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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 13-090-9024
Sharon Healthcare Facilities - Pines

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations at Sharon Healthcare Pines. The allegations were as follows:

1. Inhumane treatment, resident was assaulted by staff and other residents while in facility.
2. Resident not allowed personal property while in facility.
3. Communication violation, resident not allowed to contact family or 911 for seizures.

If found substantiated, the allegations would violate the Skilled Nursing and Intermediate Care Facilities Code (77 ILCS 300) and the Nursing Home Care Act (210 ILCS 45).

The Sharon Healthcare Pines is a 116 bed intermediate care facility for individuals with traumatic brain injuries and mental health issues. The age range of the facility residents is 18-50 years of age. There are 90 employees at the facility who provide social services, small group sessions, skills training groups, among other programs. The facility serves individuals from Illinois, Central Illinois and out of state referrals.

This review includes interviews with Sharon Pines representatives, and a review of program policies as well as specific, authorized records.

The Illinois Department of Public Health was contacted regarding the possible abuse violations.

Complaint Statement

The allegations state that a resident at the Sharon Healthcare Pines was assaulted by staff and other residents while in the facility. The complaint alleges that the resident was hit in the arm and was given bruises on the knee. The complaint also alleges that the security staff gave

the resident a black eye and caused the resident to be taken to the hospital. Another individual allegedly broke a resident's toe with a walker.

The second allegation states that the facility took the resident's flash drive, jewelry and watch and did not allow the resident to use the items while at the facility.

The final allegation is that the facility did not allow the resident to contact family members or 911 about seizures.

Interview with staff (4/30/2013)

Staff explained that the resident was discharged from the facility and was assaulted while in the community and was not a resident when the assaults occurred. Staff explained that on 2/14/2013 the resident left the facility on her own accord without a pass, which means that she left the facility and failed to follow pass privileges. The facility refers to this action as a "pass violation." The resident left and then called the facility from a local thrift store. Staff went to the thrift store to bring the resident back to the facility but the resident would not return. Staff explained that they then contacted the police who took the resident to a local hospital with a psychiatric unit. The staff explained that the facility is not a locked facility, so the resident left on her own and did not return.

Staff explained that the resident left on another pass violation on 3.1.2013. The facility filed a missing persons report for the resident and, on 3.11.2013 discharged the resident against medical advice (AMA). Staff explained that they do not like to discharge a resident unless they know the resident's location. In this instance, they spoke with police and Illinois Department of Public Health (IDPH) who both said that the resident was safe, but they did not inform the facility where the resident was located. The police and IDPH are the organizations that informed the facility about the assaults after the resident left. The IDPH conducted an investigation at the facility and had no findings. Staff explained that the facility has an abuse policy and staff are trained on the policy when hired. Staff also receive a yearly, mandatory training on the abuse policy and Crisis Prevention Institute (CPI) Training.

Staff said that the resident complained that her suite mate was going through her personal property but had no complaints of assault by the suite mate. Staff said that if they saw a staff member abuse a resident, they make sure the resident is safe and then they follow the line of hierarchy to report the abuse, starting with informing a supervisor. If a staff member is accused of abuse, they are suspended pending an investigation. If the violence is resident-on-resident, staff would intervene, and if there was an injury the nurse would assess, complete a report, and send the to report public health. Staff explained that the facility has a privilege system, so to discourage behaviors, they decrease privileges. For example, if residents smoke in their rooms, the residents would lose the locks on their room doors. Staff said that if the violence was between two roommates, they would separate them from the room. Staff explained that if there

was violence between two residents in the same hall, they may separate the proximity of them living together. Staff also said that they offer aggression classes and social skills classes.

The complaint alleged that students on staff from a community college had possibly abused the resident and staff explained that they have no students on staff from the mentioned community college at the facility. Staff said that the people named as assailants did not commit any of the acts and that none of the individuals are physically aggressive. Staff said that the resident's toe was not broken at the facility and she left the facility ambulatory. Staff also explained that the resident voiced delusions while at the facility.

Staff said that although the resident had a diagnosis of seizure disorder the resident did not have seizures while staying at the facility and there is a resident phone that can be accessed. Staff said that they do have residents who call 911 often. Staff said that the resident did use the phone often and never had complaints. Staff explained that usually they receive complaints from residents that other residents are using the phone too often. Staff said that if a resident has a seizure, a nurse stays with the resident. If the seizure escalates and does not improve, they contact a hospital emergency room. They would notify family if a resident had a seizure, but in this case there was no one to contact.

Staff stated that the phone policy is explained to the residents upon admission. If a resident is waiting in line to use the phone, staff may inform the resident on the phone to end the call or hurry with the call because others are waiting to use the phone. Staff said that sometimes they cannot find a resident when they receive a phone call because they are not in the facility (e.g. on a walk or being transported somewhere).

Staff said the resident was never told not to use the phone. Even when a resident repeatedly calls 911, they only can ask them to not call that number. Staff explained that residents have access to a staff member's offices if they want to have a private conversation but the group phone is not private. The only time they would restrict the residents is if a guardian were to request the restriction or if the police are involved. Staff said they will try to set up a schedule that works best if a resident is using the phone too often.

Staff explained that when doing the resident's inventory, they had been given an envelope by the resident that contained 3 rings. The resident's mother came to retrieve items in the inventory when the resident was discharged and they gave the envelope to her. Staff said that there was a broken watch that was also returned to resident's mom. The resident had brought the watch to a staff member asking if the staff member could fix it because the hands were broke. The staff member said that she could not fix it but she could lock it in a safe for the resident. Staff said that the resident had a bag of belongings when she was admitted to the facility.

Staff said that the resident's property was never taken away and the resident never complained about missing items, even when the suite mate came into her room. The resident's mother later said that there was a pink purse that was missing from the resident's belongings. They could not find that purse but staff replaced it with a purse that was not pink and this was accepted by the family. Staff explained that typically an aide helps residents inventory their items. It was also said that a pair of pants were missing. Staff explained when they picked her

up she did not have a purse. Staff said that items will be lost or misplaced. Staff also said people will refuse an inventory but staff still writes down items that were brought in for that person. Staff said they did not know about a flash drive. Staff also said they have safes where residents are encouraged to lock personal items. Staff said if they have valuable items, staff will ask the resident to have items locked up. This resident would not do an inventory so the Social Services Director wrote down items that she was aware of. Staff explained that they were given permission to give the property and documents to the resident's mother.

Staff said there is an inventory policy, and items are inventoried on admission and yearly.

Facility Tour

The staff took the HRA on a tour of the facility where the phone is located and, as staff stated, it was not located in a private area. The staff showed the HRA where a resident may go in a staff office to use the phone if they wanted to make a private call and there was an office where you could close the door to speak on the phone if a resident wanted privacy.

FINDINGS

Complaint #1 - Inhumane treatment, resident was assaulted by staff and other residents while in facility.

The HRA reviewed pertinent resident records and saw no indication that the resident was abused while in the facility. The HRA viewed an Illinois Department of Public Health (IDPH) complaint determination form which states that the complaint allegation of abuse was considered invalid. The HRA did see a situation, on 1/31/13, in the nurse's notes where the resident said that a female peer in the adjoining room came into her bedroom and started to go through her belongings.

Also, according to the nursing notes, the resident did go on a "pass violation" on several occasions during her stay at the facility, one of which resulted in the facility filing a missing persons report and then discharging the resident against medical advice. The HRA also reviewed a behavior observation sheet which indicated that on two occasions during the resident's stay, she was physically aggressive.

The HRA reviewed facility policy and procedure and saw that an abuse prevention policy was a part of the new employees orientation checklist. The facility also has an abuse prevention program/policy which reads "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents." The policy proceeds to provide definitions of

abuse, procedures for prevention of abuse including pre-employment screenings, a section on establishing a resident sensitive environment, and procedures for reporting and investigating abuse.

The facility also provided the HRA with an in-service training report for the date of 5/31/12 on the topic of resident's rights, and reporting and preventing, abuse, neglect and theft. There is an attendance list of staff on the back of the report sheet.

There is also a resident's rights document, which is distributed to residents, provided by the Illinois Department on Aging which reads "You **must not** be abused by anyone - physically, verbally, mentally, financially or sexually."

The HRA obtained a police report related to the incident via the Freedom of Information Act. The report was a missing persons report for the resident and there was no mention of assault. The police stated there was no assault report for the resident on the record.

The Skilled Nursing Facility and Intermediate Care Facility (SNF/ICF) regulations read "a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident" (77 Il Admin Code 300.3240). The Nursing Home Care Act mandates the same (210 ILC 45/2-107).

Conclusion - Complaint #1

Because the HRA found no evidence that the resident was abused by staff or other residents while at the facility, and because the facility has policy and training in place regarding abuse, the HRA finds this complaint **unsubstantiated.**

Complaint #2 - Resident not allowed personal property while in facility.

The HRA reviewed the resident's inventory sheet and saw a note on 1/29/13 that the resident refused to let the staff help her complete an inventory. The writer of the note stated that she gave the resident an inventory sheet and pen and paper and the resident gave the writer an envelope with 3 rings and asked her to lock it up. According to the notes, they checked to see if the resident had completed the inventory sheet on 2/1/13 and then later that day the resident told the nurse that she was not going to complete an inventory sheet. The notes also stated that there was an alarm clock and purse that were acquired after original entry. The notes also state that on 3/18/13 the resident came in to retrieve belongings and they gave her the rings that were in the safe.

A discharge note in the social progress notes on 3/11/13, reads "Res. Came in with her [family member] today to pick up her belongings to discharge today. This writer took rings and a watch (which did not work that res had locked up in S.S. [social services] safe out to her van. (Res and her [family member] were sitting in it). Res had brought me her watch to try and find a battery for it - She did not have any money but I noticed afterword there was a small metal piece rolling around in the face of the watch. I let her know this when giving it to her." There was no mention of a watch on the inventory sheet.

There is another statement in the social service notes dated 3/18/13 and 3/27/13 that the family had said there were items missing from the belongings when they had returned to retrieve them but neither the resident nor the family contacted the facility to check on the belongings after the initial statement.

An acknowledgement of the resident's rights, that was signed by the resident on 2/1/2013 reads that the resident has a right to personal property. In reviewing the facility personal property policy, it reads that any new clothing brought into the facility must be taken to the staff so it can be properly inventoried. The policy also states that anytime items such as clothes, jewelry, perfume, radios, etc. are received by residents, the items should be reported to staff so that they can be inventoried. It also says that items of value can be put in the "secured area" of the facility for safeguarding. The policy also states that the facility is not liable for lost or damaged property unless it is in the secure area for safekeeping. The policy does not specifically address the inventory process.

The SNF/ICF regulations read " b) A resident shall be permitted to retain and use or wear his personal property in his immediate living quarters, unless deemed medically inappropriate by a physician and so documented in the resident's clinical record. (Section 2-103 of the Act) c) If clothing is provided to the resident by the facility it shall be of a proper fit.(Section 2-103 of the Act) d) The facility shall provide adequate and convenient storage space for the personal property of the resident. (Section 2-103 of the Act) e) The facility shall provide a means of safeguarding small items of value for its residents in their rooms or in any other part of the facility so long as the residents have daily access to such valuables.(Section 2-103 of the Act) f) The facility shall make reasonable efforts to prevent loss and theft of residents' property. Those efforts shall be appropriate to the particular facility and may, for example, include, but are not limited to, staff training and monitoring, labeling property, and frequent property inventories.(Section 2-103 of the Act)" (77 Il Admin Code 300.3240). The Nursing Home Care Act establishes the same (210 ILCS 45/2-103).

The Nursing Home Care Act states that "A facility shall establish written policies and procedures to implement the responsibilities and rights provided in this Article. The policies shall include the procedure for the investigation and resolution of resident complaints as set forth under Section 3-702. The policies and procedures shall be clear and unambiguous and shall be available for inspection by any person. A summary of the policies and procedures, printed in not less than 12 point type, shall be distributed to each resident and representative" (210 ILCS 45/2-210). The SNF/ICF regulations read "The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting" (77 Il Admin Code 300.610).

Conclusion - Complaint #2

The HRA reviewed the documentation and saw no evidence that the facility did not allow the resident personal belongings while at the facility. The evidence actually shows the opposite, that the resident asked the facility to keep a watch and jewelry for safeguarding and the items were returned. The facility mentioned that the resident and family member requested a pink purse, which the facility did not have, but that item was not named as being an issue in the complaint, nor did the HRA see any documentation indicating that the resident had a pink purse or that the resident did not receive the correct purse. The HRA finds this complaint **unsubstantiated** but offers the following **suggestions:**

- The facility dictated that the resident gave a staff member a watch to safeguard but the watch was not added to the inventory. Assure that the staff is adding items to the inventory when they are being provided for safeguarding to assure that they are not lost.
- The Nursing Home Care Act and SNF/ICF regulations (210 ILCS 45/2-210 & 77 Il Admin Code 300.610) state that facilities should have policies regarding care, but the facility does not seem to have a policy that illustrates the inventory procedure, only a policy regarding personal items. The HRA suggests the facility create a documented inventory process.
- The HRA saw evidence that the resident accused a suite mate of going through her belongings without permission, but the HRA saw no evidence of an investigation or incident report. If it was not already done, the HRA suggests that the facility assure that all allegations of this manner are investigated thoroughly.

Complaint #3 - Communication violation, resident not allowed to contact family or 911 for seizures.

The HRA saw no indication that the resident was denied contact with family or not allowed to call 911, nor was there any evidence that the resident was not allowed to use the telephone for any reason. The HRA saw no indication in the records provided that the resident had a seizure while at the facility. The resident's care plan states that she is diagnosed with seizure disorder and had steps to follow if a seizure occurs. The HRA also saw no incident reports that the resident had a seizure or a grievance that the resident was not allowed contact with family. Also, in reviewing the nursing notes and other medical notes and records, there is no indication that the resident had a seizure.

The facility staff stated above that there is no communication or phone policy but the resident's rights provided by the Illinois Department on Aging, states that the resident has a right to private phone calls.

The SNF/ICF regulations state "Every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or visitation" (77 Il Admin Code 300.3250). The Nursing Home Care Act mirrors the regulation (210 ILCS 45/2-108).

Conclusion - Complaint #3

Because there is no documented evidence that the resident had a seizure or that the resident was not allowed to contact family, the HRA finds this complaint **unsubstantiated** but the HRA is deeply concerned about the facility's lack of policy and direction on telephone and communication rights. The HRA offers the following **suggestions** regarding communication rights:

- The HRA recognizes that there is an option for privacy for the residents when they want to make a private call but still feels that, if the resident is making a call regarding a grievance or possible abuse by the facility, asking staff if they can use the office may dissuade them from making the important call. The HRA strongly suggests that the facility put a phone in a private area where the resident does not have to ask a staff member to use the phone.
- As stated in the previous complaint, the facility should have a policy and procedure for the care of residents, including a phone policy. The HRA strongly suggests creating a phone policy for the facility to comply with the SNF/ICF regulations and the Nursing Home Care Act (210 ILCS 45/2-210 & 77 Il Admin Code 300.610).
- In the interview, staff said that they restrict the resident's calls upon guardian request but the HRA contends that residents choose with whom they communicate, not guardians, and rights can only be restricted under the Nursing Home Care Act prescribed conditions. Per the Act, telephone rights can only be restricted "… in order to protect the resident or others from harm, harassment or intimidation …" (210 ILCS 45/2-108) and restrictions cannot be dictated by a resident's guardian. The HRA suggests the facility rethink their practice and train staff to comply with the Act. Any communication concerns should also be reviewed as part of care planning.