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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 14-030-9010
Eden Supportive Living

Case Summary: The HRA substantiated the complaint that the facility did not take adequate steps to provide for the safety and security of a recipient and did not provide adequate follow-up care after the recipient was assaulted. The facility response follows the report.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Eden Supportive Living (Eden). It was alleged that the facility did not take adequate steps to provide for the safety and security of a recipient and did not provide adequate follow-up care after the recipient was assaulted. This would violate the Supportive Living Facility Rules (89 IL Admin. Code 146.200 et seq.) and the Eden Supportive Living Resident Contract as signed by the complainant.

Eden Supportive Living is a 134-bed facility which is certified to accept persons with physical disabilities to provide them assistance with their activities of daily living.

To review these complaints, the HRA conducted a site visit and interviewed the Executive Director, the Wellness Director, the Wellness Assistant, and the facility Attorney. Program policies were reviewed as were the adult recipient's records upon written request, as well as the guardian's Letter of Office.

COMPLAINT SUMMARY

The complaint indicates that a resident and her roommate approached the Marketing Director in July, 2013 and expressed concern and fear regarding visits to their apartment from the roommate's boyfriend. The resident alleges that her roommate had told her that the boyfriend had been violent with the roommate in the past. The complaint states that the resident complained twice to staff about her fears regarding this man and nothing was done to protect her. On 9/11/13 the resident and this man became involved in a confrontation in which the resident was severely injured. After the incident she was not sent to the hospital for an assessment of her injuries or given the reassurance she required as a victim of this assault, but instead was later

found by her sister outside the building, shaking, and too afraid to return to the building. Allegedly, staff made a halfhearted attempt to find out what actually happened to cause the event and never resolved the issue. Additionally, staff did not consider the resident's injuries serious, and blamed the resident for the altercation.

FINDINGS

The record shows that the resident had signed her first Resident Contract in August of 2005 and yearly since that date. The record contains the Assisted Living Facilities/Adult Care Home Assessment and Care Screening form, which is completed upon admission and reviewed quarterly. In Section H. Disease Diagnosis it indicates that the resident has an Anxiety Disorder and Depression. The resident's Medication List is included in her record and indicates that she is prescribed the following psychotropic medications: Tegretol and Paxil.

The record contains a progress note dated 9/11/13 and written by the Marketing Director which indicates that the resident and her roommate approached the Marketing Director and requested that the roommate's boyfriend be told not to visit the roommate in the apartment. The two residents asked the Marketing Director to speak with the boyfriend, which she did, and he agreed to stay away. The Marketing Director then informed the resident that the boyfriend agreed to this plan.

The record contains two statements written by two staff members about the abuse incident. The first statement is written by the Wellness Assistant. It states, "[Resident] was taken to the Clinic [in- house] for evaluation. Writer then met with [roommate's boyfriend] who stated words were exchanged in [the resident's] apartment while he was visiting her roommate. Argument continued in the hall outside the apartment where [the resident] pushed his chair and he reacted by hitting [the resident] on the face with his prosthesis. Writer instructed [the boyfriend] to maintain his distance from [the resident] until he met with Executive Director. Police was called to file report but unable to do so per CPD pending hospital admission for [the boyfriend] for [mental health] evaluation."

The second statement is written by the Wellness Director and dated 9/11/13. It states, "Resident was seen by this nurse for skin tear, bruising, and bleeding sustained after a physical altercation with another resident. Resident's wound was cleansed with normal saline and dry dressing applied. Skin tear noted to be 10 mm in length below where the bruise is located. Resident encouraged to seek medical evaluation at a hospital, which resident had refused. Resident was then escorted to …… clinic for physical examination." The record also contains a form the police completed on 9/11/13 at 1:00 p.m. which identified the event as "simple battery", however the record did not contain a full police report and charges were not filed, because the boyfriend was not available at the time.

A form named Preliminary Incident Report is included in the record. It was completed on 9/11/13 and signed by the Wellness Assistant and states, "Writer heard loud screams coming from the hall by the main offices. Writer approached the situation and found [the boyfriend] and [the resident] being separated by the Activity Director and the Dining Service Coordinator. Writer instructed [the boyfriend] to go into the library while the Wellness Director took [the

resident] to assess an open cut she had on the side of her face." This is the Preliminary Incident Report that was faxed to the Illinois Department of Health and Family Services on 9/11/13 at 4:57 p.m.

Progress Notes written 9/11/13 by the Executive Director indicate that both parties to the incident were interviewed after the event. The interview with the resident states, "[Resident] appeared to be in shock. She kept asking the writer 'am I in trouble, I did say things and tip him out of his chair, but I was just defending myself!' Writer reassured [the resident] that she was not in trouble and that the priority at the moment was to have her see the doctor. [The resident] continued to ask 'am I in trouble?' and was insistent that she be able to leave the building b/c going out for coffee and a cigarette would help her feel better. Writer offered to get [the resident] coffee or juice, but she stated that she wanted to get it from the BP gas station. Writer explained that she could do those things, but to please meet w/ the Wellness Assistant to have her vital signs taken and then see the doctor. [The resident] agreed to do so, but then stated, 'after that I am going out.'

Progress Notes written at the same time describe the statement of the roommate's boyfriend. It states, "[The boyfriend] stated that he was called by his girlfriend to come and help her clean up some coffee that she had spilled. [The boyfriend] acknowledged that per the agreement his girlfriend had w/her roommate that he was not to go to the apartment. He stated that his girlfriend begged for him to come and help b/c [the resident] would be mad at her if she saw the spilled coffee on the floor. [The boyfriend] stated that [the resident] was outside the door trying to get in, but could not do so b/c she did not have her keys. [The boyfriend] explained that his wheelchair was backed up against the entrance door to the apartment as he was cleaning up the spill and he said to [the resident] 'hold on, hold on.' [The resident] said 'I don't have to hold on, I have my lunch and I need to come into my apartment, I don't need to wait.' [The boyfriend] stated that he moved his chair out of the way and began to propel himself out of the apartment as [the resident] was coming in and the two of them began to exchange words. He stated that [the resident] then grabbed the back of his chair and attempted to tip him out of it. [The boyfriend] stated that this upset him and that he was going to show [the resident] that even if he only had one leg that he could still defend himself, and so he started swinging his prosthetic leg at her and she swung back w/ her arms. He stated that he then left the scene to come down to the main lobby to speak w/ administrative staff. [The boyfriend] stated he was knocking on the Executive Director's door when [the resident] was coming down the hall and they began to exchange words again. He stated that he then 'put her up against the wall and that she was hitting back'. Staff had to separate them." The roommate was also interviewed and indicated that the resident came to her apartment, realized the boyfriend was there, left the apartment, and was followed into the hall by the boyfriend.

Progress Notes from the Executive Director for 9/11/13 show that she contacted the resident's Public Guardian, the resident's sister, the boyfriend's brother and his case manager. The boyfriend was sent to an area hospital for a psychiatric exam.

Progress Notes from the Executive Director written 9/12/13 indicate that the resident's sister had come to Eden the evening of the event and picked up her sister, "She stated that [the resident] was 'pretty shaken up' and that she was shocked by the injury of her face. She

questioned the writer as to why she had been permitted to leave the building as she has impaired cognition as a result of her physical disability. Writer explained that they had encouraged her to remain in the building, but that she insisted that she would feel better if she could go outside to have some coffee and a cigarette. Writer explained that it was important that she be seen by the doctor before doing so, to which the resident agreed." On 9/13/13 the resident was taken by her sister to an area hospital to have her examined due to the swelling of her eye. The resident resided with her sister until 10/05/13.

Progress Notes from the Executive Director written on 9/23/13 indicate that a meeting was held which was attended by the Executive Director, the resident, her sister, and the resident's guardian regarding the event. Part of the meeting addressed the fact that the resident had alerted staff to the danger of the boyfriend and nothing was done to address it before the fight broke out on 9/11. The Executive Director stated that "there was no indication that this resident presented as a physical threat to others." The notes also indicate the resident's sister's concerns about her sister's treatment after the event: "[The resident's sister] then presented the writer w/ photos that she had taken of [the resident's] face. She asked the writer how [the resident] could have been permitted to leave the facility when clearly she was 'shaken up'. She stated that on the evening of the incident she arrived at the building at 8:30 p.m. and that [the resident] was outside 'too scared' to go back in to Eden's. [The resident's sister] questioned as to how Eden's staff could have gone home for the evening and left her all alone in her condition. Writer explained that there was C.N.A. staff present 24 hours per day in the building. Writer further explained that she had to encourage [the resident] to stay in the building to see the nurse and her PCP [primary care physician]. Writer explained that the PCP did not provide any special orders that should be followed for [the resident] that evening. [The resident's sister] asked why [the resident] had not been provided with social services. Writer explained that she had met w/ [resident], as had the Marketing Director; the Wellness Assistant, and the Wellness Director to give [the resident] an opportunity to express her feelings. [The resident] interjected 'I got tired of having to sit w/ these people; I just wanted to go out.' Writer further explained that a 3rd party psychologist did come to the building to meet w/ residents that were interested in counseling services. Writer explained that this option was still available to her."

The aforementioned meeting also addressed the resident's safety concerns: "[The resident's sister] then stated that [the resident] did not feel safe in the building and asked [the resident] to tell the writer about her concerns. [The resident] stated that she feared for her safety and that she slept with a bicycle propped up against her door. She stated that there were 'druggies and crackheads' in the building that she did not know what they would do. Writer stated that this was the first time that she was hearing about this and [the resident's sister] stated that [the resident] kept these things to herself b/c she did not want to get into trouble. Writer emphasized to [the resident] that she would get into trouble and that it was important for her to address these concerns. Writer explained that she wanted to make sure that residents did indeed feel safe in the building. Writer asked if there was a specific individual or situation that she should be aware of and she responded, 'no, but I will do that in the future.'"

Progress Notes from the Executive Director written 9/24/13 state, "Writer contacted [the resident's sister] and informed her that they would like to offer [the resident] the option to return to Eden and to remain in the unit w/o a roommate. Writer explained that she would be

introduced to roommates and would be expected to accept one that she found to be reasonable within a 3 month time frame or agree to move out after that time. Writer explained that she would remain on the waiting list for a studio. [The resident's sister] states that she would discuss this w/ [the resident] this evening. …[The resident's sister] then stated that she had forgotten to tell the writer in yesterday evenings meeting that [the resident] had reported that her glasses were broken during the altercation and that she was missing her left hearing aid. Writer stated that [the resident] could see the optometrist that visited the building when she returned to see if they could be repaired. Writer explained that no one had turned in a hearing aid or ipod [also reported missing]. Writer stated that she preferred not to look through [the resident's] room for these items w/o her present. [The resident's sister] agreed and stated that they could do so when she returned."

Progress Notes from the record show that the resident was seen by an Ophthalmologist for concerns of swelling under her eye on 10/10/13 and that she was also to be evaluated by an Audiologist on the same day (no findings from this exam). The record does not contain a final report on the altercation and the record does not indicate that it was reported to the Illinois Office of the Inspector General.

The resident's guardian has provided photographs of the resident's injuries taken the evening after the event for review by the HRA. The photos show the resident's left eye swollen shut, lacerations to the left side of her face and arm, bruises and swelling covering the left side of her face, a thumb print on the recipient's neck, and cuts to her arm.

Facility Representatives' Response

Facility representatives were interviewed about the complaint. They indicated that the altercation between the resident and her roommate's boyfriend (also a resident) had begun on the third floor where the resident lived with her roommate. Staff did not become aware of the fight until later, when the two parties had both come to the first floor of the building, to the hallway of the administrative offices, where it erupted again sometime around noon. The two parties were separated by maintenance staff and then they were assessed by the Wellness Assistant and the Wellness Director respectively. The Wellness Assistant met with the boyfriend in the facility Library, and she stated that she did not see any injuries on him. He was then voluntarily sent to an emergency room for a psychiatric evaluation and later agreed to return to the nursing home from which he had come before residing at Eden. The Wellness Director was at the same time assessing the resident in her office. She stated that the resident was "hysterical." The Wellness Director indicated that the resident had bruising, swelling, and cuts to her face which were treated immediately, and then an attempt was made to call for the in-house doctor, who saw the patient in the in-house clinic. The physician left no orders for any follow-up care for the resident. Later, the resident had expressed that she wanted to go outside to a convenience store to get a cigarette and she then left the building. The Wellness Assistant and Wellness Director left the facility at approximately 5:00 p.m. and the Executive Director left around 6:00 p.m. The resident's sister arrived at the building around 8:30 p.m. the same evening, which is when the resident was found outside the building and when the resident reported that she was too afraid to re-enter the building. Sometime after the event the Wellness Assistant returned to the 3rd floor to search for the resident's glasses which were knocked off in the scuffle, and a shattered lens was

found, however the rims were not recovered. Staff also made an attempt to find the resident's hearing aid which was knocked out of her left ear, however the hearing aid was never found.

Staff indicated that the police were called at 12:30 p.m. the day of the incident and arrived at approximately 1:00 p.m. No report was completed of the event because the boyfriend was not available for questioning. The Executive Director was asked if she had considered filing charges against the boyfriend but she said she had not. The HRA also asked the Executive Director if she had received the police report and she stated that the police had told her she could not have reports in the past so she did not attempt to get it. The Executive Director indicated that she called the Illinois Department of Health and Family Services (IDHFS) at 4:57 p.m. on 9/11/13 with the Preliminary Incident Report. The HRA requested but did not receive a Final Report of the Incident as described in the Administrative Code for Supportive Living Facilities (see below). Staff were asked if they were aware that they are mandated reporters and they did not appear to be aware of this, however the Director responded by saying that she called the incident in to IDHFS. The Executive Director indicated that the staff took the situation very seriously and she interviewed all of the parties involved in the event the same day. She also met with the resident's sister over the following days and continued to investigate the events and the condition of the residents.

Staff were interviewed about the presence of security in the building. They indicated that security staff is present from 7 p.m. in the evening until 8 a.m. in the morning. During the day there is a concierge present at the front desk and they are able to observe video screens of activity throughout the building. Staff were asked about the resident's fears regarding the boyfriend before the event, particularly the behavior plan which was agreed upon by the boyfriend to stay away from the resident's room. The Executive Director indicated that generally when there is a problem between two residents they are asked to stay away from each other, however there was no reason for staff to think that the boyfriend was dangerous and he had no history of being dangerous to her knowledge.

STATUTES

The Illinois Administrative Code for Supportive Living Facilities defines mental illness as, "A diagnosis of schizophrenia, delusional disorder, schizoaffective disorder, psychotic disorders not otherwise specified, bipolar disorder, and recurrent major depression resulting in substantial functional limitations" (89 Ill Admin. Code 146.205). It defines neglect as "A failure by the SLF to notify the appropriate health care professional, to provide or arrange necessary services to avoid physical or psychological harm to a resident or to terminate the residency of a residency whose needs can no longer be met by the SLF, causing an avoidable decline in function." Neglect may be either passive (non-malicious) or willful. Service plan is defined as "the written plan of care on the Department [IDHFS] designated form that is developed for each resident based upon the initial assessment, annual comprehensive resident assessment, or quarterly evaluation." The Code also states that "An SLF must combine housing, personal and health related services in response to the individual needs of residents who need help in activities of daily living." These needs are determined by a comprehensive resident assessment and service plan (146.245). The SLF must complete an initial assessment and service plan within 24 hours after admission and a comprehensive resident assessment within 14 days after admission

which is reviewed annually or when there is a change in the resident's mental or physical status (146.245).

The Illinois Administrative Code for SLFs outlines the requirements for participation in a SLF. Candidates must be 22 years of age or over with a disability, or over the age of 65, must be screened by the Department or other Sate agency screening entity and found to be in need of nursing facility level of care, must be without a primary or secondary diagnosis of developmental disability or serious and persistent mental illness, and must be checked against state and federal sex offender registration lists (146.220).

The Illinois Administrative Code for SLF states, "The SLF shall have response/security staff awake and available on the premises 24 hours a day to respond to scheduled or unpredictable needs and emergency calls from residents. Staff shall possess certification in emergency resuscitation. The SLF shall provide no fewer than one staff person for facilities with one to 75 residents, a second staff person for facilities with 76 to 150 residents, and a third staff person for facilities with 151 or more residents. In determining the number of staff, the SLF shall consider the number of floors in the building, and the medical needs of the residents. At least one certified nursing assistant shall be on site 24 hours a day to respond to resident needs" (146.230).

The Administrative Code for SLF outlines Resident Rights (146.250). It states that:

a) Residents shall be afforded all rights guaranteed under the Constitution of the United States and State of Illinois, federal, State and local statutes and the Department's administrative rules.

b) Residents shall be informed of all rights in conjunction with any contracted housing and services.

c) Department posters with the phone with the phone number of the Department's Complaint Hotline shall be posted on each floor of the SLF in a location accessible to all residents. Department brochures providing resident rights and phone number to the Complaint Hotline shall be made available to all residents and their families or designated representatives.

d) Long Term Care Ombudsman Program posters provided by the ombudsman shall be posted on each floor of the SLF in a location accessible to all residents.

e) Each resident shall have the right to be free from mental, emotional, social, and physical abuse and neglect and exploitation…"

The Illinois Administrative Code for SLF (146.205) indicates that "Mandated Reporter" is anyone identified in the Elder Abuse and Neglect Act (320 ILCS 20) which states that all personnel of the DHFS are mandated reporters who shall report suspected abuse while engaged in carrying out their professional duties.

The Illinois Administrative Code for SLF (146.305) outlines the process for responding to reports of suspected abuse, neglect, or financial exploitation. In part it states,

a) SLF staff shall make a report when there is suspected abuse, neglect, or financial exploitation of the SLF resident. A person making a report in the belief that it is in the alleged

victim's best interest shall be immune from criminal or civil liability or professional disciplinary action on account of making the report, notwithstanding any requirements concerning the confidentiality of information with respect to the eligible adult that might otherwise be applicable.

b) The SLF manager or employee shall contact local law enforcement authorities immediately when suspected abuse, neglect, or financial exploitation involving physical injury, sexual abuse, a crime or death occurs to a resident as the result of actions by a staff member, family member, visitor, or **another resident**. SLF serving persons age 22 through 59 may also contact the Department of Human Services, Office of Inspector General Hotline, for an investigation of allegations of abuse, neglect, or financial exploitation.

c) Facility staff shall be trained at orientation and at least annually thereafter on the definitions of abuse, neglect and financial exploitation; on appropriate interventions, on how and to whom to report suspected abuse; neglect and financial exploitation; and emphasizing that reporting should be immediate.

d) Residents, family members, and residents' designated representative shall be made aware of the SLF's policy relating to reporting of suspected abuse, etc.

e) Upon the occurrence of suspected abuse, neglect or financial exploitation that results in contact with local law enforcement, the SLF manager or designee must provide a preliminary report to the Department by fax within 24 hours after the occurrence. This includes, but is not limited to, suspected abuse of any nature, allegations of theft, elopement of residents or missing residents, and any crime that occurs on facility property. The preliminary report shall include, at a minimum:

1) name and location of the SLF;
2) description of the situation, including what is alleged, what steps have been taken to immediately protect the residents involved, and any injury;
3) number and names of residents involved;
4) other State or local agencies notified about the abuse, neglect or financial exploitation.

f) The SLF manager or designee shall submit a final report to the Department that includes how the investigation was handled, final outcome, who was involved, and what steps were taken to prevent the situation in the future.

g) The SLF manager or designee shall be responsible for notifying the appropriate law enforcement or regulatory agency if reports of abuse, neglect or financial exploitation by a certified or licensed staff person are substantiated.

The Resident Contract for this resident was reviewed for this investigation. It outlines all the resident rights and encourages residents to exercise them. Grievances and recommendations for changes in policies and services "may be voiced to facility staff or outside representatives without interference, discrimination, reprisal, coercion or restraint." Contact information for lodging complaints is offered for Eden, the Illinois Division of Rehab Services, and the Illinois Department on Aging. Contact information for IDHFS and OIG are not included. Listed under the Section 8. 24- Hour Response/Security Staff it states, "Response/security staff persons shall be available on the premises 24 hours a day to respond to scheduled or unscheduled needs and emergency calls from residents. Security shall be provided 24 hours a day and shall include

lockable entrances (accessibility controlled by Eden staff for security purposes during overnight hours) and on-site personnel. All residents shall have 24- hour access."

The Illinois Administrative Code for SLF (146.215) states that in order to participate in the Supportive Living Program, an SLF must submit an application for approval of all policies that include but are not limited to Participation Criteria, Resident Daily Check Plan, Resident Rights, Resident Discharge Policy, Grievance Procedure, Quality Assurance Plan, Prevention and Reporting of Abuse, Neglect and Financial Exploitation, and Staff and Resident Rules and Responsibilities.

FACILIY POLICY

Eden Supportive Living provided policy regarding Managing a Violent Resident. It states that if there is a direct threat to harm a person or property, staff are to call 911 immediately and complete an Incident Report to be forwarded to IDHFS immediately. Abuse is defined as "An employee's non-accidental and inappropriate contact with an individual that causes bodily harm. Physical abuse includes actions that cause bodily harm as a result of an employee directing an individual or person to physically abuse another person. The bodily harm does not have to be a visible injury." The policy does not include injury as a result of resident to resident injury. The policy requires that the Office of the Inspector General hotline as well as 911 must be called immediately. Additionally it states, "It is required that an allegation must be reported to the OIG Hotline within 4 hours after it was originally discovered by staff."

Eden Supportive Living policy on Abuse and Neglect Reporting states, "As part of the initial staff orientation or resident move-in process, the Director of Nursing and/or the Executive Director will review the Abuse and Neglect Reporting process. The Reporting process will also be posted in various strategic locations throughout the Eden Supportive Living building. Any concerns about various residents will automatically result in a review at a weekly clinical high risk meeting, hotline call, or 911, depending on the severity of the abuse or neglect."

The Eden Supportive Living "Procedure for Reporting Abuse and Neglect to OIG" offers definitions of abuse, neglect, and mental injury. To the question of when should I call the hotline? it states, "If a person with disabilities tells you that he or she has been harmed by a caregiver, if you see an employee hitting a person with disabilities, or if you see an injury on a person with disabilities' body that does not appear to have been caused by an accident."

CONCLUSION

Eden Supportive Living policy indicates that any safety concerns about various residents "will automatically result in a review at a weekly clinical risk meeting." The resident in this case reported her concerns about her roommate's boyfriend to the Marketing Director in July, two months before the assault that took place on 9/11/13 and it is not clear from the record or from staff report that any discussion was initiated with the treatment team regarding the risk associated with the boyfriend and the resident he assaulted (or any other residents). The record shows that the boyfriend was asked to stay out of the resident's room, however there was no consequence attached to the plan if he chose to ignore it. Also, the resident's Resident Contract indicates that

"Response/security staff persons shall be available 24 hours a day to respond to scheduled or unscheduled needs and emergency call from residents", however staff stated that security is only available at night.

The HRA reviewed the photos taken of the resident's injuries after the attack. In addition to bruising, swelling, lacerations, and hand prints on the resident's neck, the attacker also hit the resident hard enough to dislodge her hearing aid from her ear and knock her glasses off her face, shattering the lens. The Wellness Director described the resident as "hysterical" and the Executive Director described her as "in shock" after the event, yet she received no follow-up care beyond a dressing for her lacerations, and she was not placed on a close watch plan in case she suffered a concussion. The record does indicate that the staff offered to send her to a hospital but that she refused. Given her state of mind and the blow that she took to her head it seems reasonable that staff would convince or mandate that the resident be examined at a local emergency department. Instead, the resident left the facility to buy cigarettes and she was later found by her sister, outside the building, too afraid to come back into the facility.

The report is missing a comprehensive investigation of this event. The first report describes only a few details of the event which occurred on the third floor, which the staff writing the report did not witness. It does not mention who reported these events, injuries to the resident, the loss of her hearing aid or glasses, or her fear of being in the building. The second report describes the resident's injuries but again does not mention her glasses, her hearing aid, or what had happened to cause her injuries. The third Preliminary Incident Report describes nothing at all and relates the final moments of the event when the resident and the boyfriend are separated. Most of the information is provided by the boyfriend, who admitted that he struck the resident with his prosthetic leg and "put her [the resident] up against the wall…" which explains the resident's neck bruises and the strength of the boyfriend against this rather small woman. The roommate also gave a rather telling statement in which she indicates that the resident approached her room, realized the boyfriend was inside, left the room and the boyfriend followed her into the hall, initiating the attack. The victim's account of the event occurred when she was, by staff account, "in shock" and "hysterical." The Administrative Code for Supportive Living Facilities mandates that the SLF manager or designee "shall submit a final report to the Department that includes how the investigation was handled, final outcome, who was involved, and what steps were taken to prevent the situation in the future." The HRA requested, but did not receive, this report. And finally, the HRA has, throughout this investigation, been surprised by the facility staff's defense of the gentleman who attacked the resident. The boyfriend in this case suffered no injuries, while the resident was beaten on her face, head, and body, and staff continue to blame inflammatory language as a defense to his behavior. Additionally, those staff persons most adamant in their defense of the boyfriend, had never seen the pictures of the resident's face until the HRA presented them on the day of the site visit. These pictures would make clear to anyone the seriousness of this resident's injuries.

The Administrative Code for Supportive Living Facilities as well as the Eden Supportive Living Policy mandate that the Illinois Office of the Inspector General hotline as well as 911 must be called immediately when abuse occurs within the facility. Additionally it states, "It is required that an allegation must be reported to the OIG Hotline within 4 hours after it was

originally discovered by staff." The record does not show that the facility ever contacted the OIG.

The HRA substantiates the complaint that the facility did not take adequate steps to provide for the safety and security of a recipient and did not provide adequate follow-up care after the recipient was assaulted.

RECOMMENDATION

1. Train all staff in the facility policy which instructs the staff to automatically review at-risk residents at a weekly clinical risk meeting. If a resident reports a fear of another resident, review this at the weekly meeting and take steps to ensure the safety of all residents.

2. Develop and review with staff the policy and procedure for responding to allegations or actual incidents of abuse/violence. Ensure that all staff are aware that they are Mandated Reporters and that they have a duty to report all allegations of abuse, neglect, or financial exploitation. Report all abuse immediately to the police and within four hours of the occurrence to the Illinois Office of the Inspector General. Include on the Resident Contract contact information for both the Illinois Department of Health and Family Services and the Office of the Inspector General.

3. Review with nursing staff the protocol for responding to emergency situations, particularly those which may involve head injuries.

4. Complete a thorough investigation of every allegation of abuse, neglect or financial exploitation which results in the Final Report that is mandated by the Administrative Code and facility policy to include how the investigation was handled, the final outcome, who was involved, and what steps were taken to prevent the situation in the future. Revise facility policy to include the completion of the Final Report. Revise facility policy to comport with the mandated requirements for reporting abuse as outlined in the Administrative Code for Supportive Living Facilities.

5. Post the contact information for OIG throughout the facility.

SUGGESTIONS

1. What happened in this event was a crime of battery. The man who inflicted these injuries on a facility resident voluntarily transferred himself to his former nursing home, where he now resides with other, even more vulnerable residents. If a complete investigation had been done to reveal all the details of the crime in one report, the HRA believes the facility would have realized the wisdom of pressing charges so that this crime would be punished and possibly deterred from happening again.

2. The facility policy on reporting abuse is confusing and does not comply with Supportive Living Facilities regulatory requirements. Policy directs staff to call the OIG hotline: If a person with disabilities tells staff that he or she has been harmed by a caregiver, if staff

witness an employee harming a resident, or if staff see an injury on a resident that does not appear to have been caused by an accident. In related policy, resident on resident injury is not reportable. The facility should clarify their own reporting policy and procedure and train staff to respond whenever an alleged injury has occurred that was not caused by an accident.

3. The facility in this case resisted the advocacy of the HRA due to the qualification for residency as outlined in the Administrative Code for Supportive Living Facilities: "Candidates must be 22 years of age or over with a disability, or over the age of 65, must be screened by the Department or other Sate agency screening entity and found to be in need of nursing facility level of care, must be without a primary or secondary diagnosis of developmental disability or serious and persistent mental illness, and must be checked against state and federal sex offender registration lists (146.220)." The resident in this case, however, has been adjudicated a ward of the State, is also noted in her Resident Assessment Instrument to have a diagnosis of Anxiety Disorder and Depression, and is also receiving psychotropic medication to treat her symptoms of mental illness- all of which qualifies her as a mental health recipient and an "eligible person" under the Mental Health Code. The HRA suggests that the facility review its policy and procedure for screening residents. And finally, the HRA is not confined to Mental Health Code investigations but instead may make recommendations to any service provider about safeguarding the rights of eligible persons. In this case, we have applied the Administrative Code which authorizes and regulates the operation of the facility and their own policy and procedure.

RESPONSE

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

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Hines, Illinois 60141

Re: #14-030-9010

I represent Eden supportive Living in Chicago. This report serves as the response from Eden Supportive Living regarding case #14-030-9010. The facility requests this response be included in any publicly released report concerning this matter. To preserve the privacy rights, the 3 residents involved in this matter shall be designated "R1 (the female represented by the Advocate, R2 (R1's apartment mate), and R3 (the other resident with the prosthetic leg).

JURISDICTIONAL MATTERS

As acknowledged in the Advocate Report, R1 has been a resident of Eden SLF for about 8 years. She has a tertiary diagnoses of an anxiety disorder and depression in addition to her primary diagnosis of physical disabilities including, brain injury. Eden provides a residential apartment, meals and assistance with her activities of daily living. Were her mental disabilities to be deemed "serious" or "significant" mental illness under Illinois mental health laws and the State's Supportive Living Facilities Program, she would not be eligible for residency at Eden. Similarly, the Mental Health Code distinguished between "significant" mental illnesses and "non-significant." R1's 2004 application papers indicated both conditions of "anxiety" and "depression" in addition to her physical diagnoses. There is nothing in her initial screening nor in Eden's subsequent experience with her as a resident for about 8 years to indicate these conditions should be considered either "significant" or "serious". It also should be noted that Eden is not a hospital or medical care facility. It is not staffed with or licensed to provide

physicians or psychiatrists and the financial assistance provided under its Medicaid Waiver Program does not cover such services.
Nevertheless, while not acquiescing in any suggestion this matter should be governed by the State's Mental Health Code as it applies to persons with "significant mental illness", Eden has cooperated with the Advocate's Office in its investigation of this matter with a view to gaining better insight into ways in which its operations might be improved with respect to matters related to the subject incidents while operating within scope and intent of the "Supportive Living" regulatory matrix.

RESPONSE TO ADVOCATE'S FINDINGS AND CONCLUSIONS

Going beyond the above jurisdictional matters, the Advocate's Report contains a number of findings, and conclusions Eden wishes to either supplement, clarify or, in some cases, dispute, including:

- Although R1 claims to have complained to Eden staff in July of her fears for safety due to actions of R2, there is no record ofany such complaint. To the contrary, the files contain reports of many statements and occurrences, but nothing about a danger posed by R2. Instead the 9-11 report of Eden's marketing director refers only to a joint request by R1 and R3 that R2 not visit R2 in the joint apartment she shared with R1. Eden's manager's understanding of this request is that it related to a personal dislike R1 had of R3.
- Eden provides response/security for the entire facility on a 24/7 basis, in that it has a fully operative video camera system in place monitored by the front concierge desk, plus at least 3 CNAs on duty at all times, including the weekend day when the events took place. There is a security person seated at the concierge desk during the evening hours when the need for CNAs and other staff services is greatly reduced. There is nothing in the DHFS Regulations or in the Resident Leases to limit or define the word "security" to mean anything more than what is provided by Eden. The Eden SLF facility, which is carefully monitored by the DHFS, has never required SLFs to engage persons functioning solely as security guards on a 24/7 basis. Nor is there any basis for believing the presence in the 4 story 70,000 foot building of a daytime security guard (in addition to the concierge, 3 CNAs, the Wellness Director, Marketing Director and Activity Director would have prevented any of the events here involved.

- The incident at hand arose as a result of a pre-existing personal conflict or dislike between 2 residents that started in and outside the 3rd floor apartment shared by R1 and R2 as an exchange of racially tinged words and insults, moved to a shoving incident followed by a retaliatory strike by R3 who removed his prosthetic leg and used it as a stick to ward off R1, all out of the presence of Eden staff. The parties then removed from the 3rd floor apartment to the first floor corridor outside the manager's office where the parties re-engaged each other with each of them apparently swinging and/or shoving the other for a time interval measured in seconds or minutes until staff intervened and restored order. While the Advocate concludes R1 was the victim and R3 the perpetrator, the persons who investigated the matter contemporaneously with the incidents, did not view the matter as so one sided. Apparently, the Advocate's conclusion is based upon the pictures of R1 taken 1 or 2 days after the incidents, the statements of R1's sister who was not present during the incidents, the roommate R2, and of course R1 herself. It appears gender imbalance and presumed weight and size differentials of the 2 residents outweighed the offsetting physical impairment's of R3 in the Advocate's determinations. Eden staff persons present immediately afterward had the benefit of hearing the spontaneous utterances of the parties and observing their comparative demeanors reached a different conclusion, as did the Chicago police officers who arrived to the scene within minutes of the incident.
- The injury pictures of R1 taken at the R1's direction 1 or 2 days after the fight show facial abrasions and cuts which are disturbing. When R1 was interviewed on the day of the incident, the cuts and bruises had not yet swelled and the injuries appeared far less disturbing than those shown in the photos which showed the effects of the time lapse on the injuries, and the swelling that occurred during the 24 or 48 hours aftermath. The Report concluded "those staff persons most adamant in their defense of the boyfriend, (sic.) had never seen the pictures of (R1's) ... face until the HRA presented them on the day of the site visit (in December)...." This is not true since R1's sister later showed them to Eden's manager at their September 23rd meeting. Clearly, R1 received facial and other contusions during the exchange of blows with R3 in the first floor hallway and also during the unobserved third floor encounters between them. It is not known whether or to what extent R3 may have also suffered physical injuries during these exchanges as he immediately removed himself from the premises and has not returned. While R1's physical injuries appear more serious than any physical or psychological injuries to R3 from the racial taunts and insults or blows delivered by R1,

it is unfair to belittle them. So far as is known to Eden, the injuries to both parties do not appear to be permanent.

- The Report concludes Eden's manager had a mandatory duty to report the incident to the OIG. It interprets the word "may" in the State DHFS Regulations as "mandatory." This is not the meaning of the word "may" . Nor is there a legal duty or responsibility created under either the Eden Resident Contract or the Eden policy statement on violence on the part of Eden staff to report to the OIG injuries incurred in "resident to resident" conflicts. Eden reported the incidents immediately to the DHFS and to the Chicago Police Department. Follow up reports were sent to DHFS and the 2 residents were each directed to appropriate persons or facilities for medical attention. R3 was sent to the emergency room at a nearby hospital for psychiatric examination resulting in his voluntary removal from Eden and placement in his former nursing home. Eden's manager initially R1 suggested go to a nearby hospital for evaluation and treatment, but R1 preferred not to do so. Instead she was directed to her own Primary Care Provider ("PCP") , a Dr. S. , who examined R1 and directed her medical condition. In addition the Eden manager notified R1's sister and her Public Guardian, as well as R3's brother and case manager. As the matter did not involve an injury caused to either resident by any Eden employee, the OIG was not notified.
- The Advocate refers to the PCP to whom R1 was referred for evaluation and treatment on the afternoon of the incident as an Eden "in house doctor" and his office as an "in house clinic". This is untrue. The doctor and his clinic is an independent medical office which leases space from Eden but is in no way affiliated or controlled by it. While the doctor and his clinic lease an office in Eden's building as a convenience to Eden's residents, Eden is affiliated with them and is no more responsible for the treatment they proscribe than for that provided by the nearby hospitals. Should the Advocate question what the doctor proscribed that day, she should direct the criticism toward the doctor and his clinic. Should the Advocate question the credentials of independence of the doctor and the clinic, she is free to do so, but Eden stands ready to defend its position as completely independent of the doctor and his clinic and strongly resents any suggestion or inference to the contrary. In addition, it should be noted R1's sister, a health care professional, apparently took R1 to a hospital near the sister's home for treatment during the 24 days R1 was residing with her.
- The doctor's office assumed control of R1's health by examining her at the clinic and proscribing her course of treatment. No warnings to Eden were given of a possible

concussion and, to Eden's knowledge, there is no evidence R1 ever suffered a concussion as a result of the subject altercation. Upon return to the Eden manager's office, R1 took matters in her own hands and asked to leave the building. Eden had no right to prevent her from doing so. Eden is not a nursing home and is not a medical treatment center. Eden's manager could not have prevented R1 from leaving the building. R1's sister was called and arrived 2 to 2 1/2 hours later, took R1 home with her. R1 did not return to Eden and resume her residency there until October 5th, 24 days after the incident. R1's sister is known to Eden to be a health care professional. During R1's absence from the building for these 24 days, R1 was in her sister's care, not Eden's. Thus Eden was not in a position to take pictures of her facial injuries or to even know of their extent.

- The statutes and Eden policy directives clearly require reporting of abuse and injuries to the DHFS and the local police. Eden did so immediately, notifying police within minutes and DHFS several hours of the altercation. R3's case manager, R1 sister and public guardian was also so notified the same afternoon. It is not clear "resident to resident" injuries are included in the mandated reporting to the OIG. The DHFS Regulations and the Eden policy directive clearly make this requirement discretionary in the resident to resident situations.
- R1's Eden Resident Contract was executed in July, 2005 as one of the very earliest Eden residents. The form of this early contract does not list either the DHFS or OIG as agencies with Hotline Phone Numbers for reporting of grievances. Eden agrees DHFS should be listed as a contact agency on the form Residential Contracts and Leases used by Eden and in fact it has included this information on its new contracts and leases since at least 2008. Most probably, the change in the original contract to include DHFS was made at DHFS's request and insistence when it reviewed and approved the form of Eden's contracts shortly after it opened as a SLF facility in 2005. Regardless of exactly when and how the change came about, the current Eden contracts (including R1's own contract) clearly list DHFS as one of the alternative contacts concerning contract and policy disputes and questions.
- The Report recommends OIG be included in the list of agencies for residents to contact with their "grievances", presumably those relating to their residency at Eden. It is doubtful OIG would be interested in being contacted about these types of issues. Even so, were OIG to be included, they it would only make sense to include the other investigatory offices involved in abuse cases, such as the DHFS Ombudsman, the Cook

County States Attorney, the Chicago Police, the Consumer Affairs Office and the like. To do so is more likely than not to create confusion on the part of the residents intended to benefit from the listings. Rather than including such agencies in the leases and resident contracts, it would be more effective to list them on signage to be posted on the message boards throughout the Eden facility.

- The Report concludes Eden never made a final report of the incident as it is required to do under the DHFS Regulations while acknowledging Eden did make 3 preliminary reports on a timely basis. It is true a comprehensive final report was never generated. This is partially because the facts concerning this matter were still developing when the Advocate first entered the scene and requested to see the files relating to the incidents and continued into February when the Advocate visited the Eden facility in Chicago to interview the manager. This had the effect of extending the investigation of the matter to where we are today. The Advocate's investigation of this matter also raised jurisdictional matters and issues concerning the definition of "mental Illinois" under the various statutes in place, as well as the statutory bases for requiring a SLF operating under the certification of the DHFS to comply with statutes governing mental health facilities and also the extent of the mandated duties of health care personnel at SLFs to report instances of injuries at SLFs caused by one resident to another resident. In addition, one of the consequences of the altercation is it became impossible for R1 to continue sharing her apartment with her roommate, R2. This meant Eden had to find a mutually acceptable roommate situation for R1, unless a single apartment became available. Finding an acceptable roommate took time but was a prerequisite to filing a final report and concluding this matter. While this eventually happened, it took time and was overtaken by the entry of the Advocate into the picture. As Regulations requiring a final report do not specify a time period for such filing, the time for filing such a report is still running. Should the DHFS desire that a final report be prepared, Eden will do so.

EDEN'S CONCLUSION

The incidents at hand resulted from a most unfortunate altercation between two of Eden's residents. It was apparently incited by R1's own racial taunting and insults which were followed by pushing, shoving and hitting on the part of both parties. It seems R1 got the worst of it, although this cannot be known as a certainty as R3 has not been seen or interviewed since he removed himself from the Eden facility. The fact R1 was a woman while R3 was a physically incapacitated man and that R1 is the only one who appears to

have received physical contusions and cuts does not *ipso facto* justify the conclusion R3 is guilty of a battery. R1 is a longtime and valued Eden resident. So was R3. Their mutual dislike and disagreements had nothing to do with Eden, but led to the unfortunate and regrettable incidents at hand. Once brought to Eden's attention, Eden's staff gained immediate control of the situation. Staff separated the parties, allowed them to cool down their emotions, let them have a chance to get things off their chests, contacted R1's PCP to inform her of the incident and ensure she could be seen that day for evaluation and treatment, while sending R3 to a nearby hospital equipped with the staff to undertake his psychiatric examination. The later resulted in his voluntary separation from Eden which removed any further threat to the safety of R1. R1, by removing herself from the Eden facility the day of the incident and going to her sister's home and another hospital for treatments or follow up care during the next 24 days, relieved Eden of the duty and responsibility for her care during that period. Eden contacted all parties is was legally required to notify of the incidents. The Chicago Police were called to the building and made whatever investigation it deemed necessary. Eden was under no duty to "press" charges against either party and both Eden and the police tacitly determined this was not appropriate under the facts then known to them. The Advocate has as much a right to press the police to file charges against R3 as does Eden. It is free to do so, even at this late date if any purpose can be served by doing so.

EDEN'S RESPONSE TO RECOMMENDATIONS

Eden takes note of the training and policy suggestions made in the Report and will implement them in its meetings and procedures in an effort to head off another incident of this kind. It will pay particular attention to the suggestions regarding modern concussion protocols. Eden already made the requested changes listing DHFS at an agency to be included among those to contact in case of contract grievances in its new Residential Contracts at least 6 years ago and will make sure the current contract forms are used for future lease renewals. Rather than adding OIG to these Contracts where they will not likely be seen in a crises and are more likely to confuse Residents with questions about their contracts, the contact information for the OIG will be prominently displayed throughout the building where notices relating to other agencies are posted. It will also include OIG as an agency to be contacted in cases of resident abuse or injuries caused by staff members and will extend this duty to abuses or injuries caused by one resident to another when such involve injuries requiring outside medical intervention. Eden's policy statement will be so amended.

Eden has attempted to cooperate with the Advocate's requests for information and to give full and due consideration to the Advocates recommendations. It stands ready to listen to other constructive suggestions as to what else it might do to handle situations like this in the future.

SINCERELY,

MICHAEL J. HAMBLET

cc: Patricia Betzen