FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case #14-090-9003
Sharon Healthcare Facilities - Woods

INTRODUCTION

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

1. Property violation, a resident was not allowed property after being discharged.
2. Inadequate treatment, a resident was not given proper dosage of medication and was not allowed to see a physician for back pain or allowed to use a wheelchair.
3. Inhumane treatment, a resident was videotaped while in her room and while showering, constant fighting among other residents, staff talking down to residents, and residents being provided clothes that did not fit and then being reprimanded for the clothing.
4. Visitation violation.

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

The Sharon Healthcare Woods is a 152 bed facility with 110 employees, which include nurses, housekeeping staff, dietary personnel, counselors, social workers, social work assistants, security staff and psychiatric rehabilitation aides. They offer programs such as anger management training, self medication training and have psychosocial and activity departments. They transitioned 33 individuals into independent living this year. Their geographic region ranges from Southern Illinois to Eastern Iowa.

Complaint Statement

The complaint alleges that the facility had a resident's property and would not release the property after the resident was discharged. Allegedly, the facility had the resident's state ID, credit card, Subway (restaurant) card, community college ID and medications that they would not return. It was alleged that a social worker finally offered the property without the medications and said that the medication was sent back to the pharmacy. When the facility was called again, they said that they never had the medication.

Another allegation states that a resident was not given two doses of Klonopin and possibly other medications. The nurse reportedly documented that the doses where administered, but verbally expressed that the resident did not receive the doses because the facility was short on the medication. The facility allegedly would also not allow the resident a wheelchair or to see a physician for back pain while at the facility. The resident was not allowed to see her personal physician or the facility physician and the resident was only given Tylenol per the complaint.

The third allegation states that a resident was videotaped in the shower and in her room. It was also alleged that residents in the facility were fighting constantly and the atmosphere was very violent. The allegations also state that staff verbally demeans the residents and calls them "Bad Girls." A resident was reportedly also given clothes that were too small and then blamed her for her midriff being exposed in the clothes that were provided.

Finally, the resident was not allowed a home visit while other residents were allowed as per the complaint. The restriction was reportedly only for one resident.

Interview with staff (8/20/2013)

Staff explained that the resident was at the facility from 5/17/2013 until 5/26/2013. The resident had a diagnosis of schizophrenia and paranoia and other physical ailments. The resident left the facility against medical advice. The resident's mother wanted the staff to put the resident in a cab by herself and send her to a location and the facility took issue with the request. Staff said that when the resident was admitted, there was a restraining order against the resident's mother. Her mother did call the facility and said that the resident was being held against her will. The resident was on elopement precautions and wanted to call the police to come and force the staff to allow her to leave the building. The resident's mother also told the facility that the resident was being given Seroquel and the food that she was eating was making her sick. Staff explained to the resident's mother that this was untrue and said that the resident could leave the facility against medical advice. After the phone conversation, the staff contacted the Assistant Administrator of the facility. The Assistant Administrator told staff that if the resident was to get into a taxi cab to leave, they would have to know that the resident was actually going to her mother's house. The resident's mother also complained that she was receiving the wrong medication and the staff explained that she was now receiving different medication than she had been receiving. Staff explained that they were concerned about elopement because she was found just walking around Peoria in the middle of the night and she did not know where she was going.

The resident's mother said that they have all the proper medication that the resident needed at home and no other medication was required. The facility allowed the resident to take the taxi cab to her mother's house. The facility had asked the resident's mother to contact them when she arrives, but they did not receive a telephone call. They contacted her mother, who did not answer the telephone call and explained that they would have to file a missing person's report if the resident did not contact the facility. The resident's mother called later saying that she did arrive at her house.

Staff explained that 2 or 3 weeks later the resident and her mother came back to the facility. The resident's mother stated that when the resident was at the facility, she had a bag of

diapers and they wanted them back. The resident was not admitted with a bag of diapers but staff gave her diapers away. The resident's mother also wanted the medicine from the hospital that the resident was transferred from prior to the facility admission. The medication was in bottles when the resident was admitted, and because the staff did not know if it was the correct medication, it was sent back to the pharmacy. Staff explained to the resident and her mother that if the resident left against medical advice, they would not be able to take any medication and also it was explained to the resident and her mother that the medication the resident was admitted with was sent back to the pharmacy. Staff provided them with the pharmacist's name and telephone number. The resident and her mother also asked about the IDs and staff contacted their social services staff who explained that she thought at the time did not receive any cards. The resident also had said that items were brought into the facility that were actually not, and there was a request to give those items back to the resident.

During the interview with the HRA, the staff discovered through reviewing the resident's record documentation that the facility had some of the cards that the resident and her mother requested. What occurred was the resident had given the cards directly to a counselor for safeguarding and the cards were not added to the inventory. The cards were not returned to the resident when she left the facility because the resident left AMA (against medical advice) on a Saturday, and the counselor was gone at the time. The resident's mother had called and asked about the cards, and the counselor told her that they had them, but the resident would need to be there to pick them up. When the resident and mother came to pick up the items, the counselor she spoke to was not there and they referenced the inventory which did not have the cards listed, so they were told that they did not have the cards. Staff said that they would send the items to the resident via certified mail and that there was a miscommunication with the property. When staff are handed items by a resident, they should be inventoried. The counselor had written that the cards were received in the notes, but did not add the items into the inventory. When items are given to staff for safeguarding, they lock them in an actual safe.

Staff said that the medication is provided in 7 day packets and not in bottles. The packets replaced the bottles. The resident's mother was told if they wanted to plan a discharge, staff could prepare the resident with medication, but they chose to leave AMA. When the resident was admitted, she had two sacks of property which was all inventoried. Also everything that was brought into the facility and inventoried was given back (except the cards which were not inventoried). When residents enter the facility, they sign the inventory. In this case, the resident was not able to sign that she received her property because she left AMA. The resident's counselor notated that the resident did not sign. The facility has an inventory policy and a personal property policy.

Staff reported that the resident saw a physician on May 24th, who assessed her and reviewed her lipid panel (cholesterol). There was no mention of back pain from that session. On May 19th, the resident told a Certified Nursing Assistant (CNA) that she wanted a back brace and staff did not see any follow-up on the request. The physician comes every Friday to visit each wing. When a new resident is admitted, he/she are examined by the physician. The physician receives all the records to review and then examines them the first Friday they are at the facility. Staff said that the resident was ambulatory and even went outside to smoke. The resident had no complaints of pain but told the CNA she wanted the brace. Staff was not aware that she

requested a wheelchair. They did not realize that she needed a wheelchair because she was ambulatory. Staff explained that when the resident was admitted to the facility, she signed a consent for psychotropic medication and the medications were reviewed.

Staff said that there is no videotaping at the facility. The closest that the facility comes to videotaping is taking pictures at a party. There are no security cameras at the facility and the facility contract reads that there is no videotaping without consent. As far as the fighting, staff said residents have some verbal arguments but it is not constant. There is no real average to the amount of conflicts that the facility has per day but on any given day, the facility is pretty calm. The biggest issue with residents deals with cigarettes. The residents rarely have physical fights. The staff do try to be proactive about stopping fights and there is always a staff presence. The staff advocate for the resident and they can talk to the administrators. Staff will also come to administrators. Residents are also invited to staff meetings.

Staff stated that talking down to residents is an administrative pet peeve and speaking appropriately to residents is covered in meetings almost on a monthly basis. Staff are educated on how to talk to residents and how to act and react to residents. This is training on an ongoing basis and the facility does not have a lot of turnover with staff. The training is completed on payday as an in-service to assure all staff are present for the training. The facility also has a safety program in which they award cash for safety each month.

The resident was provided pants, shorts and shirts to wear by the facility that were purchased at a mission. Staff said they did not believe that the resident was reprimanded for a top not covering her midriff. They could understand staff telling her she needed to pull her shirt down if her midriff was showing but they do not believe that she was reprimanded. The resident was the one that picked out the clothing from the mission.

When the resident's mother called, she wanted the resident to visit overnight and the facility thought that maybe it would be better if it was a day visit. Staff never actually declined the resident's overnight visit, they only wondered if it was good idea. Even though they were apprehensive, they agreed to a day visit. Staff explained that this made her mother angry. The facility has home visit passes. A counselor fills out a home visit pass, gives the pass to the nurse and they fax the pass to the pharmacy so they have the medications. Staff asks that they know about the visit ahead of time so they can provide medication. Staff explained that the resident was discharged AMA before the home visit. The resident's mother agreed to a day visit and then the next day was when the resident was discharged. Staff explained that there are situations where they would deny a home visit, such as if there was abuse by the person being visited or if there was an order of protection. The resident may have to wait a day for the home visit if the medication is not prepared but they have also had their pharmacy call another pharmacy in the resident's home location and then medication was picked up by the resident. They have also had situations when they went to pick up the resident and the resident was drunk, so the facility did not allow another visit because of the alcohol interaction with the resident's medication.

Facility Tour

The HRA toured the facility and casually spoke to a couple of the residents during the visit. The HRA observed the residents getting along with each other and even playing games. No fighting was seen during the tour.

FINDINGS

With proper consent, the HRA reviewed resident records and facility policy that pertain to the allegations in this case. According to the documents reviewed, the resident was admitted into the facility on 5.17.2013 and was discharged on 5.26.2013.

Complaint #1 - Property violation, a resident was not allowed property after being discharged.

The HRA began with a review of the resident's social progress notes which read, on 5.18.2013, that "She asked me to secure her Master Card and Visa and Subway cards locked in [illegible] safe." On 6.21.2013, social progress notes reaffirm what was said in the HRA's staff interview and states that the resident's mother called the facility asking about the resident's ID cards. According to the notes, the resident's mother was told that they did not have ID cards, but they did have a Visa debit card, Master Card, and a Subway card that was waiting for the resident to pick-up from the facility. The notes then read that the mother reported that the resident was fearful of coming to the facility and requested that the resident's "ID card" be given to an specific employee that the resident knew and could "identify to the police." The notes state that the social services director was then given the phone to speak with the resident's mother. A later note on the same date states "Advised ADM (administrator) of conversation with Mother. He said to hold cards for pick up by [Resident]." A note on 8.22.2013 states that the cards were mailed to the resident via certified mail.

The HRA reviewed the resident's inventory of personal effects which does not include the cards documented in the social progress notes. The inventory also states that the resident took belongings on 5.26.2013.

In regard to the medication, a progress note dated 5.26.2013, reads "Inquired about [resident's] medication. [Resident's mother] stated 'I have medicine here - I know what she takes.' I asked [mother] to please tell me the list of meds …" and the note lists the medication. The note continues to read "I asked about the other meds to which she stated 'I got them here and if I need anything else I'll just call [grocery store] pharmacy and get the medicine.'" The HRA saw no other indication that the medication was requested from the facility.

The HRA reviewed the Personal Property policy which has sections regarding clothing requirements, valuables, replacement of clothing, and proper labeling of clothing. The valuables section indicates that if a resident receives new clothing or anything valuable, they need to contact the nurse in charge to record the items on the inventory sheet. There is also a section regarding discharge which indicates that the resident is required to remove all clothing and

personal property from the facility within 14 days after a transfer or discharge.

The facility did not have an inventory policy/procedure but as a part of their documented "New Resident Protocol" it reads that a CNA will complete a clothing inventory, vitals and weight for a new resident.

The resident's contract, which was signed by the resident, reads "Medicines, treatments or special diets will be offered to the resident if ordered by physician, the facility Medical Director, or any other physician approved by either of them or the resident." The contract also reads "No food, liquids or medicines will be brought into the facility without permission of the Administrator or nurse in charge … No medication will be kept in the resident's room or possession unless in accordance with the plan of care." Also "The facility is not responsible for money, valuables, or personal effects of the resident unless delivered to the Administrator for safekeeping."

The Skilled Nursing and Intermediate Care Facilities Code reads "All legend medications maintained in the facility shall be on individual prescription or from the licensed prescriber's personal office supply, and shall be labeled as set forth in Section 300.1640" (77 Il Admin Code 300.1610) and "All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber" (77 Il Admin Code 300.1620). The Act also reads "All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. All physician's orders and plans of treatment shall have the authentication of the physician. For the purposes of this subsection (b), “authentication” means an original written signature or an electronic signature system that allows for the verification of a signer's credentials. A stamp signature, with or without initials, is not sufficient" (210 ILCS 45/2-104).

The Act also states "A facility shall establish written policies and procedures to implement the responsibilities and rights provided in this Article. The policies shall include the procedure for the investigation and resolution of resident complaints as set forth under Section 3-702. The policies and procedures shall be clear and unambiguous and shall be available for inspection by any person. A summary of the policies and procedures, printed in not less than 12 point type, shall be distributed to each resident and representative" (210 ILCS 45/2-210).

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

inventories.(Section 2-103 of the Act)" (77 Il Admin Code 300.3210). The Nursing Home Care Act reads "The facility shall provide adequate storage space for the personal property of the resident. The facility shall provide a means of safeguarding small items of value for its residents in their rooms or in any other part of the facility so long as the residents have daily access to such valuables. The facility shall make reasonable efforts to prevent loss and theft of residents' property. Those efforts shall be appropriate to the particular facility and may include, but are not limited to, staff training and monitoring, labeling property, and frequent property inventories. The facility shall develop procedures for investigating complaints concerning theft of residents' property and shall promptly investigate all such complaints" (210 ILCS 45/2-103).

Complaint #1 - Conclusion

Because the resident did not receive all of her property upon discharge (with the exception of the medication which was sent back to the pharmacy) until after the HRA intervened with an investigation several months later, the HRA finds this complaint **substantiated** since, according to the contract between the facility and the resident, the facility was responsible for her personal effects which were stored for safekeeping**.** The HRA acknowledges that the items in question have been returned and provides the following **recommendation** to avoid further occurrences**:**

- The counselor failed to communicate either by inventorying or informing other staff that the property was received, which resulted in the resident not having all property properly inventoried, safeguarded and dispensed to the resident at discharge. Educate staff in communicating, documenting and inventorying property (if inventory is the means chosen to safeguard property) that is handed over for safeguarding to assure future incidences like this do not occur. The HRA requests evidence of this education.

Complaint #2 - Inadequate treatment, a resident was not given proper dosage of medication and was not allowed to see a physician for back pain or allowed to use a wheelchair.

The HRA started reviewing this complaint by reading a physician progress note dated 5.24.2013, which is a week after the resident was admitted into the facility and two days before she was discharged. The physician's progress note does not mention the need for a wheelchair or a request for a wheelchair. There is mention of osteoarthritis but no mention of a wheelchair. The HRA reviewed an incident/accident report on 5.26.2013 where the resident ran as an attempt to escape from the building.

On 5.19.2013 the progress notes read that the resident wanted a "back brace" but the HRA saw no follow-up documentation with the request.

The HRA also reviewed the physician's orders and the medical administration records (MAR) for the resident's stay at the facility. All medications and treatments that were ordered appeared on the MAR and it appears that Klonopin and all other medication was given as ordered while the resident was at the facility. The MAR does show that Tylenol was given twice and Tramadol was given once. The physician's orders indicate that the Tylenol was for a high temperature or pain and the Tramadol was to be given for hip pain.

The HRA reviewed another passage in the progress notes dated 5.24.2013 which read "[Resident] yelled that the nurse did not give all her meds to her (which happened 2 hours ago). [Resident] noted a medicine that was not prescribed for her. She wanted to call the police and leave the building. She cried and said the nurse is fired." On 5.26.2013 in the progress notes, the resident's Mother is quoted in making the statement "'[Resident] complained the food you feed her gives her diarrhea and she isn't getting the correct medication' I explained to [Mother] her medication has changed since admission from hosp."

The HRA reviewed the facility medical administration procedure which reads that "Medications must be prepared and administered within one hour of the designated time." The procedure defines processes for a medication pass and then the administration of specific treatments. The HRA also reviewed the medication error and drug reaction policy which the facility defines as having the purpose "To safeguard the resident and provide emergency care as necessary." The policy defines a process for medication errors.

The Nursing Home Care Act reads "(b) All medical treatment and procedures shall be administered as ordered by a physician" (210 ILCS 45/2-104).

Complaint #2 - Conclusion

The HRA found no evidence to indicate that there was a medication error nor that the resident was not allowed a wheelchair or to see physicians regarding back pain, therefore we find the complaint **unsubstantiated** but offer the following **suggestion:**

- The HRA is concerned at the lack of documented follow-up regarding the "back brace" request. The HRA suggests in the future, document all follow-up or reasoning for no follow-up to resident medical requests.

Complaint #3 - Inhumane treatment, a resident was videotaped while in her room and while showering, constant fighting among other residents, staff talking down to residents, and residents being provided clothes that did not fit and then being reprimanded for the clothing.

The HRA reviewed a form for audio, video and photographic release that was signed by the resident. The intended internal use reads "Audio recordings, videotapes and photographs are an important medical tool and therapeutic activity at our facility. We use audio, video and photographs to record resident health conditions, milestones, events and other successes. We use names and pictures of the residents in arts and crafts projects, scrapbooks, bulletins, room nameplates, visitor books, newsletters, displays and activity boards, as well as in medical records. We will share your name with clergy and other volunteer groups visiting our resident under facility supervision." The intended external uses reads "Audio recording, videotapes and photographs offer a positive image of this facility and our residents to the community as a whole. On occasion, audio recordings, videotape and/or photographs are published in brochures, magazines, newspapers, or via other media outlets in order to present our resident's milestones, events and other successes in a positive light." Both areas were checked that the resident

understood that pictures may be taken.

The HRA reviewed the Sharon Healthcare Woods Code of Conduct which reads "Ethics can be defined as rules of conduct that are used in regard to behaving correctly and morally in a particular group situation. Ethical behavior or obligations are essential to know and understand when dealing in the healthcare field." The Code proceeds to list ethical obligations, obligations with the resident's record, dealing with the resident's family and obligations with the job.

The HRA reviewed in-service training reports which indicate training on the code of ethics; trainings on the attitudes toward staff and others (re: residents) were conducted by the Housekeeping Supervisor to 14 employees on 8.22.2013; and on the same day, the Executive Director conducted a meeting regarding code of conduct and resident abuse. Another in-service training report was conducted by one of the facility owners and the Executive Director on 7.25.2013 which covered verbal abuse, mental abuse, physical abuse and procedures and methods to reduce aggression. This training was for all staff.

The HRA reviewed the social progress notes which, on 5.20.2013, read "Spoke to [resident's] bathroom neighbor regarding [resident's] complaint that someone kept her awake talking on the phone in the bathroom overnight. Resident agreed to introduce herself with [resident] and attempt to keep quiet overnight." Another passage on 5.21.2013 reads "Met with [resident] to begin assessments. I took her to [mission] where she got a pair of paints, one pair of shorts and two tops." Another passage reads "[Resident] said that someone had 'crossed her territory.' She repeated this several times and finally was able to say that her toothbrush and toothpaste was missing and a pair of pants. Toothbrush and paste were replaced. I told her I had a lock box for her and this seemed to satisfy her."

The Nursing Home Care Act reads "A resident shall be permitted respect and privacy in his medical and personal care program. Every resident's case discussion, consultation, examination and treatment shall be confidential and shall be conducted discreetly, and those persons not directly involved in the resident's care must have his permission to be present" (210 ILCS 45.2-105). The Act also reads "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'" (201 ILCS 45/2-107). The Skilled Nursing and Intermediate Care Facility Code cites the Act regarding abuse (77 Il Admin Code 300.3240).

As stated earlier in this report, The Code also states "*If clothing is provided to the resident by the facility it shall be of a proper fit.*(Section 2-103 of the Act) " (77 Il Admin Code 300.3210).

Complaint #3 - Conclusion

The HRA saw no evidence that the resident was videotaped while in the shower or in her room, that there was constant fighting at the facility, that staff talked down to patients or provided clothing and then reprimanded residents for clothing not fitting. Because of this, the HRA finds this complaint **unsubstantiated.**

Complaint #4 - Visitation violation.

The HRA reviewed the facility progress notes, which read, on 5.24.2013 "Resident is put on elopement precaution due to planning and attempting to leave." In the progress notes, it was notated that she had not tried to leave the building until 5.26.2013 when the resident did elope. She stated on that day that she wanted to leave the building. On 5.26.2013 the resident's mother called and said that the resident had called her and complained that the facility was holding her against her will and that she does not want to stay there. The notes read "The nurse explained to the resident's mother that the resident is free to leave anytime she chooses and all the res. has to do is sign the AMA sheet … After their discussion, the mother told the nurse that she wants the res. to leave the building and she has instructed the res. to sign the AMA sheet which the res. was willing to sign too." According to the progress notes, the resident was eventually helped to get a cab and left the facility.

The physician's orders, dated 5.17.2013 through 5.31.2013 read "May go out on pass with medications for therapeutic reason." The resident's treatment plan states that the "Resident records reflect past issues with elopement or with facility rules/pass policy." The goal reads that she will have no incidents of elopement. The plan also states "IDT (interdisciplinary team) will determine changes in pass status allowing time outdoors or community access."

The facility stated that they have no home visitation policy.

The Nursing Home Care Act reads "Every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or visitation … (d) Unimpeded, private and uncensored communication by mail, public telephone and visitation may be reasonably restricted by a physician only in order to protect the resident or others from harm, harassment or intimidation, provided that the reason for any such restriction is placed in the resident's clinical record by the physician and that notice of such restriction shall be given to all residents upon admission. However, all letters addressed by a resident to the Governor, members of the General Assembly, Attorney General, judges, state's attorneys, officers of the Department, or licensed attorneys at law shall be forwarded at once to the persons to whom they are addressed without examination by facility personnel. Letters in reply from the officials and attorneys mentioned above shall be delivered to the recipient without examination by facility personnel" (210 ILCS 45/2-108). The Act also reads "A resident may be discharged from a facility after he gives the administrator, a physician, or a nurse of the facility written notice of his desire to be discharged. If a guardian has been appointed for a resident or if the resident is a minor, the resident shall be discharged upon written consent of his guardian or if the resident is a minor, his parent unless there is a court order to the contrary. In such cases, upon the resident's discharge, the facility is relieved from any responsibility for the resident's care, safety or well-being" (210 ILCS 45/2-111)

Conclusion - Complaint #4

The HRA saw no evidence that the resident was not being allowed a home visit while other residents were allowed visits. Because of this, the HRA finds the complaint

unsubstantiated but offers the following **suggestion:**

- The HRA suggests a home visitation policy be created to assure consistency with the Nursing Home Care Act (210 ILCS 45/2-210).

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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December 12, 2013

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Illinois Guardianship and Advocacy Commission
401 Main Street
Suite 620
Peoria, Illinois 61602

Re: Sharon Health Care Woods
HRA Case No. 14-090-9003

Gentlemen and Ladies,

I represent the Sharon Health Care Woods, Inc. On November 22, 2013, the Peoria Regional Office of the Human Rights Authority issued a "Report of Findings" in connection with the above matter. Enclosed is a "Response of Sharon Health Care Woods, Inc." to such Report and, in response to the recommendation contained therein, evidence as to additional education/training.

In the event that the HRA decides to make such Report or any of the findings or recommendation contained therein a part of the public record, the Facility respectfully request that its Response also be made part of the public record.

Should anything further be required in connection with this matter, please so advise.

Thank you for your assistance.

Very truly yours,

Gary A. Weintraub

Gary A. Weintraub

GAW/g
encl.

PEORIA REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE # 14-090-9003

RESPONSE OF
SHARON HEALTH CARE WOODS, INC.

Sharon Health Care Woods, Inc. ["Sharon Woods" or the "facility"] respectfully submits this Response to the Human Rights Authority – Peoria Region's "Report of Findings" issued in the above matter on or about November 22, 2013 ["Report"], and the recommendations set forth therein.

Complaint #1: Property violation – allegation that a resident was not allowed property after being discharged.

Response: The facility respectfully disagrees with HRA's conclusion that it failed to return any personal property to one resident in violation of the contract between the resident and the facility. This allegation was also examined by the regulatory agency having jurisdiction (IDPH), which did not find any violation of applicable law or regulation.

Nevertheless, the facility accepts HRA's recommendation for additional education of staff on communicating, documenting, and inventorying resident property. Additional training on this subject was conducted on December 12, 2013. Evidence of this training is attached. [*See*, In-Service Training Report attached.]

Complaint #2: Inadequate treatment – allegation that, *inter alia*, a resident was not given proper dosage of medication.

Response: This allegation was found by the HRA to be **unsubstantiated**. [Report, at 8.]

Complaint #3: Inhumane treatment – allegation that, *inter alia*, a resident was impermissibly videotaped.

Response: This allegation was found by the HRA to be **unsubstantiated**. [Report, at 9.]

Complaint #4: Visitation.

Response: This allegation was found by the HRA to be **unsubstantiated.** [Report, at 10.]

Accordingly, the facility objects to the proposed findings as to Complaint #1, but accepts the HRA's recommendation as to resident property inventorying and controls. In the event that such findings are included in any publicly released report, the Facilities respectfully request that these comments and objections also be included in such public report.

Thank you for your consideration.

Sharon Health Care Woods, Inc.