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HUMAN RIGHTS AUTHORITY – NORTHWEST REGION
REPORT 15-080-9008
HAMMETT HOUSE

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship & Advocacy Commission opened an investigation after receiving a complaint of potential rights violations of a resident at Hammett House. Allegations were that the resident experienced inadequate care regarding assistance in receiving necessary medical attention.

Substantiated findings would violate rights protected under the Centers for Medicare/Medicaid Conditions of Participation (42 C.F.R. 483), the Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD) Administrative Code (77 Ill. Admin. Code 350) and the Mental Health and Developmental Disabilities Code (405 ILCS 5).

According to the website, Hammett House is a 16-bed intermediate care facility for persons with developmental disabilities, offering comprehensive and individualized health care and rehabilitation services to promote their functional status and independence. Located in Sterling, the home is managed by Frances House, a northwestern Illinois affiliate of the DD Homes Network.

To investigate the complaint an HRA team met at the facility where it interviewed an executive director, an administrator, a director of nursing, a QIDP (Qualified Intellectual Disabilities Professional), and a DSP (Direct Support Professional). Policies were reviewed as were relevant sections of the resident's records with written authorization.

COMPLAINT SUMMARY

The resident allegedly experienced inadequate care and neglect when the facility would not transport the resident to the hospital emergency room when advised to do so by the guardian/mother. The guardian had to travel from out of state to the facility to transport the resident to the hospital herself, and by that time the resident was said to be seriously ill and remained in the hospital for several days. The neglect portion of this complaint was reported to the appropriate enforcement agency by the guardian.

FINDINGS

The DSP stated that around 3/22/15 the resident complained of not feeling well due to a headache and dizziness. She wondered if these symptoms were due to the medication Depakote, and added that she notified the director of nursing on the same day. The director of nursing explained that a couple days after that, she received a phone call from the DSP stating that the resident was not feeling well. Reportedly, there was some nausea due to the side effects from Depakote. Per the DSP, the resident soon developed a cough and cold, but it was not until several days later that she notified the nurse. The DSP went on to say that on 3/31/15 she completed in staff progress notes that she gave the resident cough syrup and Tylenol for a cough and headache, but she adds that she does not know why she neglected to notify the nurse. On 4/3/15 she recorded notes stating that not only did the recipient have a cough and headache, but also neck pain. In addition, she wrote that the nurse "was aware of the cold and cough symptoms", but the DSP does not remember if she actually updated the nurse directly with this latest information.

The director of nursing stated that the resident was taken by the facility staff to a local walk-in clinic on 4/14/15 for the aforementioned symptoms. The guardian was not contacted. On 4/16/15 the DSP verbally informed the director of nursing that the symptoms of the resident were getting better. The DSP admitted that she never documented that the symptoms were getting better. She only communicated this verbally to the director of nursing. Reportedly, the resident saw the physician on 4/16/15 as a follow-up from the 4/14/15

visit to the walk-in clinic. The physician wanted the resident to continue on the Z-pak (Zithromax) antibiotic for a continued cough and being febrile, or feverish. The director of nursing added that she assessed the resident later the same day of 4/16/15 and although the resident still had a cough, the fever had subsided. The director or nursing continued, stating that on 4/17/15 she received a phone call from the guardian. The guardian stated that the resident was very ill and needed to be taken to the hospital and be admitted. The director of nursing informed the guardian that she had assessed the resident just yesterday, on 4/16/15 and she was getting better and did not have serious enough symptoms to be taken to the hospital.

The DSP stated that in the early morning hours of Saturday, April 18, 2015 the resident was feeling worse and she administered cough medicine and Tylenol to her. The DSP added that she called the QIDP and the QIDP informed the director of nursing. The director of nursing attempted to make clear that she had intentions on taking the resident to the hospital emergency room later this same morning. Although there is no documentation, she states that she called the guardian on 4/18/15 and the guardian stated that she was "on her way". The guardian then arrived early that afternoon and took the resident to the hospital emergency room. The staff did not accompany the guardian to the hospital. The resident was diagnosed with pneumonia in the emergency room. She was then admitted to a medical floor of the hospital and was kept for several days.

Per the administrator, the DD Homes/Hammett House staff receives the mandated training required by the State of Illinois. In addition, 1:1 training is provided to the staff from the director of nursing and updated as often as needed. The facility has a Behavior Management/Resident Rights Committee. The administrator went on to state that "this incident was not reviewed by the committee as it was not, and is still not what we consider to be a rights restriction".

RECORDS

Progress notes from the DSP dated 3/15/15 depict that the resident had a headache, dizziness, ate very little for breakfast, and there is a

question whether these are side effects from an increased medication. On 3/24/15, the director of nursing documented the following notes: "This writer received phone call from staff as reporting resident acting differently this p.m. Staff did report resident had some nausea but had resolved. This writer explained to staff of resident's Depakote level is to a level where it is effective with leveling her emotions to a more even level, and she may not like this feeling as likes the mania feelings of bi-polar which she will not like how she feels". The progress notes written by the director of nursing dated 3/27/15 state that the physician wrote an order to decrease the Depakote dosage to 1000 mgs. The nurse progress notes dated 3/31/15 with no specified time of day listed, record that the Depakote dosage has been increased to 1500 mgs. There is no mention of cough or cold symptoms. But on 3/31/15 the DSP wrote progress notes with a time of occurrence at 5:45 a.m. stating that resident does not feel well due to a headache, a slight cough, body aches and she requested to stay home. The document goes on to state that the DSP gave the resident cough syrup and Tylenol. The "nurse notified" section of the progress note was not marked.

The DSP progress notes dated 4/3/15 denote that the resident "complains of a headache and stated that her neck hurt, cough symptoms". "Resident was restless throughout the night getting up saying she didn't feel well, and complaining of thirst. Staff gave Tylenol for discomfort. Comfort care and cool pack to neck area". The form is marked that the QIDP was notified. The "nurse notified" section is again left blank, albeit under the "instructions given" portion it is recorded that the "nurse is aware of cold/cough symptoms".

The nurse progress notes dated 4/6/15 and 4/7/15 do not address the symptoms of a cough or cold, but only mention updates regarding the medication. Per the 4/14/15 DSP progress notes, "resident coughing harshly throughout the a.m. hours. Complained to staff that she does not feel well, weakness, tiredness". The notes also depict that the resident had been taking over the counter cough medicine and pain medicine for headaches since "3/30/15 through 4/8/15" for "chest area/whole body effected with weakness, cough". The temperature of the resident is recorded as 96.6. The nurse notified section is marked "no", that the

nurse was not notified. Later this same day of 4/14/15, the nurse recorded that the resident was taken to the walk-in clinic due to having "a cough for 10 days and a fever". There is no mention of guardian contact. Although requested by the HRA, no documentation of guardian contact regarding the symptoms of a cough and cold were provided for the period of 3/22/15 through 4/16/15. The Consultation Report from the local walk-in clinic dated 4/14/15 confirms that the resident was seen and treated for a bad cough, no appetite, chest congestion and coarse lungs. On 4/15/15 the nursing note only addresses stopping the medication Depakote, starting the medication Zyprexa which is related to Depakote side effects, and that the guardian was contacted regarding this change. There is no mention of any other subject discussed with the guardian. On 4/16/15, the nurse progress notes expound that the resident was seen at the local walk-in clinic on 4/14/15 for "continued cough and febrile". "Staff reports cough getting better and is afebrile". According to the progress notes by the nurse dated 4/17/15: "This writer received phone call from resident's mother on home land line. Mother stated resident was not eating, losing weight and wanting to go to hospital to be seen. This writer had seen resident on 4/16/15 as she was home from work. Resident was still coughing. Lungs sound good and did not appear in any life threatening distress. Explained to mother, resident may have developed Influenza B as have had several residents. With virus it does take several weeks to recover. Mother went on rant about how a Z-pak is not going to help etc. This writer informed mother that no amount of antibiotics is going to be effective with a virus as they need to run their course. Mother states she worked in a hospital and understands how the medical field works. Mother stated she wanted resident taken to ED tonight and wanted her admitted. This writer asked to be admitted for what. Mother states 'She does not feel well'. This writer informed her I understood that, however resident has to meet criteria to be admitted and MD's cannot just admit without a valid reason. Mother stated again she worked in a hospital and they can admit her if she says so. This writer explained to mother that I would call building to see what is going on and talk with QIDP and someone would call her back". There is no documentation that anyone called the

guardian/mother back. The progress notes from the DSP on 4/18/15 with a time of occurrence date of 5:00 a.m. and a written time of 9:50 a.m., state that the resident is coughing harshly, has a headache, chest pain and did not eat breakfast. The DSP gave the resident Tylenol and cough syrup. The "nurse notified" section is marked no, and the "check person notified" section is marked QIDP. The "follow-up including guardian notification if necessary" section of the form is left blank, as were all of the previous DSP notes mentioned in this report.

The Diagnostic Report of chest x-rays taken of the resident on 4/18/15 denote that "In this patient with a history of cough, left Basilar Infiltrate is probably due to pneumonia". The Emergency Room Physician Report dated 4/18/15 states that the resident was "admitted with 4 weeks of generalized fatigue, lethargy, fever, cough, nausea, vomiting and muscle aches". "In terms of plan, the patient will be placed on IV fluid. She is started on Levaquin for pneumonia". "She was visited recently by her family who recommended that she should be sent to the hospital". The Consultation Report dated 4/20/15 by the Psychiatrist states that "the patient has been an inpatient for 2 days now". "Mom just states she is looking a lot better than she did the last few days ago. Her mother who is guardian…who was visiting the patient when I met with the patient". "Suggested a transfer to psychiatric unit once medically cleared for observation for few days". The patient was transferred from a medical floor in the hospital and admitted to the psychiatric unit on 4/20/15 and discharged on 4/23/15. According to the Psychiatric Discharge Summary dated 4/23/15, "the patient is discharged back to the group home. She will follow-up with her psychiatrist in Rockford". The psychiatrist held a family meeting with the guardian/mother on this day. The resident's status at the time of discharge was "alert, oriented times 3, cooperative. No delusional thinking noted. Memory and concentration grossly intact. Sleeping and eating well. Eager towards outpatient follow-up with psychiatrist in Rockford". The 4/23/15 nurse notes state that "this writer received notification that resident was being discharged from hospital this afternoon and mother would be transporting resident home. This writer did have phone contact with mother concerning any medication

changes". "This writer would meet them at Hammett after resident arrived to review meds and visit with resident." Physician Consultation Reports dated 4/24/15, 5/4/15, 5/5/15 and 5/14/15, including a 5/15/15 psychiatric follow-up, depict the resident's forward progress to wellness.

CONCLUSION

The Physical Injury and Illness/Individual Medical Emergencies Policy states that individuals served by the agency shall receive timely and effective medical services for physical injuries, illnesses and medical emergencies. In the event that an individual sustains an injury or illness, staff on duty shall conduct observation and take appropriate action consistent with the following:

C. Notify the Nurse and House Manager, QIDP or Administrator for consultation and direction.

D. If the House manager, QIDP, Administrator or RN is not available in a timely manner, a designated DSP may call the local hospital emergency room for consultation.

F. The QIDP shall notify the guardian and/or relative designated by the individual of the situation as soon as possible.

The Nursing Services Policy explicates that the RN Consultant serves as a primary resource of health care and provide education to direct care personnel and individuals.

The following procedures shall be used to report minor illnesses or injuries to the RN Consultant:

a. DSP observes, or individual approaches DSP with a minor illness or injury.

b. DSP notifies the Nurse and House Manger, QIDP or Administrator for consultation and direction.

c. RN will communicate professional judgment based on given information and the DSP shall implement and document RN's responses.

d. If symptoms worsen at any point, the RN Consultant shall be notified for further instructions/follow-up.

The Medical Services Policy makes it clear that the facility shall maintain effective arrangements through which medical and remedial services outside the facility that are required by individuals can be obtained promptly when needed.

Under the Probate Act of 1975, personal guardians are to procure for their wards' support, care, and health (755 ILCS 5/11a-17). Providers may rely on any decision or direction made by the guardian that is not contrary to the law (755 ILCS 5/11a-23). Federal rules require facilities to inform each client, parent or legal guardian of the client's medical condition, development and behavioral status and to promote their participation in the active treatment process (42 C.F.R. 483.420). For ICF/DDs in Illinois specifically, facilities must provide immediate nursing supervision of each resident's health needs and immediately notify the resident's guardian whenever unusual circumstances arise. Nursing services include the training of direct care personnel on detecting signs of illness, basic skills to meet the health needs of residents, and first aid in the presence of an accident or illness (77 Ill. Admin. Code 350.1210; 3210; 1230). And, all facilities must ensure adequate and humane care and services (405 ILCS 5/2-102a).

Complaint: The resident experienced inadequate care regarding assistance in receiving necessary medical services. The DSP progress notes during the period of 3/31/15 through 4/14/15 depict the symptoms that persistently developed into a severe cough/cold illness which resulted in the staff taking the resident to a local walk-in clinic on 4/14/15. On 3/31/15 the DSP failed to notify the nurse or anyone else of the condition of the resident. The Nursing Services Policy regarding the reporting illness states that the "DSP will notify the Nurse and House Manager, QIDP or Administrator for consultation and direction". The first time notes that were written by the nurse addressing the cough/cold issue was on 4/14/15, although the 4/3/15 progress notes by the DSP state that the "nurse is aware" of these particular symptoms. On 4/14/15 the resident was treated at the local clinic for a bad cough, loss of appetite, fever and chest congestion. On 4/15/15 the nurse documented

that she spoke with the guardian regarding the change in the Depakote level, but did not document that she discussed the cough/cold symptoms or the 4/14/15 clinic visit. The Illinois Administrative Code (77 Ill. Admin. Code 350.3210) states that the facility must immediately notify the guardian of the resident whenever unusual circumstances are presented. Nor is there any documentation that any other staff notified the guardian prior to 4/17/15. Federal rules (42 C.F.R. 483.420) require facilities to inform the legal guardian of the client's medical condition, development and behavioral status and to promote participation of the guardian in the active treatment process. The Physical Injury and Illness Policy/Individual Medical Emergencies Policy states that the QIDP shall notify the guardian and/or relative designated by the individual of the situation as soon as possible. On 4/16/15 the nurse wrote that the DSP informed her that the cough was getting better and there was no fever, but the DSP did not document that she notified the nurse, and did not document that the resident was getting better. The Nursing Services Policy states that "The RN will communicate professional judgment based on given information and the DSP shall implement and document RN's responses". The policy goes on to expound that the nurse is to "serve as a primary resource of health care and provide education to direct care personnel and individuals". The Illinois Administrative Code (77 Ill. Admin. Code 350.1230) states that nursing services must include the training of direct care personnel on detecting signs of illness, equipping them with the basic skills to meet the health needs of residents who have an illness. On 4/17/15 the nurse received a phone call from the guardian/mother requesting that the nurse take the resident to the hospital emergency room. The nurse did not agree and made no attempt to follow through in transporting the resident to the hospital. The Illinois Code (755 ILCS 5/11a-23) informs providers that they hold the right to rely on any decision or direction made by the guardian that is not contrary to the law, to the same extent as though the decision or direction had been given by the resident. The guardian/mother of the resident arrived from out of state and transported the resident to the hospital emergency room. The 4/18/15 Emergency Room Physician Report denotes that the resident was diagnosed with pneumonia. She

was admitted a medical floor in the hospital from 4/18/15 through 4/20/15 and in the psychiatric unit from 4/20/15 through 4/23/15. It is therefore concluded that the complaint is substantiated.

RECOMMENDATIONS

1. Permit the legal guardian to fulfill their role in procuring for the support, care, and health of the resident. (755 ILCS 5/11a-17; 23) (42 C.F.R. 483.420) Document guardian notifications, decisions and involvement.

2. Ensure that the support staff communicates directly with the nurse verbally as well as written documentation that includes follow-up and any necessary action regarding the health and well-being of the resident. (77 Ill. Admin. Code 350.3210; 350.1230)

SUGGESTIONS

The ISP (Individual Services Plan) dated 10/17/14 does not address the guardian's intentions for medical emergencies or the transport of the resident to outside facilities for medical care and probably should if she has special requests. (405 ILCS 5/2-102a; 210 ILCS 47/3-202.2a).

The neglect portion of this complaint was referred to the Department of Public Health and a report resulted in findings where Hammett failed to implement policies/procedures prohibiting mistreatment, neglect or abuse, report such instances to an administrator and provide nursing services according to a client's needs.