accepted her medication for diabetes after medication information was provided. On that same day, the resident told the Director of Psychiatric Rehabilitation Services that she likes the light on in her room, but her roommate "intentionally" keeps turning the light off. She was informed that her concerns would be addressed and was offered a room change three days later. It was documented that the resident had refused to change rooms and that her roommate had denied the allegation. The same day, the resident reported that her roommate had just turned off the light in their room, and the Director of Psychiatric Rehabilitation Services insisted that she should go with him to address this issue with her roommate. It was documented that the resident's roommate was sleeping and that the light

was on upon entering the resident's room. The resident reportedly became agitated and profane as the staff person attempted to talk to her about making false reports. Her care plan was updated. Again, she was offered a room change and refused on that next day. She said "I don't want to move anywhere now and I don't want any new person yet [and] I don't even feel like talking about it now." She reportedly was informed that this issue could be revisited if she changed her mind.

On April 1st, 2013, a social services note stated that the resident had been compliant with medication and her care plan. The staff person wrote that he would continue to meet with the resident once a month and address her concerns as needed. On April 2nd, the resident alleged that her roommate had punched her on her left shoulder. A skin assessment was done, but there were no bruises observed. The physician and the nursing supervisor were notified, and the resident was assigned to another room. On April 3rd, a follow up note documented that the resident's roommate claimed that the resident had started the physical altercation on that previous day. The resident reportedly told the staff person that she liked her new room when she was counseled on appropriate social interactions with her peers. A corresponding form indicated that the Illinois Department of Public Health was notified about the incident on that same day.

On April 17th, 2013, a nursing note stated that the resident continued to accept medication of her choice and that she was encouraged to take all medication as ordered. The nurse also wrote that the resident was constantly seeking medication including as needed medication by mouth or intramuscular. On April 22nd, the Charge Nurse told the Director of Psychiatric Rehabilitation Services that the resident had refused all medication. And, she was reportedly informed about the importance of being compliant with medication. According to nursing entries, the resident continued to request medication and especially Vicodin before the due time. She was offered all medication as ordered by her physician. The Supervisor of Nursing and the social services staff were informed about her requests for medication. She was described as being verbally aggressive, delusional and profane when redirected at the time.

On May 2nd 2013, the Administrator and the nursing staff met with the resident concerning pain management. The resident reportedly told the staff that she wanted to continue with her current medication. She refused further intervention such as a referral to a Rheumatologist or pain clinic. On that same day, the facility administration met with the resident about medication times. The Administrator wrote that the resident presented with paranoia but seemed satisfied with the meeting outcome and that the staff would continue to problem solve with her. On May 29th, the resident told the Administrator that she was upset because she did receive her medication on time. She then alleged that she had not received the medication but a nurse told the Administrator that the medication had been administered at 2:09 p.m. The entry indicated that resident continued to deny that she had received the medication until she was informed that the camera would be reviewed for confirmation. She then told the Administrator that the medication should have been administered at 2:00 p.m., and she was informed that the nurse was on the telephone at the time. It was recorded that the resident asked to be moved to another room and "changed her mind" when the Administrator agreed to her request.

Regarding the first complaint the Acting Director of Nursing explained that the resident had previously lived at the facility for about three years before she had requested to be transferred back in 2012. She said that the resident is independent concerning activities of daily living except that she needs supervision with bathing. We were informed that residents are provided with information about medication. The resident had accepted all scheduled medication for May through June 4th, 2013. She has not been compliant with having her glucose level checked. The assigned physician is notified if a resident refuses medication three times. The Director of Psychiatric Rehabilitation Services said that the staff try to encourage residents to take medication but every resident has the right to refuse medication except in an emergency. He explained that as needed medication is given when redirections fail. The physician might order an evaluation when a resident refuses medication for consecutive days.

According to the resident, she is willing to accept Haldol, Ativan, Cogentin, Vicodin, Metformin, and blood pressure medication because the medication calms her down. We were informed that the staff is sometimes rude to the resident because she wants to be the first person in line for medication. The resident said that the staff have made comments such as "she just want to take narcotics to get high." However, she never told the Administrator about the alleged verbal abuse. She reported having problems with getting Vicodin for pain and that she is sometimes given pills that she does not want. One day, a nurse allegedly told the resident that she was wasting the nurse's time because she took one pill out of her cup that she did not want.

Regarding the second complaint the staff interviewed reported that the resident talks to staff and that she can be intimidating toward her peers. The Director of Psychiatric Rehabilitation Services said that the resident has made several false allegations such as the incident involving her roommate that was previously mentioned in the report on March 19th. We were told that the resident had declined a room change after making the above allegation, but she wanted her roommate to be moved to another room. However, her roommate did not want to change rooms. The resident reportedly moved back to her old room after the physical altercation with her roommate on April 2nd, 2013 (previously referenced in the report), without any discussion with them. According to the Administrator, the resident has requested a room change many times, but then she refuses to move to another room.

Crestwood Terrace Nursing Center "Medication [and] Treatment Refusal" policy states that residents will comply with medication and treatment to assist them in overcoming illness, to provide relief, to prevent symptoms, and help in diagnosis. According to the policy, the Director of Nursing, the primary physician, the psychosocial staff, and the resident's representative will be notified if the resident continually refuses medication and treatment, for example, two or more consecutive times for three days. It states that the resident's refusal shall be documented and the date and time, and that medication information has been provided. The resident will be monitored when medication is refused. According to the policy, the physician must be notified immediately when cardiac and psychotropic medication and oral glycemic/insulin is refused.

According to the facility's "Resident Incentive and Contingency Management Program" policy, residents are expected to be respectful towards staff, peers and visitors. It states that residents should understand that interventions such as limits setting might be required if they behave inappropriately.

CONCLUSION

According to Section 45/2-104 (a) of the NHCA and Section 300.4040 (c) (3) of the Illinois Administrative Code, every resident shall be permitted to participate in the planning of his total care and medication treatment to the extent that his condition permits.

According to the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities and Section 45/2-104 (c) of the NHCA,

> 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. The resident's refusal shall free the facility from the obligation to provide the treatment.

And, Section 5/2-107 (a) of the Mental Health Code states,

> An adult recipient of services…must be informed of the recipient's right to refuse medication ….If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent harm to the recipient or others and no less restrictive alternative is available….psychotropic medication or electroconvulsive therapy may be given under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record.

According to Section 45/2-106.1 (b) of the Act,

> Psychotropic medication shall not be prescribed without the informed consent of the resident, the resident's guardian, or other authorized representative. "Psychotropic medication" means medication that is used for or listed as used for antipsychotic, antidepressant, ant manic, or antianxiety behavior modification or behavior management purposes in the latest editions of the American Medical Association Drug Evaluations or the Physician's Desk Reference.

The Authority does not substantiate the complaint stating that a resident is being forced to take medication in absence of an emergency. The progress notes indicated that the resident was sent to the hospital three times in one week before she was admitted to a behavioral health unit. Although the notes documented that the resident was non-compliant with medication as reported in the complaint, there was indication that she was also hallucinating leading up to the hospital visits. The HRA does not discount the resident's report that she is willing to accept certain medication, but we found no clear evidence that she is forced to take medication. No clear

violations of Sections 45/2-104 (a) (c) of the NHCA, Section 300.4040 (c) (3) of the Illinois Administrative Code, the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities and 5/2-107 (a) of the Code or program policies were found. However, the Authority is concerned because there was no documentation of the resident's informed consent for medication found in the record, but there was an indication that sometimes she accepts medication. The facility must review this issue with the resident and include her input in treatment planning to ensure full compliancy with Section 45/2-106.1 (b) of the Act.

SUGGESTION

1. Include documentation in the record that the resident has been provided with informed consent regarding medication.

COMPLAINTS # 3 and 4

The complaint stated that a staff person opened the resident's mail twice without her permission. It was reported that a large package and a letter from the Illinois Guardianship and Advocacy Commission were opened on two separate occasions. The complaint also alleged that the staff have entered the resident's room many times without knocking on the door.

Information from record, interviews and program policies

There was no documentation concerning privacy issues or grievances found in the resident's record. A form entitled, "Authorization to Open and Inspect Mail" signed by the resident specifically stated that the consent only covered the resident's "business mail" but lacks a date line. The Director of Psychiatric Rehabilitation Services initially reported that the staff do not open residents' personal mail. He said that a resident might be asked to open a large package in front of a staff person for safety reasons. The Administrator told the HRA that the staff were entering residents' rooms without knocking when she was assigned as the Administrator in July 2012. She also acknowledged problems with the staff opening resident's personal mail during that same year. She explained that a couple of staff members were sorting the mail delivered to the facility by the U.S. Postal Service at the time. One day, she said that a resident was upset because a staff person had opened her mail by mistake. She said that residents' concerns are promptly addressed. She now sorts the mail, and residents' mail is delivered to them by the Activity Worker. According to the Director of Psychiatric Rehabilitation Services, a resident had complained about his mail being opened about six months ago, but the envelope had been compressed.

The HRA was provided with attendance sheets documenting that the facility's staff were trained on residents' rights to privacy in July, September and October 2012 and March 2013. For June, the HRA noticed that the inservice record does not specifically indicated what privacy issues were discussed. For September, the staff were trained on residents' right to private communications by mail. For October, the training topic focused on residents entering another resident's room without permission. For March, the staff were instructed to knock and wait for permission before entering a resident's bedroom and bathroom. The inservice record documented

that "FAILURE TO RESPECT RESIDENT'S PRIVACY CAN AND WILL RESULT IN SUPSENSION AND/OR TERMINATION."

The investigation team discussed the complaint with some of the facility's residents. We note that the residents were not interviewed privately, but they were willing to speak with the HRA concerning the privacy issues above. One resident reported problems in these areas until a state agency visited the facility. She did not provide any more information such as a timeframe about the state agency's alleged visit to the facility. Two residents denied that privacy was a problem at the facility. Some residents mentioned that they like the facility and some of them reported that residents fight with each other. The resident, whose record was reviewed, told the investigation team that the staff do knock on residents' doors, but they do not wait for permission before entering the room.

According to the facility's "Resident Mail" policy, the administrator or designee is responsible for sorting the mail upon delivery to the facility. It states that the facility's Social Services Department will deliver all personal mail unopened to residents.

The facility's "Residents' Right to Privacy" policy directs that the staff must knock on a resident's room door and wait for a response before entering the room. It states that the staff should wait for a reasonable amount of time before entering the resident's room if there is no response. The policy also addresses the right to private visitation, confidentiality, etc. The HRA noticed that there was no date or agency name found on the policy.

According to the facility's grievance, the Administrator must make every effort to resolve any complaint, concern or grievance brought to the attention of the facility in a prompt and satisfactory manner. The policy states that grievances and complaints may be given to any staff person.

CONCLUSION

According to the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities and Section 45/2-108 of the NHCA, every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or visitation. And, Section 45/2-108 (c) of the NHCA states that the facility personnel shall knock, except in an emergency, before entering any resident's room.

Section 483.10 (i) (1) of CMS' Requirements for Long Term Care Facilities guarantees residents the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.

The Authority does not substantiate the complaint stating that the staff enters the resident's room without knocking. All of the residents interviewed reported that privacy was not a problem at the facility, except for one resident who said that the staff do knock on residents' doors but they do not wait for persmission before entering the room. The Administrator said that privacy was a problem at the facility in 2012. The HRA was provided with staff training records concerning resident' rights to privacy in written communications and in their rooms. The

Authority cannot substantiate the complaint stating that the staff opened the resident's mail twice without her written consent because we found no evidence of this. No clear violations of the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities, Section 45/2-108 of the NHCA, Section 483.10 (i) (1) of CMS' Requirements for Long Term Care Facilities or program policies concerning privacy were found.

SUGGESTIONS

1. The facility should review this complaint with its staff to ensure that residents' right to privacy is respected.

2. Be sure that permission is given before entering residents' rooms unless there is an emergency.