FOR IMMEDIATE RELEASE

North Suburban Regional Human Rights Authority
Report of Findings
HRA # 13-100-9018
Niles Nursing & Rehabilitation Center

In June 2013, the North Suburban Regional Human Rights Authority opened an investigation of possible rights violations regarding Niles Nursing & Rehabilitation Center. The allegations accepted for investigation are that a resident's medical needs were neglected in that a resident reported heart attack symptoms and requested that emergency medical services be called; a supervisor was contacted instead and an in-house examination was recommended. It was also alleged that a resident filed a grievance and experienced threatening repercussions from staff members. Lastly, it was alleged that a resident was unjustly sent to a nearby hospital for behavioral health services. Residents receiving services at Niles Nursing and Rehabilitation Center are protected by the Nursing Home Care Act (210 ILCS 45/100 et. seq.).

Niles Nursing and Rehabilitation Center is a 304-bed facility that offers a Korean Program, Dementia Program and a Behavioral Health Program. The Behavioral Health Program is designed to assist individuals and their families in maintaining and improving quality of life as well as enhancing a resident's self-respect and dignity. Niles Nursing & Rehabilitation Center has a team of specialists that works closely with each resident, family member and family physicians or other health professionals to provide the appropriate care each resident needs. Residents are able to participate in vocational programs allowing for an opportunity to earn income and preparing them for community living in the discharge planning process.

Method of Investigation

In August after repeated requests, the HRA received portions of a resident's clinical record, with consent. An on-site visit was conducted in September 2013, at which time the HRA discussed the allegations with the facility's Administrator, the Assistant Administrator and the Director of Nursing (DON). The resident whose rights were alleged to have been violated was interviewed by telephone.

Findings

As stated above, it was reported to the HRA that a resident was experiencing symptoms of what he thought was a heart attack. Because the resident was not sent to the hospital upon immediate report of the symptoms, it was believed that his medical needs were neglected.

At the site visit, the Director of Nursing stated that the resident had been to the nurses' station earlier in the day (4/30/13) and he reported that he had a sore throat and wanted to go to the hospital. At this time, he was told that his physician would be contacted and when further questioned about the sore throat symptoms, the resident walked away. Later that morning (around 11:00 a.m.), the two nurses on the unit were working on a transfer of another resident (due to chest

pain) to an area hospital. The resident (whom had reported the sore throat pain) approached the nurses' station saying that he was having a heart attack and needed to go to the hospital. It was stated - and the record confirms - that the nurse observed the resident to be alert and oriented times 4; there were no observable signs of shortness of breath, no clutching of the chest, no sweating, and no nausea or vomiting. The DON stated that at that moment, the telephone rang and the nurse answered the phone and handed the phone to the resident. The call was a supervisor and the resident reported to this person that he felt like he was having a heart attack. The resident then immediately went to another telephone and called 911. The paramedics arrived and the resident was sent to the hospital. Nursing notes documented that at about 8:00 p.m., nursing staff contacted the hospital and learned that the resident had been admitted to the telemetry unit to be observed for chest pain. The resident returned to the facility on May 3, 2013, and according to documentation, there were no changes in his medical treatment. Nursing notes for the next three days document that the resident has no complaints of chest pain and he denies chest pain. The DON told the HRA that staff interviews after this incident revealed that the resident (after the reports of a sore throat) had been asking other residents and staff members about the consequences for calling 911. The DON offered that the nurse was interviewed and her observations were that the resident did not have any outward symptoms. The nurse took the time to answer the telephone call due to the fact that the resident was not acting any differently than she had observed in the past.

Regarding the allegation that the resident filed a grievance and experienced threatening repercussions from staff members, the Administrator offered a stack of grievances filed by this resident and said each resident has the right to file a grievance. The DON stated that she had no recollections of the resident reporting that a staff member had threatened him. But, in response to the opening HRA case investigation letter, the DON wrote that on May 9, 2013 the resident felt threatened by the Administrator and called 911.

In addressing the allegation that the resident was unjustly sent to the hospital for behavioral health reasons, it was stated that a resident would need to obtain a mental health evaluation if that resident was observed to be a danger to himself or others. It was stated that in this case, the resident reported that others were looking at him which he did not like and he became agitated and aggressive toward staff members. The resident subsequently called 911. The police arrived and interviewed the resident, admonishing him for calling the police for a trivial matter. The Administrator stated that the resident was then sent to the hospital as a consequence for calling the police in an effort to teach him that he cannot make frivolous calls.

According to the nursing progress notes, on May 8, 2013, the resident was sent to [a nearby hospital] on an involuntary petition for psychiatric assessment. Nursing notes documented that the resident had "poor impulse control gets angry very easily this evening requesting Ativan at 5 p.m.; he left at 7 p.m. by ambulance." The HRA reviewed the petition which stated that the "resident has a diagnosis of bipolar disorder and is presenting in a manic state as evidenced by aggressive behavior toward staff; abuse of the medical alert system; refusal to apply coping skills, all attempts by staff to redirect behavior have not been successful, resident will benefit from psychiatric evaluation on an inpatient basis and needs hospitalization to prevent harmful and further aggressive behaviors toward staff and peers."

The Center has a Guideline for Handling Behavioral Emergencies & Reducing Hospitalizations procedure which states (in part) that the organization recognizes that behavioral symptoms are a means of self-expression and most behavioral manifestations may be safely managed in the long-term care setting. The resident's best interests are generally not supported by the revolving door of frequent hospital admissions and relocations to one long-term care facility or another. The Guidelines state that the Center recognizes that some symptoms require hospitalization. In these cases staff are instructed to follow appropriate protocols to notify the

physician and make arrangements for hospital admission. This category includes violent behavior directed towards oneself or others (e.g., serious threat to injure oneself or another person). This category may include dangerous behavior with smoking materials or attempting to impose physical harm on themselves and others.

The Center has a Grievance and Concerns policy which states that the procedure for a grievance or concern is the following: 1) Have the resident complete a concern form. 2) Direct to the appropriate Department head. 3) Have appropriate Department do an investigation of grievance or concern. 4) Make Administrator aware of the investigation. 5) Follow up with resolution of grievance or concern. 6) Have Administrator sign concern form and place in Grievance binder, report results to Quality assurance meeting.

The Center's Abuse Prevention Program policy states (in part) that mental abuse includes but is not limited to humiliation, harassment, threats of punishment or withholding of treatment or services. The policy states that on a periodic basis but not less than annually, staff will receive a review of the above topics [physical, mental, sexual, verbal abuse; neglect, mistreatment, and misappropriation of resident property]. On a periodic basis, Supervisory personnel will receive training on their obligations under law when receiving an allegation of abuse, neglect, mistreatment, theft and how to monitor and correct inappropriate or insensitive staff actions, words or body language.

Conclusion

Pursuant to the Illinois Nursing Home Care Act, Section 2-112, "A resident shall be permitted to present grievances on behalf of himself or others to the administrator, the Long-Term Care Facility Advisory Board, the residents' advisory council, State governmental agencies or other persons without threat of discharge or reprisal in any form or manner whatsoever. The administrator shall provide all residents or their representatives with the name, address, and telephone number of the appropriate State governmental office where complaints may be lodged."

Section 2-107 of this Act states that, "An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. It is the duty of any facility employee or agent who becomes aware of such abuse or neglect to report it as provided in 'the Abused and Neglected Long Term Care Facility Residents Reporting Act'". The Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6) states that. "All reports of suspected abuse or neglect made under this Act shall be made immediately by telephone to the Department's central register established under Section 14 on the single, State-wide, toll-free telephone number established under Section 13, or in person or by telephone through the nearest Department office. No long term care facility administrator, agent or employee, or any other person, shall screen reports or otherwise withhold any reports from the Department, and no long term care facility, department of State government, or other agency shall establish any rules, criteria, standards or guidelines to the contrary."

The Illinois Administrative Code, Section 300.620 states that, "d) No person shall be admitted to or kept in the facility: 1) Who is at risk because the person is reasonably expected to self-inflict serious physical harm or to inflict serious physical harm on another person in the near future, as determined by professional evaluation; 2) Who is destructive of property, if the destruction jeopardizes the safety of him/herself or others."

The complaint was that a resident's medical needs were neglected in that a resident reported heart attack symptoms and requested that emergency medical services be called; a supervisor was contacted instead and an in-house examination was recommended. Nursing personnel did not observe any overt symptoms of a heart attack; before the in-house examination could be conducted the resident called 911 and was sent to a hospital. Since the resident, by his own initiative, received

emergency medical services before the in-house examination was conducted, it is concluded that rights were not violated.

The resident filed a grievance and experienced threatening repercussions from staff members. Based on the information obtained, the DON gave conflicting recollections about this allegation. She wrote to the HRA that the resident had reported being threatened by the Administrator; at the site visit she said the resident had not made this claim. During the site visit the DON could not recall that the resident reported being threatened. However, the DON recalled prior to the visit- in writing- that the resident complained about being threatened by the administrator; the HRA concludes that this written evidence supports the assertion. The allegation is substantiated.

It was alleged that the resident was unjustly sent to a nearby hospital for behavioral health services. The Administrator stated that the resident was sent to the hospital for an evaluation as a consequence for calling the police and an effort to teach him that he cannot make frivolous calls, neither meet the criteria for serious physical harm or destruction of property. The allegation is substantiated.

Recommendations

1. The facility must ensure that when determining the need for a psychiatric evaluation, the resident must be at risk because the resident is reasonably expected to self-inflict serious physical harm or to inflict serious physical harm on another person in the near future, as determined by professional evaluation or who is destructive of property, if the destruction jeopardizes the safety of him/herself or others. In addition, the petition shall include (405 ILCS 5/4-601) all of the following: 1. A detailed statement of the reason for the assertion that the respondent is subject to involuntary admission on an inpatient basis, including the signs and symptoms of a mental illness and a description of any acts, threats, or other behavior or pattern of behavior supporting the assertion and the time and place of their occurrence.
2. The facility must make certain that the Illinois Department of Public Health is contacted for all reports of suspected abuse and neglect.
3. The facility must ensure that all residents are treated with dignity and respect.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

01/31/2014

Guardianship & Advocacy Commission
9511 Harrison Street, W-300
Des Plaines, IL 60016-4263

Re: Michael Perl, Administrator
Statement Refute
HRA #14-100-9001

The facility's administration received the Guardianship & Advocacy Commission letter dated December 4, 2013. After reviewing the contents of the letter, the facility makes the following statements:

The Director of Nursing did, in writing, AND verbally to the Rights Coordinator that the resident, [redacted] "felt threatened by the Administrator", not that the Administrator threatened him, verbally or physically. No abuse occurred and no threat was made by the Administrator. Due to the resident's mental illness, he was responding to internal stimuli and delusions involving the Administrator and as a result perceived that there was a threat.

Also, [redacted] was evaluated by the nursing and interdisciplinary team on the day of discharge. He had been monitored throughout the day. His outbursts and anger escalated over the course of the day to where staff assessed that the resident was a threat to himself (he had pounded on walls with his fist and head on prior occasions and did make holes in the wall board) and he was pounding on the wall outside of the Administrator's office. It was also thought that [redacted] could potentially hurt others because of his anger. He was not responding to attempts at redirection; he was very angry with the Administrator because upon return from the hospital he felt management had not taken action towards staff members involved with his complaint of chest pain appropriately (he wanted the staff members fired). At no time did the Administrator threaten to send [redacted] to the hospital because of "calling the police and ... making frivolous calls."

The facility has been and currently is in compliance with all state and federal regulations in regards to reporting suspected abuse and neglect. [redacted] case was determined NOT to be abuse or neglect.

The facility does ensure that all residents are treated with dignity and respect, even when they exhibit verbal/physical aggression and behavior issues.

Sincerely Yours,

Michael Perl

Michael Perl