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REPORT OF FINDINGS 13-040-9010
MIDWAY NEUROLOGICAL AND REHABILITATION CENTER
HUMAN RIGHTS AUTHORITY— South Suburban Region

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

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA) has completed its investigation into allegations concerning Midway Neurological and Rehabilitation Center. The complaint alleged that a resident, who has a legal guardian, was placed in a nursing facility for mental health treatment over her objections and without a court order. It was also alleged that the resident is not allowed passes in the community with her significant other, who does not pose a risk of harm to the resident, because the guardian prohibits this.

If substantiated, these allegations would be violations of the Nursing Home Care Act (NHCA) (210 ILCS 45/2 et seq.), the Illinois Administrative Code for Skilled Nursing and Intermediate Care Facilities (77 Ill. Admin. Code Part 300 et seq.), the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.), the Illinois Probate Act (755 ILCS 5/11a-17) 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).

Midway Neurological and Rehabilitation Center provides 24-hour skilled nursing care and offers a range of programs. The 404-bed facility located in Bridgeview reportedly had about 320 residents when the complaint was discussed with the facility staff. We were informed that about half of the facility's residents are diagnosed with a mental illness.

METHODOLOGY

To pursue the complaint, the Facility Administrator, the Facility Assistant Administrator, the Director of Nursing, the Director of Admissions, the Assistant Director of Social Services and a social worker were interviewed. The resident's fiancé was interviewed by phone. The complaint was discussed privately with the resident at the facility. Sections of the resident's record were reviewed with written consent. Relevant policies were also reviewed.

FINDINGS
Complaint # 1 Admission Process
Information from the record, interviews and program policies

After reviewing the record, the HRA determined that the resident was admitted to Midway Neurological and Rehabilitation Center on May 15th, 2013. She was diagnosed with Bipolar Disorder, Anxiety Disorder and some physical problems. Tegretol and Seroquel and medication for the resident's physical problems were ordered upon her admission to the nursing facility. A court order documented that the resident's mother had been appointed temporary guardian of the individual on May 3rd, 2013. The order specifically authorized the guardian as follows: 1) to communicate with the transferring hospital regarding discharge planning and to provide consent for an appropriate placement, 2) to have all rights under the Health Insurance Portability and Accountability Act, and, 3) to complete and submit a signed application for Medicaid benefits on behalf of the resident. The HRA found no documentation during the record review that the resident had agreed to the nursing facility placement or that she had objected prior to her transfer.

On the admission day, a social services note stated that the resident was alert, oriented times three and was able to make her needs known. She denied having suicidal ideations or being an elopement risk. She told the social services person that she had been tearful and that she missed her family. She reportedly was reassured that everything would be okay and was informed about the facility's rules. Her care plan developed on that next day documented that her potential for discharge was fair and would be reviewed every three months. Her plan stated that she would have to verbalize her desire to be discharged from the facility. Her plan targeted behaviors such as problems with depression and coping skills. It consisted of many interventions to manage her psychiatric and physical symptoms such as medication, counseling and therapy groups. According to a nursing note, the resident was compliant with all scheduled medication on that same day.

On May 17th, the guardian signed some of the admission forms, and the facility intake worker affirmed on the admission checklist sheet that the resident or the guardian was provided with a copy of the "Residents' Rights," the "Resident Agreement" and other forms. A court report written by the resident's attorney, dated May 29th, stated that she had been admitted to the nursing facility based on the individual's care plan as determined by the transferring hospital and her guardian. On Friday June 7th, a care plan staffing was held. The guardian attended the staffing, but there was no indication that the resident was involved in treatment planning decisions. On that same day, the Director of Social Services was informed that the resident wanted to leave the nursing facility "Against Medical Advice" (AMA) and was planning on living with her boyfriend. She reportedly was not happy about the lack of community passes and the staffs' excuses about why they could not take her to the bank or help her to obtain an identification card. According to the note, the resident was informed that she would receive assistance with getting an identification card on that next Monday. She reportedly agreed to stay at the facility until that Monday at the minimun. Her record lacked follow up concerning this issue or whether she still wanted to leave against medical advice as per progress notes from June 10th through the 28th.

On August 13th, a physician's note stated that the resident "was capable of managing her funds and [was] able to make her own decisions soundly." A court order documented that the guardianship was vacated on August 26th. According to the discharge summary report, the

resident was admitted to the nursing facility for "psychiatric treatment regiment," and she was non-compliant with medications. The report stated that the resident was "excited" about leaving the facility and that she was discharged on September 6th.

When the complaint was discussed with the staff, the Director of Admissions explained that residents are admitted to the nursing facility for medical and mental health problems as determined by their physician. She said that referral information is sent to the facility. The resident's physician and her guardian had agreed to the placement decision and the guardian told the Director of Admissions that the resident also was in agreement with being transferred to the nursing facility. She said that the resident's guardianship order was first faxed and then the referral packet was sent to the facility. On questioning, the Director of Admissions acknowledged that she was not aware that a guardian cannot place a resident in a mental health facility over the person's objections without a court order. She said that the resident never told her that she did not want to stay at the facility.

According to the Assistant Facility Director, he is familiar with the Mental Health Code that protects a person from being forced in a nursing home for mental health treatment without a court hearing. He explained that the resident had some medical problems that needed to be addressed. He said that the resident's willingness to provide banking documents and other information needed to apply for Medicaid benefits is evidence that she had agreed to the placement decision. Once there, she reportedly changed her mind about staying at the facility and told the Assistant Facility Director and other staff members that she wanted to live with her boyfriend. The staff reported that the resident had refused to consider moving to alternative nursing facilities discussed at discharge planning meetings, but they were unable to provide documentation of these meetings. According to the staff, the guardianship order was dismissed on August 26th, but the resident chose to stay at the nursing facility until September 6th. The resident told the HRA that she never agreed to the placement decision and that she did not want to remain at the nursing facility. She said that she was looking forward to the court hearing to have the guardianship revoked. According to the Administrator, the nursing facility does not have a formal policy on admissions but has unwritten criteria concerning this issue.

Midway Neurological and Rehabilitation Center policy (no title) states that all residents with a serious mental illness admitted to the facility will participate in a comprehensive assessment with various members of its Interdisciplinary Team. An initial discharge plan will be developed after discussing the resident's goals with the individual and family. According to the policy, this will allow the treatment team and the resident to begin working towards the ultimate goal upon the individual's admission to the facility.

The facility's "Resident Discharge" policy states that a continuity of care plan will be developed when residents are discharged back home. According to the policy, discharge planning will be initiated upon admission to the facility and communicated to the resident and family members during the discharge process.

CONCLUSION

Section 45/1-113 of the NHCA states that,

> A facility or long-term care facility means a private home, institution, building, residence or any other place, whether operated for profit or not … which provides through its ownership or management, personal care, sheltered care or nursing…. It includes skilled and intermediate care facilities.

The Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities and the Illinois Probate Act Section 5/11a-17 states that a resident's legal guardian may exercise the individual's rights to the extent ordered by the court and under the direction of the court. Section 5/11a-17 further states that the personal guardian shall make provisions for the ward's support, care, comfort, health, education and maintenance.

According to Section 300.610 (c) (1) of the Illinois Administrative Code,

> The facility shall have written policies and procedures governing the admission, transfer and discharge of residents, including categories of residents accepted and not accepted, residents that will be transferred or discharged, transferred within the facility from one room to another, and other types of transfers.

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 Section 5/2-102 (a) of the Mental Health and Developmental Disabilities Code,

> Services shall be provided in the least restrictive environment, pursuant to an individual services plan…. In determining whether services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided

Section 5/3-700 of the Code states that a person 18 years of age or older who is subject to involuntary admission may be admitted to a mental health facility upon court order pursuant to this Article.

According to Section 45/2-111 of the Act and Section 330.3300 (a) of Chapter 77 of the Administrative Code state that a resident may be discharged from a facility after he gives the administrator, a physician, or a nurse of the facility written notice of his desire to be discharged.

The complaint stated that a resident, who has a legal guardian, was placed in a nursing facility for mental health treatment over her objections and without a court order. The record confirmed that the resident was admitted to the nursing facility for mental health treatment on

May 15th, 2013. A court order documented that the resident's temporary guardian was authorized to provide consent for an appropriate placement upon her discharge from a hospital. The order does not give the guardian express authority to place the resident in a nursing home for mental health treatment over the individual's objections. The nursing facility reportedly lacks a written policy on admission. The resident told the HRA that she was transferred to the nursing facility against her will and that she did not want to remain at the facility. The facility's Director of Admissions said that the guardian told her that the resident had agreed to the nursing facility placement. The staff interviewed further said that the resident did not want to remain at the nursing facility but refused alternative facilities identified at discharge planning meetings. Again, we note that the HRA found no documentation during the record review of these meetings or any indication that the resident was involved in care planning decisions. A note written on June 7th indicated that the resident wanted to leave the nursing facility against medical advice. The staff reported that the resident chose to remain at the nursing facility until September 6th, although the guardianship order was dismissed on August 26th.

The Authority reminds Midway Neurological and Rehabilitation Center of the Illinois Appellate Court, Fourth District ruling- In re Muellner- citing the Mental Health and Developmental Disabilities Code, Section 5/2-114 which defines a mental health facility as any licensed private hospital, institution or facility… or section thereof, operated by the State… for the treatment of persons with mental illness and includes all hospitals, institutions, clinics, evaluation facilities, and mental health centers which provide treatment for such persons. The court ruled that a specialized behavioral health unit in a nursing home meets the definition of a mental health facility under the Section above. The court also ruled that a recipient cannot be admitted to a nursing home that primarily serves individuals with psychiatric needs or held against the recipient's objections without a court order obtained through the involuntary commitment process under Article VII of the Code.

The Authority substantiates the complaint as presented above. The HRA finds that Midway Neurological and Rehabilitation Center is a mental health facility as defined under the Code. The nursing facility violates the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities, Section 45/2-104 (a) of the NHCA, Sections 300.4040 (c) (3) and 300.610 (c) (1) of the Illinois Administrative, and Sections 5/2-102 (a) and 5/3-700 of the Code. No violations of the nursing facility policies were found.

RECOMMENDATON

1. A legal guardian under Illinois law cannot consent to involuntary psychiatric placement in a state-operated or community based mental health facility absent a court order which can be obtained under the Code. The facility shall provide training to the appropriate staff concerning admitting and continued placement of non-consenting residents, who are under guardianship, for mental health treatment. The HRA requests a copy of the training attendance record.

SUGGESTIONS

1. Midway Neurological and Rehabilitation Center should consider developing a formal policy on admitting residents to its nursing facility.

2. Document in residents' records when discharge planning meetings are held

Complaint # 2 Communication/Visitation

The first entry found in the resident's record concerning the right to communication with persons of choice was a social services note written on May 17th. According to the note, the guardian told a social worker about some "traumatic events" involving the resident and verbalized concerns about her well-being. She reported that the resident's male friend (fiancé) had discharged her from various treatment centers and had possibly influenced her willingness to receive care. She said that she would prefer that the resident should have "limited contact" with him so that she might fully participate in her treatment needs. It was recorded that the social worker agreed to notify the guardian about the resident's behaviors, visitors and medical appointment as requested. Another note stated that the guardian was informed that the resident had a visit with her fiancé on that same day. And, she reportedly was comfortable with that particular visit but voiced her concerns again.

On May 18th, 19th and 29th, the social services notes documented that visits between the resident and her fiancé were allowed. There was no mention that the guardian was informed as requested, but the notes detailed problems with visitation. On the 19th, the resident's fiancé reportedly was observed sleeping in his car in the facility's parking lot and was asked to leave the facility's premises due to his behavior. It was recorded that he complied with the staff person's request and that visits would be monitored to ensure the resident's safety. On the morning of the 29th, he was observed sleeping in his car again, and the staff suspected that he had been in the facility's parking lot all night. On that same morning at 10:00 a.m. he was asked to leave the nursing facility due to his bizarre behavior when he tried to visit the resident. It was recorded that he left the facility after the police were called for assistance. Shortly afterwards, the social worker received a call from the resident's attorney who asked why the resident's fiancé had been restricted from visiting. Her attorney reportedly was informed that the resident is allowed visitors, but her fiancé was asked to leave the facility due to his bizarre behavior and excessive phone calls to the facility. Her attorney asked whether or not the resident's significant other would be allowed to visit if he returned to the facility at 11:00 a.m. and could he stay until visiting hours ended at 8:00 p.m. Her attorney was reportedly informed that the resident's fiancé would be allowed to visit during the hours above but must comply with the facility's policies.

The court report written by the resident's attorney (previously mentioned on page 2) referenced that the information contained in the report was obtained from the nursing facility's social worker. According to the report, the resident's behavior had been appropriate overall, and she participated in activities, except when her fiancé was visiting. It stated that the resident was sometimes agitated and delusional when her fiancé was at the nursing facility and that visits were supervised. According to the report, the resident's fiancé had problems with following the facility's rules. He was reminded several times that visiting hours ended at 8:00 p.m. and sometimes resisted leaving the facility. One day, he was escorted from the facility because visiting hours had ended and was found sleeping in his car in the facility's parking lot after visiting hours on a different day. According to the report, the resident's fiancé sometimes called the facility every fifteen minutes, and his behavior was unstable at times.

On May 29th and 30th, the social services notes documented that the resident wanted a community pass and was described as being anxious when she gave the necessary completed form to the staff person on the 29th. According to the note, the resident might be eligible for passes because of her 14-day residency at the nursing facility, and her request would be reviewed by the clinical team on that next morning. The note also documented that she has a history of elopement and that she might not return to the facility if she was given a pass. On the 30th, the resident and her fiancé reportedly walked away from the staff person when they were informed that passes had not been authorized. Her record lacked further documentation concerning the right to communication.

When the complaint was discussed with the staff, the Assistant Director of Social Services said that the resident's boyfriend (fiancé) was at the nursing facility every day and that he even ate lunch at the facility. The HRA was informed that the nursing facility keeps a visitor's log, but the staff were not able to provide documentation of the resident's boyfriend visits to the facility. The staff interviewed reported that there were problems regarding his visits to the facility. The Assistant Facility Director explained that he had met with the resident's boyfriend concerning sleeping in his car in the facility's parking lot at night. He said that the resident's boyfriend wanted to stay overnight in another client's room, but the individual objected. Her boyfriend reportedly was restricted from the facility while the incident was investigated by the staff. It is unclear how long the restriction was in place because the staff were not able to provide an incident report or any documentation concerning this matter.

The resident's fiancé told the investigation team that he lives about a three-hour drive one way from the nursing facility. He acknowledged sleeping in his car in the facility's parking lot as documented in the record. He reported that an unnamed facility's security employee said that it was okay for him to sleep in his car but is now aware of the facility's rules. He said that there were no problems with visitation after the incident in the parking area. However, the staff reported that visits were restricted during an internal investigation of a complaint involving the resident's fiancé and another client of the facility.

Regarding community passes, the staff reported that a resident's appropriateness for unsupervised passes is determined by his or her assigned social worker. According to the Assistant Facility Director, the resident was allowed passes in the community near the end of her stay at the facility and that she always returned as planned. The resident reportedly told him that she spent her time away from the facility with her boyfriend at a motel. As before, we note that there was no documentation in the resident's record that she was given passes in the community. Prior to the site visit, the resident told the HRA that her fiancé can visit her at the facility, but she is not allowed passes in the community with him due to the staff's assertion that she is an elopement risk. She reported that she was given a community pass with a female friend on May 25th, although she was supposed to be a flight risk.

According to Midway Neurological and Rehabilitation Center "Visitation Policy" and notice, 24-hour access is available to family members or others with the consent of the individual. Visiting hours are from 10:00 a.m. to 8:00 p.m. and certain "reasonable restrictions" may apply when visiting outside of normal visiting hours. To ensure the safety of all residents,

the facility may impose "reasonable restrictions such as: 1) keeping the facility locked at night, 2) denying or providing limited supervised access to visitors who have abused, exploited or coerced a resident, 3) denying access to visitors who have committed a criminal act, and, 4) denying access to visitors who are inebriated and disruptive.

The facility's policy (no title) previously mentioned in the report further states that all residents diagnosed with a serious mental illness admitted to the facility will remain on level one for a minimum of three months. This level focuses on assessments, stabilization, and integrating into the Midway community. Residents on this level participate in community activities at the discretion of the nurse and the social worker, and the token economy. It states that supervised or independent passes for short periods of time are based on medication compliance, participation in treatment, and behavioral and other safety issues.

CONCLUSION

Section 45/2-108 of the NHCA, 300.3250 of the Illinois Administrative Code, the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities and 5/2-103 the Mental Health Code guarantees the right to communication with persons of choice by mail, public telephone and visitation.

Sections 45/2-108 (d) of the NHCA and 300.3250 (f) of the Illinois Administrative Code states that,

> Unimpeded, private and uncensored communication by mail, public telephone or visitation may be reasonably restricted by a physician only in order to protect the resident or others from harm, harassment or intimidation, provided that the reason for any such restriction is placed in the resident's clinical record by the physician and that notice of such restriction shall be given to all residents upon admission.

Section 483.10 of CMS' Requirements for Long Term Care Facilities guarantees a resident the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside of the facility.

Section 300.4040 (f) of the Illinois Administrative Code states that,

> A facility shall document all leaves and therapeutic transfers. Such documentation shall include date, time, condition of resident, person whom the resident was released, planned destination, anticipated date of return, and any special instructions on medication dispensed.

The complaint stated that the resident is not allowed passes in the community with her significant other, who does not pose a risk of harm to the resident, because the guardian prohibits this. The resident's record documented that the guardian wanted to put some limitation on visits between the resident and her fiancé because he had allegedly discharged the individual from previous treatment centers. The social services notes, the staff interviewed, the resident and her

finance indicated that visits were allowed at the facility. However, there were some problems concerning visitation such as the resident's fiancé sleeping in his car in the facility's parking area at night. One day, he was asked to leave the facility's grounds after he was found sleeping in his car several times. He reportedly left the facility's premises as requested and was allowed to return when visiting hours started on that same day. The HRA was also informed about an altercation between the resident's fiancé and another client who objected to his request to sleep in his room overnight. According to the staff, the resident's fiancé was restricted from the facility during an internal investigation of the incident. As before, the resident's record lacked documentation concerning the incident, and the staff were not able to provide an incident report. We found no written evidence that the resident's physician was involved in the restriction in her record. Regarding passes in the community, a note written on May 29th stated that the resident was an elopement risk and passes were denied on that next day. The Assistant Facility Director reported that the resident was given passes in the community toward the end of her stay at the facility, but her record does not support this. The facility policy states that newly admitted residents, who are seriously mentally ill, will be given community passes at the discretion of the staff.

The HRA cannot substantiate the complaint as presented above. However, the facility violates Sections 45/2-108 (d) of the NHCA and 300.3250 (f) of the Illinois Administrative Code because there was no physician's order for the reported visitation restriction involving the resident's fiancé and another client found in the resident's record. The facility also violates Section 300.4040 (f) of the Illinois Administrative Code because there was no documentation that the resident was given passes in the community as reported by the staff. No violations of the facility's policies were found.

RECOMMENDATONS

1. Follow Sections 45/2-108 of the NHCA and 300.3250 (a) of the Illinois Administrative Code and document the resident's physician involvement when restricting communication by mail, telephone and visitation.

2. Document all authorized passes in the resident's record as required by Section 300.4040 (f) of the Illinois Administrative Code.