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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case #16-090-9002
Sharon Healthcare Facilities - Elms

INTRODUCTION

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

1. **Failure to inform guardian of situations involving resident, including bruising and weight loss that resulted in the resident being admitted to the hospital.**
2. **Inadequate resident safety.**

If found substantiated, the allegations would violate the Skilled Nursing and Intermediate Care Facilities Code (77 ILCS 300), the Nursing Home Care Act (210 ILCS 45), and Centers for Medicare and Medicaid Services requirements for Long Term Care Facilities (42 CFR 483).

Sharon Healthcare Elms is a skilled nursing facility with residents from all around Illinois, with a large population of people with mental health needs, brain injuries and dementia. The staff is comprised of approximately 100 individuals and they provide occupational and physical therapy, speech, and have a restorative nursing program and psychotropic reduction program. At the time of the site visit interviews, there were 73 residents and 98 beds.

Complaint Statement

The complaint states that a resident was admitted to a hospital for bruising, weight loss, and dehydration but his guardian was not informed of issues that led to the hospitalization and it was the hospital, rather than Sharon Healthcare Elms, that informed the guardian that the resident was there. Also, the complaint states that the resident was not kept safe, which led to the injuries and hospitalization.

Interview with staff (8/28/2015)

Staff began the interview by stating the resident had been admitted to the facility on 2 or 3 different occasions. The last occasion, when the complaints occurred, the resident was dependent and had a gastrostomy tube. The resident had a cognitive impairment, was a fall risk, and had multiple falls at the facility. The resident would also flail his body parts and hit the

walls with his hands and arms. Once the resident even had an incident where he attempted to crawl out of his bed. There was a Broda chair placed by the nursing station for the resident where they could supervise him. On one occasion, a Certified Nursing Assistant (CNA) took him to the chair but there were no nurses, so the CNA took him back into his room and propped his feet up on the bed so he could not move. The resident then fell from that chair and developed a large bruise.

Staff said three people spoke with the resident's guardian and he was aware of the behaviors. The facility stated that often when they sent the resident to the hospital, it was after 5pm and they have had to leave a message and, in this case, they talked to an Office of State Guardian's (OSG) staff that was working after hours on-call. They did not speak directly to the guardian. Staff have documentation that they contacted the guardian on 5/8 at 7:19am and never received a return phone call. Whenever there is an incident they contact the resident's guardian and that contact is noted in the incident report. There was a complaint from the Illinois Department of Public Health (IDPH) and there were findings in the investigation because staff could not answer for each single bruise on the individual. For the resident's protection, the facility had a low bed, a mat next to the bed, as well as a helmet, and a bed sensor. They also moved items away from the bed. Staff never used restraints on the resident.

During the investigation, it was discovered that there was an issue with the resident losing too much weight. The facility discovered that the weight loss was due to a deficiency in the recording system. The facility would document residents' weight then calculate the percentages and notify the doctor. They discovered this was too much for the staff. The system was changed to weighing one wing of the facility at a time and notifying after each wing was completed. On the first Tuesday and Thursday of the month, weights are completed and documented. The resident's weight at the facility was less than the weight while at a hospital stay. The scale was checked and they were told that the scale was too close to the wall and they needed to move it further away. Also the weights needed recalibrated. Staff said the weights at the facility may not have been accurate. When the resident entered the hospital, the facility had weighed him the day before and his weight was 122 but the hospital weight had him at 136. The dietician assessment states that the individual's ideal weight should be 122-150 and this is documented in the care plan. This is how the facility discovered there was an issue with their weights. Staff said that on 4/30 the resident's weight was 125, on 4/23 it was 134 and the week before it was 123. Before that, the weight was 126.8. They try to have the same staff consistently weighing the residents and they hired lead CNAs. The reason for the same staff performing the weigh-in is because there may be different variables in weighing the residents, such as one time they could be wearing a blanket and on another occasion they are not. The CNA reports on any change and they re-weigh if there is a big change. New admissions receive weekly weigh-ins until staff are sure that residents are stable.

The resident was admitted to Sharon on February 17th. He was sent to the emergency department on February 23rd and again on March 12th. On March 30th he was admitted through the Emergency Department (ED) and was gone 10 days and did not return until April 9th. On April 18th he was admitted through the ED again until April 23rd and finally, on May 8th, the resident was discharged and did not return. The guardian was notified each time. The patient had gone into the hospital for a fall, a cardiac episode, pulling his peg tube out, acute respiratory failure, sepsis, seizures and more respiratory trouble.

Because of this incident, there were many changes. The facility questioned how CNAs are notifying the nurse if they notice a skin change. When staff notice a bruise, but they do not

know how the bruise originated, they now use a different form. Previously the staff used incident reports but now there is an unusual occurrences form for injuries of unknown origin. Incident reports cover resident on resident abuse, staff on resident abuse, and observed injuries such as a fall. If a resident falls and tells staff that they got back up, there would be an incident report completed. Often residents fall and an incident report is completed but the bruise appears later. The nurse's aides now complete a form when they report to the nurse that a resident fell so they can track and assure that an incident report is completed. CNAs also have shower sheets and if they see a bruise while the resident is showering then it will be documented and a nurse investigates. These sheets are reviewed daily and the nurse is required to respond to the shower sheet. During the shower sheet review, if something new is discovered, then an incident report is completed. If a resident is admitted to the hospital from the facility, they check skin before they are admitted, and document the review. They also check the patient's skin when they return and document the review.

This resident had a fall protocol and whenever there is a fall with any resident, they change interventions on the resident's care plan. The resident received either 15 minute or 30 minute checks while at the facility which are documented. The call light was also always in reach. After this incident, the facility started utilizing a dehydration risk screener if there was a significant change in condition, new medications, admission/discharge from a hospital, or if there is a decrease in fluid intake. The screener reviews the resident's skin, fluid intake, weight, continence, and other risk factors. The screener is also completed quarterly for all patients. This resident had a dehydration care plan and in this case they identified the dehydration the day before the resident went to the hospital. Before this they used lab work to detect issues with residents. They have routine lab work set up with the residents depending on the medication. The resident was missing the labs because he was going in and out of the hospital. The resident had 5 hospitalizations in 3 months and was in the hospital for 27 days out of the 3 months. They actually initiated the dehydration care plan the day before the resident went into the hospital. The facility also records fluid and eating patterns at mealtime and if someone has a g-tube, they complete labs for that individual. The individual's last admission to the hospital was for pneumonia and not dehydration. The individual is now at a different facility.

Staff explained that staffing levels are fine according to the public health survey conducted in July. There is a calculation for the amount of skilled versus medium care residents and the staff needed. Staff said they have 2 or 3 nurses plus a treatment nurse, restorative nurse, a Director of Nursing and an Assistant Director of Nursing. They also have 9 CNAs, RNs, and LPNs. The Director of Nursing is on call at all times and they have 7 or 8 CNAs covering second shift and 4 or 5 on third shift, as well as nurses.

Social service explains to new residents that they can use the telephone when they are admitted. There is a phone at the front of the facility and a more private phone in one of the wings. The facility posts the contact information for all the needed agencies and social services explain each agency's function. Additionally, residents are provided rights and with agency hotline numbers. There is a facility grievance procedure and there is an anonymous form in the dining room that that can be completed for grievances. The facility also posts the staff contact information above the time clocks, so if residents need to, they can contact administration.

They contact guardians when there is a fall, an incident, change in condition, if there is a need for hospital admission, consent for psychotropic medication, death, and weight loss or gain. All staff are trained to contact the guardian. The nurses make the call to the guardians and occasionally other staff depending on the situation. They sometimes have issues with family

members because they are unable to contact them. They have a morning meeting and often they can use this meeting as a quality check because they can review if all the procedures have been followed through the incident reports. There have been times when it was caught that the procedures were not followed.

The resident thrashed around so much that they could not determine the origin of each bruise. Staff also could not determine all the bruises were caused from falling. Staff said that they do not have to report to public health for small bruises and staff did not report the same way that the hospital did. Staff noted bruises on the arms and legs but they did not know how many bruises the resident had. They completed an internal investigation on the resident's legs but it was hard to pinpoint causes. The investigation was prompted by the hospital discussing the bruises. Staff said that what they heard made the situation sound worse than what they saw and they started discussing with staff. The investigation did rule out abuse. Staff talk with roommates or other residents, staff, and anyone else to investigate possible abuse. They try to make a judgement on the information they gather. They can now usually pinpoint where a bruise is from because of their changes. If a resident has a history of falls, they have a care plan meeting and list the basic steps they can take. They figure out what is causing the falls and it depends on the individual what steps are taken. Staff do not contact public health, administration does.

FINDINGS

With proper consent, the HRA reviewed resident records and facility policy that pertain to the allegations in this case.

Complaint #1 - Failure to inform guardian of situations involving resident, including bruising and weight loss that resulted in the resident being admitted to the hospital.

The HRA reviewed the facility transfer/discharge report that dealt with the 5/8/2015 hospitalization of the resident. The document was signed on 5/8/2015 and among the typewritten diagnoses were unspecified protein-calorie malnutrition, acute kidney failure, acute respiratory failure and 18 other diagnoses. The chief complaint section indicates that the resident has lung sounds that are rattling and they suctioned phlegm from the lung. They stated the resident was able to speak but not clearly and his skin was pale but warm to the touch. Also the bowel sounds were hypoactive and his condition was declining from the past day. There is no mention of weight, bruising or dehydration in the discharge report. The report reads "Called Guardian [Name] to report sending to [Hospital] for eval."

A Sharon Healthcare Elms Progress Note reads that at 7:19am on 5/8/2015 the facility contacted the resident's guardian to report sending him to the hospital for an evaluation. This was the date of the incident in question. The previous note at 7:09am identifies the same chief complaint as on the transfer/discharge report. At 1:33pm a nursing note on that same day reads "Resident admitted for severe dehydration, leukocytosis, encephalopathy and hypernatremia."

A progress note dated 5/7/2015, which was titled a plan of care note, states that one of the diagnoses that the resident was admitted into Sharon Elms with was malnutrition and the resident was admitted from the hospital with these diagnoses. There are other examples of the guardian being contacted by the facility within the progress notes, for example another note dated 4/29/2015 reads "CNA reported that resident peg tube was laying on the floor next to bed. New

orders: ok to send to er for peg tube placement per T.O. [Name] APN." The passage states the Director of Nursing (DON) and guardian were contacted. Another admission summary from 4/24/2015 reads that the resident was transported by AMT and the individual has a history of altered mental status, Parkinsonism, macrocytic anemia, bradycardia, and others. The passage states that the physician and guardian were contacted and the guardian gave verbal consent for psychotropic medications. Another progress note on 4/14/2015 reads that the facility was updating psychotropic consent forms and they mailed a form to the guardian. A note on 3/31/2015 reads "spoke with [guardian] regarding resident update and admission to hospital with subdural hematoma. [Guardian] stated that resident is his own worst enemy, due to noncompliance with asking for assistance, using devices, and using call light." On 3/20/2015 a note reads "Resident was observed trying to exit door on C hall. When the alarm sounded he fell to the floor landing on his bottom. Assessment was done, no injuries noted, no bruising, no redness, MAE, no complaints of pain. [Physician] and [Guardian] was notified." On 3/18/2015 there was another where the resident fell and the guardian was contacted. The HRA was also provided with a sample of 12 incident reports between the dates of 2/25/2015 and 4/27/2015 and each of the reports documented that the resident's representative was contacted (one report stated that there was contact but without a name). All the situations were fall related except for one where the resident hit the wall with his hand.

As part of the record provided by the facility, the HRA reviewed the admission history and physical from the admitting hospital. According to the hospital record, the patient was admitted from Sharon Healthcare Elms for AMS [altered mental status] and hypoxemia. The HPI [history of present illness] comments state that the hospital RN said the resident was sent to the hospital because he started requiring oxygen, which he usually does not require. Also his baseline seemed to be altered at the nursing home. At the nursing home, the resident's baseline status was confused but somewhat verbal and able to follow commands and at the nursing home he was not following commands. Later in the documentation, the clinical impression diagnoses the resident with leukocytosis, altered mental status, hypernatremia, and severe dehydration and in the emergency department medical decision making section; it reads "Suspected elder neglect – pt with severe dehydration, poor oral care, and bruises noted on arms and legs."

The HRA reviewed a facility policy, which was provided by the Illinois Council on Long Term Care, titled the "Abuse Prevention Program Facility Procedures." Within this policy, there is a section titled "External Reporting of Potential Abuse" which states that "If mistreatment has occurred, the resident's representative and the Department of Public Health shall be informed as soon as possible." The phrase "within 24 hours" is crossed out after that sentence and there is an addendum that is handwritten into the policy which reads "As soon as an allegation of abuse, mistreatment, or misappropriation of funds is made, the resident representative will be notified an investigation has been initiated." The policy proceeds to describe that a written report needs to be sent to the Department of Public Health (DPH) and what the report should contain. After that, a section reads "The administrator or designee will also inform the resident or resident's representative of the report of an occurrence of potential mistreatment and that an investigation is being conducted." The policy also states that if there is suspicion of a crime that was committed, the DPH and the resident's representative should be informed immediately for serious bodily injury and "as soon as possible" for the others. In this section the timeframe of not later than two hours, was crossed out for bodily injury and not later than 24 hours was crossed out for all other injuries. There are initials by both sets of addendums but no dates. The HRA also reviewed a blank, preliminary 24-hour abuse investigation report, and in the report there is a checklist of

actions that need taken. Part of those actions are that "The resident representative has been notified by telephone of the allegation, and will be notified of any conclusions of the investigation." There is another final abuse investigation report which indicates "the resident and/or resident's representative will be informed of the conclusions of the investigation."

The HRA reviewed the resident accident/incident policy that was revised on 5/10/2015. The final statement in the policy reads "In all cases, the Facility will notify the family/guardian, physician and the proper authority in accordance with State and Federal Regulations." The HRA reviewed a blank form for Unusual Occurrences which requests the name and date of the Responsible Party Notified to be documented and also a Skin Tear/Bruise of Unknown Origin Investigation that makes the same request. Both forms appear to be provided by the Illinois Council on Long Term Care. The HRA also reviewed the facility Weight Policy which states that "If there is a significant weight change noted, the resident will be reweighed. If the significant change persists, the doctor and responsible party (if applicable) will be notified. This notification will be documented." This policy was also revised on 5/28/2015.

The HRA also reviewed the documents regarding the resident's weight. According to the progress notes, on 2/20/2015 the resident's weight was 136 and this was documented again on 3/2/2015. On 3/23/2015 there was a mention in the note that the resident had significant weight loss for the month at 6.8%. The note states that the resident has had a recent hospital stay and MRSA of the nares and sputum. The note states the resident care plan was reviewed. The notes also state there are no new orders at this time. The patient's weight was 126.8. A note on 5/7/2015 reads that the patient's current weight is 134 pounds. A progress note from 5/11/2015 reads "res. has had a significant wt. loss 10.3% in (3mos) wt. 122. due to medical condition. res. care plan reviewed will monitor for wt. changes." The HRA reviewed a care plan for the resident which reads "The resident requires tube feeding r/t Weight Loss. 3/23/15 res. has had a significant wt. loss 6.8% in (1mo) wt. 126.8 res. has had a recent hosp. res. is still within IBW 122-150. 5/15 significant wt. loss 10.3% in (3mos) wt. 122." There are multiple interventions with the suggestions and they are all dated 3/2/2015. The interventions include the resident HOB [Head of Bed] needs elevated at all times, check for G-tube placement and gastric contents/residual volume per facility protocol and record, listen to lung sounds, monitor lab work, and monitor caloric intake. The HRA reviewed a previous care plan which states that the resident "requires tube feeding r/t Weight Loss" and this is dated 3/2/2015. There are no examples of significant weight loss on this care plan and all the interventions match the interventions on the newer care plan where there had been weight loss. The HRA reviewed no documentation that the guardian was contacted regarding the weight loss. The HRA also reviewed an Illinois Department of Public Health report where the facility was sited for failure to inform a physician of the resident's significant weight loss. The report states that, according to clinical records, between 2/17/2015 and 3/13/2015 the resident experienced 5% weight loss and from 4/23/2015 until 4/30/2015 the resident experienced 6.7% weight loss. The report also states the resident was admitted to the emergency department with severe dehydration and hypernatremia. Additionally, the Sharon Elms Director of Nursing stated that the resident had significant weight loss of 134 to 122 from 4/23/2014 to 5/17/2015 but that had not been reported to the physician yet because they have weight loss meetings monthly but they had not had a meeting yet in May. In the report, the dietary manager indicated that the resident dropped from 135 pounds in February to 126 pounds in March and then in May 2015 the resident had significant weight loss of 10.3 % from three months prior." The HRA saw no documentation informing the guardian of the patient's weight loss and asked if there was any documentation

that the guardian was informed of the resident's weight loss. Within the new documentation provided upon that request, the HRA still did not see evidence that the guardian was informed about the resident's weight loss, only that the guardian was informed that the resident was sent for a hospital evaluation and other instances regarding injuries.

The Centers for Medicare and Medicaid Services Requirements for Long Term Care Facilities requirements read "(i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is— (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications)" (42 CFR 483.10).

Complaint #1 - Conclusion

The HRA did see evidence that the facility contacted the guardian about the 5/8/2015 hospitalization. The facility sent the resident to the hospital for lung issues and this was documented in two different areas, but the hospital admitted the resident for dehydration, leukocytosis, encephalopathy and hypernatremia. The HRA feels that the facility did contact the guardian but there is still an issue of inadequate treatment of the resident, considering that the resident's state once admitted to the hospital. Although the guardian was contacted about the hospitalization, the HRA saw no evidence that the guardian was contacted about the resident's weight loss which is in violation of 42 CFR 482.10. Because of this, the HRA finds this complaint **substantiated** and **recommends** the facility assure guardians are being contacted if there is a significant change in weight loss and provide documentation of compliance with the HRA. Additionally, the HRA did not see evidence that the guardian reviewed the facility care plan and **suggests** the facility begin documenting this act. Also, the HRA had concerns that in the care plan, there were no new interventions for significant weight loss and **strongly suggests** the facility review this to assure that actions are taken to prevent health decline.

Complaint #2 - Inadequate resident safety.

The facility shared a dehydration risk screener dated 5/7/2015 at 14:17, which was the day before the patient was taken to the emergency room. The screener instructions read "Complete on admission, significant change in condition or medication that affects hydration and quarterly." The scoring section of the screener reads that scores of 10 or higher indicate that the resident is at risk for dehydration and further assessment should be conducted to review the resident's fluid status. The questions deal with items such as skin, mobility, fluid intake, weight, etc. When adding the answers to the questions, the score adds up to 10, which would make the resident at risk for dehydration.

A physician's order sheet for the patient dated 2/17/2015 through 2/28/2015 reads to discontinue the use of soft restraints but to use a floor mat as a safety device. Another physician's order, dated 3/1/2015 through 3/31/2015 reads to use a Broda chair. In that same physician's order, under safety devices, it reads floor mat and bed sensor. A physician's order sheet, dated 3/19/2015, and another physician's order dated 3/20/2015 through 3/31/2015 has no safety devices but also no discontinued devices and is only one page long. A physician's order

for 4/1/2015 through 4/30/2015 also does not have any safety devices or discontinued safety devices but under miscellaneous orders it states that the resident can wear a binder to keep the g-tube in place and have a therapeutic bed. There is another physician's report that does not have a date range, but has a report date of 4/9/2015, and does not have safety devices or discontinued devices. The 4/9/2015 physician's order does state to check the resident's weight once a week on Fridays. Another physician's order, dated 4/23/2015 through 4/30/2015 adds that the resident can wear a helmet for safety but does not mention other safety devices and does not discontinue any other safety devices. This physician's order also states to check the resident's weight. The final physician's order, dated 5/1/2015 through 5/31/2015 does not discontinue but also does not list safety items. This order also mentions checking the patient's weight weekly. The HRA was provided samples of the resident's medical administration report. The samples were from 2/17/2015 – 2/28/2015, 3/12/2015 – 3/29/2015, 4/10/2015 – 4/21/2015, 4/24/2015 – 4/30/2015, and 5/1/2015 – 5/13/2015. The 2/17 – 2/28 record states that on 2/20 the patient weighed 128.0 and on 2/27 the patient weighed 131.4. 3/12 – 3/29 had no weekly weight included. The records that span from 4/10 – 4/30 stated that the resident was 123 on 4/17 and 134 on 4/24 and the 5/1 record had the patient on hold for 5/8 weighing, which was when the patient was in the hospital.

The HRA reviewed the resident's most recent care plan, with a date of 4/23/2015 regarding the complaint about resident safety. One of the focuses of the plan, with a creation date of 3/20/2015 reads that the resident is at risk for abuse due to the resident's cognitive impairments and the goal is to keep the resident free from abuse or neglect. The interventions include encouraging him to participate in activities of interest, encourage him to report any abuse, observe changes in attitude or behavior, and report if any signs of abuse or neglect are seen. Another intervention for the resident's self-care states he requires skin inspection monthly for redness, open areas, scratches, cuts, bruises, and any changes are to be reported to the nurse. This intervention was dated 2/19/2015. This also appears in the care plan dated 2/24/2015. In reviewing the facility progress notes, there is a mention of the resident having no skin breakdown in notes for March, April and May. In the February section of the notes, there is no specific mention like the other months but the intervention was created on 2/19/2015 and the first check was on 3/2/2015. Another goal on the plan is that the "resident will remain free of complications related to immobility, including contracture, thrombus formation, skin-breakdown, fall related to injury through the next review date which is dated 2/19/2015. The interventions are to assure the resident is away from a wall when having behaviors to prevent him from hitting the wall" Another focus dated 2/19/2015 and revised on 3/2/2015, states that "The resident is moderate, risk for falls r/t, Unaware of safety needs, confusion resident is non-compliant with asking for assistance, and will become verbally aggressive if staff tries to help, will place self on the floor." And the goal is to keep the resident free of serious injury through the review date. The interventions to do this include assuring bed sensor is on at all times, 30 minute checks and staff monitoring, keeping the call light within reach, education on safety reminders and what to do if fall occurs, placing a floor mat next to bed and bed sensor, and use the Geri chair (which was created on 4/14/2015).

The care plan, dated 4/23/205, mentioned in the previous complaint, has a focus related to the tube feeding. This focus also documents an interventions in the care plan which requires staff to "Monitor/document/report PRN any s/sx" of dehydration. Another intervention is monitoring caloric intake. This also appears in the care plan dated 2/24/2015. The g-tube feedings are monitored on the medication administration notes and a dietary note on 4/15/2015 states the resident's calorie goal as 2000-2500 and the g-tube feeding provides 2160 calories. An

annual dietary assessment on 3/27/205 reads that the resident's goal is 2000 calories with 57 grams of protein and he is receiving 1908 calories with 73 grams of protein. The HRA did not see the calories from when the resident was first admitted.

The HRA asked for documentation of monitoring the resident's hydration and was told the hydration can be monitored through lab work. The HRA only saw one occasion, on 2/25/2015, where the facility ordered lab work completed that would indicate if the patient could be dehydrated but there were 3 other occasions where a hospital had lab work completed.

The HRA reviewed 12 incident reports and fall investigation sheets that were provided. Each incident had a recommendation/intervention completed for the fall, except one incident and another did not have a fall investigation sheet. The recommendation/interventions ranged from reviewing medication, reassessment, neurological referral, speaking with staff at the previous facility, using a floor mat and sensor, reminding the resident not to get up without staff and bringing the resident to the nurse's station when not in bed.

The resident's progress notes mention on 5/7/2015 that the resident has had some recent falls and has been in and out of the hospital due to medical conditions. It also states that the resident has had some trouble understanding others and being understood and staff monitors the resident throughout the day. Another note on that same day states that "Staff keep a close eye on him … His decision making is poor, and he is displaying more confusion. He has had some falls. He refuses to stay in his W/C. If he decides he wants to walk he will and he usually falls. He has a floor mat next to his bed and a low bed. He wears a helmet when he is up." A note on 4/24/2015 states that the "Resident remains at the nurses station at this time due to his fall risk." Another note on 4/18/2015 reads "noted resident is in Geri chair having episodes where he is hitting his hand on the wall." This incident made the staff contact the physician because he was also staring and delayed when asking his name. On 4/13/2015 there is a note describing the resident falling and there is an intervention note stating they are to make sure the resident is at the nurse's desk when not in bed to be watched constantly. An incident note on 4/10/2015 reads that the resident was found on the floor with a hematoma over his eye and another note on 3/30/2015 stated that the resident was found lying on the floor bleeding from his eye brow. On 3/3/2015 there was another note that the resident was in his Geri chair and stood up and then fell forward, landing on his face causing a small laceration on the eyebrow. Another note on 3/4/2015 reads "Pt sitting in Gerry chair in the dining rom. He is having bouts of extreme jerkiness, almost to the point of jumping out of the chair. Increased lethargy and making a loud snoring noise. Will cont to monitor." Another note on 3/18/2015 reads that a nurse stated "I heard a resident yelling when I went into the TV room resident was observed sitting on the floor. Another resident stated this resident fell out of wheelchair and was walking in TV room and tripped over walker. The other resident grabbed resident ot help him from falling so hard and laid him down to the floor." A note on 3/2/2015 mentions that the resident was admitted from the hospital with the diagnoses that includes malnutrition. This diagnosis was mentioned elsewhere in the progress notes. Another note on 2/28/2015 states a nurse found the resident squatting outside of his room holding a rail with 3 drops of blood on the floor next to him and the resident stated he fell and bumped his head. The resident had a quarter inch abrasion on his head. Another progress note indicates the resident was admitted to Sharon Elms on 2/17/2015 with a diagnosis of malnutrition. Another note on 2/19/2015 reads "Resident has good tolerance to PT but safety awareness is poor. Treatment for SPT/Gait/balance/STR." A note on 2/20/2015 reads "res. was here at facility previous but came here from hosp. res. was at sister facility Sharon Willows. DM stated that res started going downhill and has had some wt. loss."

In accordance with an Illinois Department of Public Health report, there were findings against the facility for not reporting the resident's weight loss and failure to investigate and inform the administrator of unknown bruises. A quote from the facility physician in the report reads "I have not been notified of [Resident] having significant weight losses. I would have expected to be notified. Had I been notified, I would have increased [Resident's] caloric intake and fluids. [Resident's] dehydration could have been prevented. There is no reason a resident fed by a g-tube (gastrostomy tube) should become dehydrated or have a weight loss. Now that weights are on the facility's computer, I no longer see the residents' weight logs when I make rounds." The report also states that a CNA took the resident into his room and propped his feet up on the bed which resulted in the resident falling on 3/31/2015. The report also stated that "Based on observation, interview, and record review, the facility failed to follow their Abuse Prevention Program policy, by failing to investigate and report bruises of unknown origin to the administrator for one of the three residents reviewed for abuse in the sample of three." The report also indicates that the facility "failed to follow their fall policy, provide supervision, and implement fall interventions to reduce the risk of falls for one of three residents reviewed for falls in the sample of three." The report stated these led to falls on 3/30/2015. Additionally, the report stated that the facility failed to assess weight loss and hydration status that led to hospitalization for severe dehydration and hypernatremia.

The HRA reviewed the facility's internal investigation process, which is not dated, and reads "It is the policy of Sharon Healthcare Elms to investigate all suspected abuse, injuries of unknown origin, etc. per the Illinois Department of Public Health regulations. This includes reporting all serious injuries, possible abuse and abuse to Illinois Department of Public Health per those same regulations within the specified time expectations. All staff are required to notify the Administrator of any suspected abuse immediately so that the investigative process may begin and be reported to the Illinois Department of Public Health in a timely manner." The facility abuse prevention program policy, provided by the Illinois Council on Long Term Care, reads "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents." The policy illustrates some of the methods used to prevent abuse include pre-employment screenings, resident screenings, trainings on dealing with stressful situations and recognizing abuse, identifying patterns of potential mistreatment, and immediately protecting residents involved in identified reports of possible abuse. In the reporting requirements section, it reads "The nursing staff is additionally responsible for reporting on a facility incident report the appearance of suspicious bruises, lacerations, or other abnormalities as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator or in the absence of the administrator, the person in charge of the facility." In addition to this policy, the HRA was provided handouts that go with the abuse prevention program and the second handout deals with staff obligations to prevent and report abuse, neglect and theft. The handout states that every employee is mandated to report abuse under law and it must be reported to the department head or administrator so it can be properly investigated. The handout illustrates the difference between abuse and an accident, and defines neglect and misappropriation. Other handouts with the training include causes of angry or agitated resident

behaviors, approaches to prevent violent outbursts, managing an aggressive or violent outburst, resident communication, recognizing stress, symptoms of stress, and dealing with stress.

The HRA reviewed flyers, provided by the Illinois State Police, that were said to be posted throughout the facility that read "Nursing home abuse, neglect, and fraud is a crime" and provides phone numbers to contact if there is suspected abuse. The HRA also reviewed the facility abuse reporting procedure, again not dated, that is specific for family members/legal guardians who want to report suspected abuse. The policy states that any time someone is concerned about abuse, they can report the abuse through the steps in the report, which include informing and administrator, a nurse, and a 24 hours hotline number. The HRA reviewed some in-service attendance records that covered the topics "observed/unobserved falls reporting form" (dated 6/4/2015 along with the form), the abuse prevention program, identification of bruises, skin tears and reporting, new weighing procedure, reporting on shower sheets, nursing skin assessment, hydration of residents (5/28/2015), the resident's bed sensor (4/28/2015), hydration and accidents and supervision (4/16/20150), safety and bed mobility, and natural disasters (12/2/2014). The HRA reviewed two physician's telephone orders for a Broda chair dated 3/3/2015, one for a floor mat dated 3/3/2015, and one for a soft, safety helmet dated 4/23/2015.

The HRA was provided a copy of the shower sheet procedure which stated the Ward Clerk will prepare the shower sheets according to the day's shower schedule and then the assigned CNA will be given the resident's shower sheet and they will pay close attention to the condition of the resident's skin during bathing. The CNA will then complete a shower sheet by noting any areas of "bruising, redness, broken skin, rash, or discoloration and label the body diagram on the sheet with the noted areas." The CNA signs the sheet and provides it to a nurse with any areas noted. The nurse reviews the sheets and addresses any areas seen by the CNA and then signs the sheet once verified. If there are new, problem areas, the nurse will examine the resident and if there are new areas of unknown origin, an unusual occurrence form is completed. The DON and Assistant Director of Nursing (ADON) will review the sheets daily to insure that this step is occurring and all unusual occurrence forms will be investigated for cause.

The HRA also reviewed the facility fall procedure, dated 5/7/2004 and revised 6/8/2015, which illustrates the procedure to take if a resident falls, including proper documentation into the clinical record. The fall events will be reviewed by the interdisciplinary team and care plans will be updated as needed to reduce risk for falls. The facility also has a resident accident/incident policy, dated 5/20/2015 which begins "It is the Policy of Sharon Elms to provide a safe environment for all residents. We understand there will be a time when our best efforts will not be enough. Accidents will happen. Residents will fall." The policy states that residents are assessed for falls upon admission and quarterly and then those found identified for falls will be monitored more closely. "Residents that end up with an unexplained bruise or skin tear will be investigated to ensure there has been no abuse. In the event of alleged staff on resident abuse, the facility Abuse Prohibition Policy will be followed and each case reviewed by the Facility's Abuse Prohibition Committee." If a safety device is used an order detailing specific instructions will be obtained by the physician and the device will be periodically reviewed. Additionally, incidents/accidents will be investigated and reviewed by the staff and necessary intervention changes will be made in the care plan. The policy reads "The DON or designee will instruct, supervise and/or in-service the staff on resident's plan of care (interventions) in an effort to improve the safety of our residents. Some of the areas that will be considered for review are each resident's mood, behaviors, medication, possible infections, vision, hearing, lighting, environmental hazards, lab work, cognitive ability, footwear, gait, strength, etc." The policy

states changes will be made as necessary to keep residents safe and the resident's progress and issues will be discussed with the physician and resident representative. Monthly, a report will be provided to the QA Committee and recommendations will be made and followed. Incidents that occur as a result of two residents' behavior will also be reviewed as outlined in this policy. Resident on resident behavior will be reviewed carefully to see if transfer to a mental health ward or jail is necessary.

The facility has another procedure titled "Quality Care Practice Falls," with an origination date of 6/8/2010 and a revision date of 10/23/2014, which reads "We know residents are going to fall. It is our responsibility to try and reduce the risk for fall. Below is a list of things that can help reduce the risks for resident falls." The list includes actions that should "automatically be done for all residents" such as eyeglasses on and clean, keeping incontinent residents dry, offering a drink and asking them if they are thirsty, keeping the pathways clear and clutter free, and keeping all spills mopped up. The policy also states that if there are additional, individualized items, they will be listed on the individual Kardex in the residents' rooms. The facility provided an Unusual Occurrence Report Form, which documents the resident's name, location of occurrence, description of occurrence, if an occurrence was witnessed, if ER treatment was needed, treatment for pain, and physician and responsible party notification, among other questions. There is also a skin tear/bruise of unknown origin investigation document which reads "Aging leads to many changes in the skin. As a result of these changes, the elderly are highly vulnerable to skin impairment and injury. Often these injuries occur with no known cause. It is the policy of this facility to investigate all skin tears and bruises in an effort to determine possible cause." The documentation includes a description of the tear or bruise, location, summary of resident interview, internal risk factors, resident equipment in use, etc. Then there is a final conclusion. Both of these forms were provided by the Illinois Council on Long Term Care.

The facility furnished a weight policy with their records that is dated 5/28/2015. The policy states that, unless a physician orders, the weights are taken 48 hours from admission/readmission and then monthly. The policy defines a significant weight change as 5% or more in a month, 7.5% or more in three months, 10% or more in six months. The policy states that if there is a significant weight change, the resident will be reweighted and if the change persists, a physician and the responsible party will be notified. The policy documents the schedule of weighing and states that changes will be reported to the physician within 48 hours. The policy states order changes will be recorded in the clinical record and the care plan will be revised as needed. The policy states "The dietician will be consulted by phone when a g-tube patient is admitted, when there has been a significant weight loss/gain or where there are any other complications with a residents nutritional or hydration status otherwise, the dietician will visit the facility twice a month." The policy also discusses that the dietician will review the clinical record of resident with pressure sores and those who have g-tubes on a monthly basis and whenever there is a recommendation, they will be referred to the physician for approval. Also, the HRA reviewed an in-service training sheet that indicated that hydration was covered in a nurses meeting on 4/16/2015.

The SNF and ICF regulations reads "b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident" (77 Il Admin Code

300.1210).

Complaint #2 – Conclusion

In reviewing documentation, the facility did appear to make attempts to keep the resident physically safe by employing the use of a Broda chair, mats, headgear, etc., The HRA also saw indications that the facility monitored the resident's skin and caloric intake. These actions were all taken per the resident's care plan. The HRA only saw one instance where the resident was checked for risk of dehydration and that was the day before hospitalization for symptoms that were not dehydration. When questioned, the facility pointed to using laboratory work to determine dehydration, but there was only one instance where the facility ordered laboratory work that could determine dehydration (although there was lab work completed by a hospital). The care plan states to monitor dehydration "as needed" and the HRA is not in a position to determine whether the monitoring was needed beyond what was completed. Because the facility followed the care plan in regard to resident safety, the HRA finds this complaint **unsubstantiated** but does have grave concerns regarding resident care considering the facility took such actions, yet the resident was admitted to the hospital with dehydration and, while at the hospital, they were concerned that the resident had been abused because of their findings.

1. The HRA **suggests** the facility review this resident's care to specifically determine how the resident became dehydrated and how they could improve the care of other residents. Additionally, the HRA did not see that there have been changes in the protocol and procedure regarding dehydration protocol and the HRA **suggests** that the facility take action to enhance their dehydration protocol to ensure that residents do not become dehydrated.
2. The HRA has additional concerns because, in the weight assessment reviewed, the resident did not appear to be receiving enough calories to meet the resident's goal. The HRA **suggests** the facility review the assessment and other resident assessments, to assure residents are meeting their calorie goals. In addition ensure that physicians have access to weight logs or are notified promptly of weight changes.
3. The HRA is also concerned that the resident's safety devices only appeared in one physician's order but did not appear in other physician's orders. The HRA **suggests** that the facility document the safety devices ordered by the physician in each order so that staff will know of their existence and also document in the care plan. Also, because of the extreme nature of the resident's fall risk in this case, HRA questions why a one-on-one aide was not used for safety and **suggests** the facility considering this in the future.
4. The "Abuse Prevention Program Facility Procedures" document provided to the HRA had timeframes for reporting injuries crossed out; the HRA **strongly suggests** that timeframes are clarified in this document.
5. The HRA **suggests** including in care plan documents, guardian information, including notification requirements.
6. The HRA **suggests** ensuring policies and procedures are dated, including any review or revision dates.
7. When the facility adopts a policy/procedure/protocol from an external entity, the HRA **suggests** ensuring that this item is clearly identified as a facility policy/procedure.

RESPONSE

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

REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 16-090-9002

SERVICE PROVIDER: Sharon Healthcare Elms

Pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq.*), we have received the Human Rights Authority report of findings.

IMPORTANT NOTE

Human Rights Authority reports may be made a part of the public record. Reports voted public, along with any response you have provided and indicated you wish to be included in a public document will be posted on the Illinois Guardianship and Advocacy Commission Web Site. (Due to technical requirements, your response may be in a verbatim retyped format.) Reports are also provided to complainants and may be forwarded to regulatory agencies for their review.

We ask that the following action be taken:

__X__ We request that our response to any recommendation/s, plus any comments and/or objections be included as part of the public record.

_____ We do not wish to include our response in the public record.

_____ No response is included.

Sherry Ford
NAME

Administrator
TITLE

3/11/16
DATE

Sharon Healthcare Elms

3611 N. Rochelle Lane

Peoria, Il. 61604

Phone: 309 688-4412

Fax: 309 688-0559

sford@sharonhealthcare.org

March 3, 2016

Regional Human Rights Authority

HRA Case No. 16-090-9002

Introduction

In response to your complaint conclusions I want to remind you by the time you came into the Facility to investigate these issues, Il. Department of Public Health had been here on the initial and subsequent follow-up visit and all issues had ben successfully cleared. The Facility had implemented changed that remain in place in an effort to ensure there are no recurrent problems of this nature.

I will keep my response simple and to the point. Please if you have any further questiond, give me a call.

Complaint #1-Conclusion

Response: We have completely reorganized how we weigh residents and who is in charge of notifying guardian/physician. Only one wing of weights are taken at a time. The loss/gain is figured by the Dietart Manager within 1-2 days and notifications , including the Dietician, are made. Then they proceed to the next wing until the whole wing has been weighed. Residents with g-tubes are weighted

weekly. The ADON also monitors these results and notifies all the apporiate people. Weights are also talked about among the IDT on a weekly basis to make sure we haven't forgotten anything.

Complaint #2- Inadequate resident safety.

1. We started using a dehydration assessment on 5/7/15 that we had never used before.

We are also doing weekly BMPs on residents that may be at risk for dehydration. The DON and ADON are monitoring these lab reports.This lab work informs us if a resident is or is not receiving enough hydration.

The CNAs are also now documenting when and how much water is offered to a resident in their daily documentation. This is also monitored by the DON and ADON.

2. We have addressed weight in Complaint #1.
3. Our orders for safety devices ae written in accordance with Il. Department of Public Health's Regulations. One on one observation is an intervention that we certainly have used in the past and will again when it is deemed necessary.
4. Timeframes for reporting Allegation of Abuse by law is within 24 hpours. However, CMS wants that done sooner and it was a surveyor in our facility during an inspection that told me that, as well as the Regional Supervisor, Kim Stoneking. The surveyor told me I could just cross it out and write in immediatey. We follow that pPolicy and report as required.
5. Guardian notification information is being added to the care plans.
6. We do not date Policies unless they are new or have been revised. We review the Policy Manuals with the Medical Director yearly. Signatures of that nature are in the front of each Manual. There was a time in the past when the individual Policy was not being dated as we are now
7. This information , as above in #6 is now being done.

Sherry Ford, Adm.