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North Suburban Regional Human Rights Authority
Report of Findings
HRA #14-100-9030
Pathway Senior Living, LLC
Victory Centre of Vernon Hills

Introduction

In June 2014, the North Suburban Regional Human Rights Authority opened an investigation of possible rights violations within Victory Centre of Vernon Hills. The complaint accepted for investigation was that a resident's rights were violated when the Director of this site put his knee on a resident's shoulder/neck while the resident was being restrained by paramedics. Residents receiving services at Victory Centre of Vernon Hills are protected by the Illinois Administrative Code (89 IL Adm. Code 146).

Background

According to Pathway literature, Pathway communities serve the growing needs of America's aging population. Supportive Living communities operated by Pathway are designed for seniors (those age 65 and over) who are no longer able to live on their own safely, but do not require the high level of care provided in a nursing home. Assistance with medications, most activities of daily living (ADLs), meals and housekeeping are routinely provided. Three meals per day are provided in a central dining room. Residents live in their own private apartments, which frequently have a limited kitchen area. Staff are available 24-hours per day for additional safety. Social activities and scheduled transportation are also available. The difference between assisted living and supportive living in the state of Illinois is that, by providing services as outlined by the state, supportive living communities are able to offer a financial assistance program to their residents. These programs vary, but, in general, unlike with typical assisted living programs, residents who qualify for the financial assistance program are able to stay at the supportive living community if and when personal funds are depleted. Victory Centre of Vernon Hills is a supportive living community.

Method of Investigation

To pursue this investigation, the HRA interviewed the resident via telephone. The HRA conducted an on-site visit in July 2014. While at the facility, the HRA discussed the allegation with the Executive Director; the Director identified in the allegation no longer works for Pathway Senior Living. The HRA was sent facility documentation regarding the cited allegation. The HRA acknowledges the full cooperation of facility personnel.

Findings

The resident stated that the Director grabbed her by her arm and pulled her out of her apartment, and threw her down on the paramedics' stretcher that was waiting outside of her apartment. It was stated that he placed his knee over her left shoulder blade and neck and held her down until the paramedics could strap her down. The resident was asked if she had contacted the

police regarding this matter; she initially stated that she had not, and then stated that she had contacted the police subsequent to the incident but they were of no help.

In response to the HRA case opening correspondence, the facility sent an incident report, stipulating that the facility does not usually send internal incident reports to outside entities, but they thought that the narrative description by the nurse in this instance would be beneficial for the investigation.

The incident report documented that on October 2, 2013 the resident was sent to a nearby hospital on an involuntary petition for behavioral health admission. (The writer of this document no longer works for Victory Center.) She returned the same day via ambulance and it was noted that she had left the hospital Against Medical Advice. It was documented that the Director spoke with her and papers were completed for an involuntary admission. A behavioral health hospital was contacted and they said they had a bed for the resident; an ambulance was called to transport the resident to the behavioral health hospital. The report went on to say that the Director, the nurse and paramedics went to her room and the Director attempted to talk her into coming out of her room and getting on the stretcher. The report noted that the resident "became violent, striking [the Director] and shouting." The paramedics went in and the resident "hit him several times". The paramedics were able to get her to the doorway and beside the stretcher. The resident then started kicking at the nurse and the other paramedic. It was documented that "they got her on the stretcher and restraints were attached. She continued to scream obscenities and thrash about; she was taken down the elevator, out the back door and put in the ambulance."

At the site visit, the Director of Life Enrichment explained the Pathway Senior Living programs. When asked about admission criteria, she stated that admission is pursuant to state regulations. All assessments are completed prior to admission to determine if the resident is a candidate for supportive living. The "Determination of Need" or "DON" is a tool used by the Department or the Department's authorized representative to determine functional needs of a resident or prospective resident of the SLF. A minimum score of 29 is required on the DON before payment may be authorized for the SLF resident. The DON is comprised of three sections which are: Part A - the Mini-Mental Status Examination section which is used to determine the individual's cognitive functioning; Part B - measures the individual's need for care in the completion of ADLs; and Part C - measures the individual's unmet need for care in the completion of ADLs. A finding of mental illness does not necessarily prevent a resident from entering a supportive living facility. Revisions to 89 Ill. Adm. Code 146.220(a) (3) on October 18, 2004, allow for the admission of a person with mental illness if the condition is not serious and persistent.

When asked about staff training, specifically training for those residents with a mental illness, the Director again referred to state regulations, stating that training takes place no later than 30 days after beginning employment and semi-annual/annual training in areas related to their employment. Training covers resident rights; infection control; crisis intervention; prevention and notification of abuse, neglect and financial exploitation; and behavioral intervention to name a few. The Director offered that no staff member would intentionally cause harm to a resident. She further stated that she personally knew the staff member in question, and said it was not in his nature to act maliciously toward a resident. The Director also noted that the resident was involuntarily discharged from Pathway Senior Living because she posed a threat to others.

When asked if the facility has written policies regarding the training of staff members, the Director stated that the policies are the applicable sections of state regulations.

Conclusion

Pursuant to Section 146.250 of the Illinois Administrative Code,**"** e) each resident shall have the right to: 1) be free from mental, emotional, social, and physical abuse and neglect and exploitation…"

The HRA cannot discount the resident's recollection that the Director of the site put his knee on her shoulder/neck while she was being restrained by paramedics. However nothing was found in the information obtained to support the assertion. The incident report documented that the resident was violent and combative and intervention was needed by facility personnel and paramedics so that she could be transported to another site for a behavioral health examination; the allegation is unsubstantiated.