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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 14-030-9015

Cedar Point Rehabilitation and Nursing Center

The HRA did not substantiate the complaint that the facility did not follow Nursing Home Care Act and Probate Act requirements when a resident went on an approved pass, did not return to the facility, and the staff did not contact the guardian until the recipient was missing for more than a day. The HRA did find that the guardian was not included in the decision making regarding the ward's pass level.

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 Cedar Point Rehabilitation and Nursing Center LLC (Cedar Point). It was alleged that the facility did not follow Nursing Home Care Act and Probate Act requirements when a resident went on an approved pass, did not return to the facility, and the staff did not contact the guardian until the recipient was missing for more than a day. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5), the Nursing Home Care Act (210 ILCS 45), the Illinois Administrative Code for Skilled Nursing and Intermediate Care Facilities (77 Ill. Admin. Code 300 et seq.), and the Illinois Probate Act (755 ILCS 5/11).

Cedar Point is a 485-bed rehabilitation and nursing facility located in Cicero, IL. Approximately 50-60 percent of the population has a diagnosis of mental illness.

To review these complaints, the HRA conducted a site visit and interviewed the Facility Administrator. Facility policy was reviewed as were the adult recipient's records upon written request of the recipient's guardian.

COMPLAINT SUMMARY

A Cedar Point resident was given a pass and left the facility on 10/21/13 at 10:00 a.m. and never returned. His guardian was not notified until after midnight the day the resident left and he only found out because he was "on call" when the message came in. The recipient has diagnoses of mental illness and dementia, and had been in and out of psychiatric hospitals prior

to the elopement for aggressive and erratic behaviors. The complaint questions the facility's decision to give the resident an unsupervised pass in his unstable condition.

FINDINGS

State guardian case notes indicate that the resident in this case was appointed a state guardian in January of 2013. The notes indicate that the resident had a mental health diagnosis of Psychosis, a number of health issues, and a history of "walking out of nursing home placement." Accompanying the admission paperwork is a standard letter from the guardian to the facility administrator outlining the timeframe in which to report various events which may occur while the recipient is in the care of the guardian. It states: "Section III. Events requiring immediate notification and, where appropriate, the consent of the Office of the State Guardian, either to the regional office during business hours or to the after-hours emergency service: Unauthorized absence (AWOL) for more than 8 hours or where circumstances of the absence suggest more immediate contact is necessary..."

On 4/24/13 a letter was forwarded to the facility administrator regarding communication between the facility and guardians regarding notification:

“Mr. [Administrator],

I wanted to send you the attached Notification letters and Emergency Medical Consent forms. The notification letter outlines timelines when we want to be called and informed regarding medical concerns or incidents regarding our wards. The emergency medical consent forms can accompany the persons to the hospital and assist with the consent for treatment process. When I have read through charts, many charts did not have our forms or the forms had different caseworkers' names on them. I am now the primary case worker assigned from our office to cover Cedar Pointe.

I believe we need to improve our communication. I wanted to make you aware of a few things. Our office was not informed when [a resident] recently passed away, I was informed two days later by the funeral home. Recently [another resident] was sent to the hospital for a psychiatric admission. I found out about this the following day when [resident] used the hospital phone to contact me and inform me where she was. No one from Cedar Pointe ever informed me when she left or when she returned. I read in a chart yesterday that [a resident] had been hospitalized after trying to choke his roommate with a pillow, Cedar Pointe had called me to inform me he was sent out due to aggression. That is a significant fact to omit. There are other incidents as well since I assumed this caseload in January of 2013....

I realize that you and the staff at your home have a difficult job with many residents with difficult behaviors and histories. I had talked to my supervisor to discuss no one notifying us of [a resident's] death or hospitalization and she suggested that I call Public health. I would prefer to work with you. I would like to be notified of the careplans as they come up and I will try to attend when I am able. Let me know what I might do to be an effective guardianship representative for these persons. My direct number is... My email is... "

The facility administrator responded to this letter in another letter dated 4/29/13. It offers an Action Plan which states, "The following is to serve as a credible action plan in response to the letter received from the Office of State Guardian Wards. The facility will continue to work toward improving care and communication not only for the guardian wards but for all residents. [Resident #1] – the facility sincerely apologizes for the lack of communication with the guardian office surrounding the death. [Resident #2] – the Nurse was not aware of her guardianship at times of discharges as this information was not listed on her facesheet. Her facesheet has now been updated. [Resident #3]- the facility apologizes for the incomplete reporting." The letter continues: "As a result of the above situations:

- All Guardian Wards' facesheets have been updated appropriately.
- Nurses have been re-inserviced on notifying the Guardian Office of 1) any significant change in condition, 2) all transfers and incidents, 3) to give full details of events being reported and 4) document name of Guardian notified and all attempts to notify if necessary." The letter specifically addresses the issues of the residents named in the original letter and more broadly addresses further action resulting from the guardian's request:
- All residents' wheelchairs and geri-chairs will be power washed initially on Tuesday night April 30, 2013.
- A weekly cleaning schedule has been developed (attached).
- Activity Director will review Guardian Wards as well as all other residents' trust funds in an effort to purchase necessary properly fitting clothing for those in need. Facility will notify Guardianship Office if assistance is needed in this area for their Wards." This letter then gives the care plan conference dates for all the residents under state guardianship. It lists a care plan conference date of 5/20/13 for the resident in the extant case.

Guardian representative notes entered on 4/30/13 show that the guardian was notified that his ward had been involved in an altercation with another resident. On 9/04/13 the notes indicate that the guardian was notified that his ward had been admitted to a hospital psychiatric unit because of aggression he had shown towards his roommate. On 10/22/13 (no time given) notes state, "Rec'd call from [staff] from the 8th floor of Cedar Pointe that [the resident] was given a pass 10:00 a.m. on 10/21/13 and has not returned to Cedar Pointe. No messages were left on my voicemail, this oncall worker is the primary rep for [the resident]. I called the Dept. Of Public Health to lodge a complaint about the elopement. I followed up by speaking to [staff] of the 8th floor this morning...."

Cedar Point physician's progress notes for the recipient were reviewed for this investigation. Notes entered on 10/01/13 state, "Still rambling and delusional and not able to accept that things are not as he imagines. Sleeps to 4 AM and may get up and need prn [as needed] medication as was given recently. Was not sleepy and eating meals and energy is good. Was not aware of what is delusional and prefers to live in that world." On 10/15/13 the notes state, "Still manic and still talking with pressured speech and manic type grandiose delusions. Speaking to me then walking off abruptly. Was not sedated at all from thorazine and depakote

so will need 1000 mg at night as his level was 27 as was called to my attention. Still manic and now will see if therapeutic with recheck in 6 days. Thorazine to be kept."

The record contains the facility sign-out sheet which shows that the resident in this case signed out at 10:50 a.m. and was expected to return at 10:00 p.m.

The first mention of the resident's pass in the nursing progress notes is entered on 10/21/13 at 5:32 p.m.: "Resident remain oop [out on pass]." It does not indicate when the resident left on pass. The next entry is made on 10/21/13 at 10:01 p.m. and states, "Resident remain oop." On 10/22/13 at 1:22 a.m. the notes state, "Received report that resident went oop. But if the resident did not come back after 12 am call people who is in charge. After called them I called police [sic]. They came and took the information about the resident. The [sic] gave me the report number. The state guardian was notified also. He said that the resident has been gone for 14 hours ok." The notes indicate that a missing persons report was filed and hospitals were notified. On 10/24/13 at 2:27 p.m. notes state, "Res has discharged AMA Dr... and Dr... was notified voice message left for [guardian]." On the same day at 2:28 p.m. notes indicate, "All appropriate parties were notified."

The record contains an email written by the resident's guardian to the facility administrator at 11:56 a.m. on 10/22/13 which states, "I was 'on-call' last night for the Office of State Guardian and I rec'd a call from Cedar Point at 12:40 a.m. from [staff] on the 8th floor. She informed me that [the resident] had gone out on a pass at 10 AM on 10/21/13. This was the first I had heard of him not returning or of even having the 'status' to get an offsite pass. I was informed that the police were called. Do you have a copy of the police report or missing persons report? Have you heard anything else? Is there something else I could do?" The administrator responded in email by saying, "I have been informed about the situation and made sure that not only we filed a police report but we made numerous calls to surrounding hospitals asking if he was admitted, see attached police report #. Actually there's nothing that you need to do 9 out of 10 times res who stay out late return after a few hours, since he didn't we filed a police report just to be on the safe side. We will continue to update you if we find out any more information. Feel free to contact me if you have any questions or concerns."

The clinical record contains the resident's Petition for Requesting a Level Increase, completed on 10/17/13. It indicates that the resident requested to be increased to level Three, Independent Pass. The form contains a checklist of behaviors which were to be initialed by the petitioner indicating his achievement of various goals. He initialed that he had maintained appropriate personal hygiene, had complied with his prescribed diet, meal times, appointments, and medications, had maintained his personal space, had followed smoking rules, had attended groups and activities, and had maintained behavioral compliance including no physical or verbal abuse, no intimidating or aggressive behavior and had not used alcohol or any non-prescribed substance. The signatures of the treatment team are included on the form and the level increase is approved. There is no guardian signature on the form.

FACILITY REPRESENTATIVE RESPONSE

The facility administrator was interviewed regarding the complaint. He stated that the resident had achieved a Level 3 pass after being evaluated by the Social Service Department and determined to be appropriate for a pass. He indicated that the resident had several trial runs at which time he was given shorter passes and monitored passes with staff. He was then given day passes and demonstrated that he had the community survival skills necessary to be safe in the community. Although the resident suffered from schizophrenia, and had been undergoing some medication adjustments, he was making his own decisions regarding his right to be in the community. The administrator indicated that the resident's level increase was discussed at the resident's quarterly Care Plan conference and he was granted the increase after review by several clinical staff. The administrator indicated that the guardian had not been involved in any of the recipient's care planning sessions, which were scheduled at the guardian's request. Generally, guardians are invited to attend all Care Plan conferences and any other meetings concerning their wards. Care Plans are not generally sent to guardians after they are completed.

The administrator was interviewed about the guardian notification of the resident's unexplained absence. He indicated that the resident had left the facility on the morning of 10/21/13 for a day pass as he had done several times before. The resident was due back at the facility at 10:00 p.m. as indicated in the nursing note entered at 10:01 p.m. The nursing note entered at 1:22 p.m. shows that the staff made a decision at 12 midnight to call the police which they did. This progress note entry also indicates that the guardian had been notified at this time. The administrator also indicated that the resident had not eloped. He was out on a regular day pass and probably made the decision to not return to the facility. The administrator indicated that even had the police found the recipient, he could not be forced to return to the facility. The administrator also indicated that the facility was not required to call the police however the police were notified because the staff was very concerned about the resident.

The administrator was interviewed about the policy for immediate notification of the guardian when residents are away on unauthorized absence. He stated that the resident was authorized to be on pass until 10:00 p.m. and even by the standards developed by the guardian, the facility had 8 hours in which to investigate the situation and notify the guardian. However, the facility made a decision to notify both the police and the guardian which they did shortly after midnight.

STATUTORY BASIS

The Nursing Home Care Act defines "Neglect" as, "A facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident" (210 ILCS 45/1-117).

The Mental Health Code states that, "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient." The Nursing Home Care Act also includes the guardian in the development of the recipient's

services plan: "A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measureable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable."

The Illinois Administrative Code for Long Term Care Facilities (Ill. Admin. Code 77 Part 300.3210 (o)) states, "The facility shall also immediately notify the resident's family, guardian, representative, conservator, and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings or related administrative matters arise."

The Illinois Probate Act of 1975 defines the duties of the guardian:

"To the extent ordered by the court and under the direction of the court, the guardian of the person shall have custody of the ward and the ward's minor and adult dependent children; shall procure for them and shall make provision for their support, care, comfort, health, education and maintenance, and professional services as are appropriate....The guardian shall assist the ward in the development of maximum self-reliance and independence." (755 ILCS 5/11a-17a).

Also, the Probate Act gives direction to providers to rely on guardian decision making:

"Every health care provider...has the right to rely on any decision or direction made by the guardian....to the same extent and with the same effect as though the decision or direction had been made or given by the ward." (755 ILCS 5/11a-23).

HOSPITAL POLICY

Cedar Point provided information on its Pass level System. Level One allows no passes and is for residents who are elopement risks or have medical/psychiatric issues that do not permit them to be outside safely. Level Two allows for Supervised Passes meaning residents may go out with supervision of staff members. Level Three allows for Independent Passes for residents who can go out alone from 10:00 a.m. until 10:00 p.m. The Level system guidelines are as follows:

- *Upon admission, every resident starts at a level One pass. PRSC [psychiatric rehabilitation services coordinator] will assess community survival skills (part of initial assessments that are completed). Once resident is deemed appropriate, staff will notify doctor of findings to get the doctor's order permitting them for increase in pass level. If resident does not show appropriate community survival skills, that stay at level One pass. PRSC may work with resident on increasing community survival skills.*

- *Residents may only move up one level at a time. For example, one cannot move from a Level One to a Level Three. This helps ensure compliance and appropriateness of increase in pass levels as the resident increases to more independence.*
 - *Every Thursday at 3 p.m., residents who would like and increase in their pass level meet with the Social Service staff. They fill out a petition form requesting a Level increase, state their case as to why they feel they are appropriate for increase in pass level, and social services will approve or deny the increase.*
 - *In order for a resident to be considered for an increase in pass level, he or she must demonstrate the following:*
 1. *Compliance with ADL's (personal hygiene)*
 2. *Treatment and medication compliance, including diet, meal times, scheduled appointments, medications, and treatments with only one reminder*
 3. *Care of personal space (room must be neat and clean)*
 4. *Compliance with smoking policy/rules (no unsafe smoking, maintain ongoing safety and cleanliness)*
 5. *Maintain attendance with groups and activities*
 6. *Behavioral compliance i.e. no verbal or physical abuse, no intimidating or aggressive behavior, and no substance abuse.*
- Pass level increase may be denied based on violation of aforementioned factors. Pass level can also decrease upon discretion of PRSC and Social Services staff due to violation of aforementioned factors. If this is the case, PRSC will come up with a plan with resident on how to gain back a more independent pass level.*

The pass level policy does not include the participation of or review by the guardian and appears to be separate from the treatment planning process.

Cedar Point provided their policy and procedure for Accident/Incident Reporting. It states that an accident is "an unexpected, unintended event that can cause a resident bodily harm." An incident is "an event out of the ordinary which happens to or involves a resident. This may include but is not limited to medication errors, drug reactions, and all situations requiring the emergency services of a physician, hospital, police, or fire department." The policy indicates that when accidents/incidents occur the nurse in charge shall immediately respond and provide immediate nursing intervention, including arranging for emergency services. After the immediate situation is resolved the nursing supervisor is notified an accident/incident form is completed. At this time the resident's family is notified along with the attending physician. Additionally, the policy states that "Accidents or incidents requiring the intervention of the police or fire department, or the services of a physician or hospital emergency room must be reported to IDPH within 24 hours and a written follow up within seven days by mail or fax." The facility is mandated to notify IDPH of any incident or accident which has or is likely to have a significant effect on the health, safety or welfare of a resident or residents. Also, the facility must maintain a file of all written reports of serious accidents or incidents involving residents.

Cedar Point provided their policy and procedure on Change In Resident's Condition or Status. It states that facility staff will promptly notify the resident's attending physician and legal representative/family of changes in the resident's condition and/or status. The policy states

that the nurse will notify the resident's next of kin or legal representative, or family, when the resident has an accident or incident that results in an injury, when there is a significant change in the resident's physical, mental, or psychosocial status, when there is a need to change alter the resident's room number, when a decision has been made to discharge the resident from the facility, when it is necessary to transfer the resident to a hospital, when there is a need to alter the resident's therapy significantly, or when the resident is in need of involuntary or voluntary admission for psychiatric services.

CONCLUSION

The resident in this case did not return from a day pass which initiated on 10/21/13 at 10:50 a.m. The facility gave the resident until midnight to return late to the facility and then notified both the police and the guardian. This timeframe is within the guideline set up by the guardian to be notified within 8 hours after an unauthorized absence. The HRA does not substantiate the complaint that the facility did not follow Nursing Home Care Act and Probate Act requirements when a resident went on an approved pass, did not return to the facility, and the staff did not contact the guardian until the recipient was missing for more than a day.

Another item at issue in this case is the guardian's notification that his ward had received a level increase which allowed an unescorted day pass. Staff indicated that the pass level system is a motivational tool that is determined by the social service staff and physician, without the input of the guardian, although guardians are notified of the level increases at the ward's care planning sessions which involve the entire treatment team. The Mental Health Code and the Nursing Home Care Act direct facilities to include the guardian in the formulation and periodic review of the their ward's care plan and thus the decision to allow passes should rightly be considered not just by the social services team and physician, but also by the guardian who has legal responsibility for the ward.

RECOMMENDATION

1. Involve guardians in decisions regarding pass levels, revise pass level policy to include the guardian, and revise the incident/accident policy to include notification of the guardian.

SUGGESTION

1. Mail or email residents' care plans if the guardian is not able to be present at the care plan conference.
2. Include guardian notification in the facility policy on Accident/Incident Reporting.