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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case #16-090-9014
El Paso Healthcare and Rehab

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations involving services at El Paso Healthcare and Rehab. The allegations were as follows:

1. Unsanitary conditions, including dining room table not cleaned, chairs not cleaned after bowel or urinary incidents, and residents waiting 45 minutes or longer to be cleaned after urinary or bowel incidents.
2. Staff are demeaning towards residents and routinely yell at them.
3. Inadequate resident safety, including residents not properly clothed for outdoor weather and resident was in a physical altercation with staff.

If found substantiated, the allegations would violate the Nursing Home Care Act (210 ILCS 45), the Illinois Administrative Code (77 Il. Admin. Code 300), and Federal regulations (42 CFR 483). The facility provides service to the entire state but most residents are from the Central Illinois areas. The facility has 123 beds and residents' primary diagnoses must be mental health related. They have 87 staff members that consist of RNs, LPNs, CNAs, unit aides, social service staff and more. They offer occupational therapy and physical therapy, psychosocial programming, and substance abuse treatment among other programs.

Complaint Statement

The complaint alleges that tables in the dining room are not routinely cleaned after meals which leave the conditions of the dining room unsanitary. Additionally, the chairs are not cleaned after residents have bowel or urinary incidents and residents have to wait 45 minutes or longer to be cleaned after an incident. Another allegation states staff routinely yell at residents. Additionally, residents are not properly clothed for outdoor weather when taking smoke breaks. Allegedly a resident was cleaning tables but the residents were told not to clean. A resident decided to clean his area and was yelled at to stop and a staff member rushed to the table and

jumped in front of the resident to wipe the table. In the process of this, the staff shoved the resident with his shoulder and almost knocked him down.

Interview with staff (3/11/2016)

Staff began by stating that the first complaint is inaccurate and the tables are cleaned after each seating. There are two seatings for each meal and when residents are complete, there is a food count and tables are cleaned. The first seating is for the less ambulatory and those who need assistance and the second seating is for those residents that are more ambulatory and need less assistance. Housekeeping and kitchen staff perform a full, deep clean after the second seating and as needed. The deep clean consists of a rewipe, sweep and mop. Staff will mop in between meals if there is a spill. After a snack pass, there is another cleaning and then as needed if the residents use the tables for any other activities. The dining room can be used at any time. The room is also cleaned before breakfast. The cleaning crew arrives at 6:30am and kitchen staff arrive at 5am. The kitchen staff perform a check as well. CNAs on third shift make sure areas are kept clean at night and at 10am they try to discourage residents from using the room. There is a second dining room outside of the main dining room and the same process applies. The second dining room is called the Sun Room and is for people who need less stimulation. The Sun Room is available for other activities as well, such as playing cards.

Staff said that breakfast begins at 7:30am and then there is a quick and thorough turnover which is less than 45 minutes depending on how messy the dining room is. They attempt the second seating at 8:30am but no resident is rushed through a meal. Lunch begins at 11:30am and dinner begins at 5:30pm. There is no 45 minute wait for residents with bowel incidents to be cleaned, they take immediate action. If a resident is incontinent, a CNA would clean the resident and then housekeeping disinfects the area. They also have ample staff so they are aware of incidents. There are many staff that assist with meals and others can be used. Incontinence is monitored on bowel or training programs and if something is out of the ordinary. Residents with incontinence are checked in accordance with their plans which are customized. They have never received a complaint or a resident grievance about the dining rooms. If they did, residents could report to a nurse, social services, or an administrator. They also have resident council meetings where they can talk about issues and a complaint has never been discussed there.

Regarding the second complaint, there is a facility abuse coordinator and an abuse policy. There have been some allegations by residents reported to the administrator. The administrator reports to public health and then they investigate and send their findings to public health within 5 days. In this case, the resident involved in this case had numerous complaints. Staff followed up on each of his complaints and had no findings. Staff said they receive a lot of allegations. Staff receive continuous trainings and are taught the abuse policy when hired. The staff abuse training is completed during orientation and there is an in-service 26 times a year. This training is at the same time as the treatment training. They also have annual training and abuse is touched on with every in-service. They have many in-services on communication, different types of mental health issues and how to deal with the issues. They coordinate in-service with paydays so staff come during their off hours. They do receive occasional complaints during resident council meetings. They touch on corporate compliance with new hires and they have to follow a handbook with a code of conduct. Staff members are automatically suspended until investigations involving them are complete.

Staff said that there was no physical altercation between staff and the resident. The resident asked staff to clean the table again because it was still dirty and was flailing his arms and was agitated when the staff member came to the table. The staff member reached around the resident to clean the table and staff explained that they did not even really touch. The situation was caught on the surveillance cameras. The administration contacted the police when the incident occurred per facility policy. The police spoke with the resident and administration and did not have any findings. The residents are discouraged from cleaning the tables because they are using sanitation solution and they wanted to assure thoroughness. Although it was not known how frequent the police are at the facility, the VP of Business Development, a previous administrator, commented that they sometimes come for entertainment.

Regarding the cigarette breaks, the residents line up down the hall and wear hats, coats, and gloves. If a resident does not have warm clothing, the facility provides them. Generally there are 2 or 3 staff outside with the residents while smoking. There are 6 smoke passes per day and they light and pass out the cigarettes. The staff keep all the smoking items and the residents complete a smoking assessment and disclosure. The assessment determines a resident's mental and physical state in regard to smoking. Any redirection occurs in the line and they will be told to put on warm clothes if they are not wearing them. Residents also have walks, fishing trips, trips to the zoo, trips to see Christmas lights as well as playing soccer, having cookouts and gardening, to name a few activities. During the summer, they provide coolers with water and if the weather is bad, they cancel going outdoors. The summer has a similar set-up reviewing the clothes. The residents can also go under a roof if it is raining. Residents do complain when they cannot go outside in bad weather conditions, like when there is lightning or if it is too cold.

On the day of the interview, the HRA observed residents walking outside and all were dressed appropriately for the weather. Also two other residents were sitting outside in the smoking area when the HRA toured the facility and they were dressed appropriately as well. The HRA also toured the two dining areas which were clean and the rest of the facility that the HRA observed was clean as well. On 4/5/2016 the HRA performed an unannounced visit to the facility during dinner time. When the HRA arrived, the first round of residents were completing dinner and the HRA observed staff cleaning the tables between the meals. A staff member arranged meal cards for the residents, while other staff (including the administrator) collected the dirty dishes from the table. Then staff wiped the crumbs off each table and wiped them with water and followed that by wiping the table with disinfectant. When staff announced it was time to eat, they also announced that if a table looked unclean, please let them know and they would wipe it down.

FINDINGS

With proper consent, the HRA reviewed resident records and facility policy that pertain to the allegations in this case. The HRA combined the two complaints due to their relation to one another.

Complaint #1 - Unsanitary conditions, including dining room table not cleaned, chairs not cleaned after bowel or urinary incidents, and residents waiting 45 minutes or longer to be cleaned after urinary or bowel incidents.

The HRA began by reviewing a blank facility housekeeping morning checklist which consists of different areas that need cleaned which include; A through D-Wing shower rooms, corner bathrooms, front bathrooms, break room, front offices and the Sunroom. In the Sunroom, which was determined in the interview as a room that residents use to eat, it states to wipe down the table, chairs, trash, sweep, mop and clean the walls if needed. The morning checklist also states that there must be a housekeeper in the building at all times when breaks are being taken and also reads "All morning breaks must be taken before the dining room has to be cleaned at 9:30." Another blank housekeeping checklist, that is specifically for A-Hall and B-Hall, has the first task as "Help with dining room after breakfast at 9:30am." Additionally it reads to clean the living room while waiting for the floor to dry in the dining room. It also reads to help with dining room after lunch at 1:30pm. Working on the hallway, cleaning edges, dusting the hallway, wiping down walls, etc., is included. Both A and B-Hall checklist state to do deep clean before going to lunch. C-Hall checklist asks to help with breakfast and then help clean the Sunroom after assisting with the dining room. It also reads to perform a deep clean and help with dining room after lunch. D-Hall checklist has the same responsibilities as C-Hall. The night housekeeping cleaning lists includes assisting pass trays for first dinner and to help as soon as completing the first six cleaning chores on the list, then pass trays for the 2nd dinner, help with smoke pass, clean the Sunroom and clean the dining room with laundry staff. A specific note for the Sunroom reads "This means the trash, wipe off the tables, sweep and mop" and includes the phrase "VERY IMPORTANT." The HRA requested completed checklists but were notified that those do not get saved.

The HRA was provided resident council meeting notes for 9/2015 through 12/2015. There are no statements about cleanliness in September and October but in the November meeting notes, it reads that "Tables wiped better." In the December 2015 meeting notes it states that there are no more issues with the tables needing wiped but one item of new business reads that the bedroom floors need mopped more frequently and the response is that the facility will contact the housekeeping manager and staff will be re-educated.

The HRA also reviewed a policy titled "Perineal Cleaning" with an objective to "… eliminate odor; to prevent irritation or infection and to enhance residents' self-esteem." The responsibility of cleaning is all nursing personnel and explains the cleaning procedure for females and males. Additionally, the HRA was provided a blank "Nursing Progress Review" which logs resident continence patterns for a 7-day span. The HRA was also provided 2 redacted care plans with interventions related to incontinence. The first care plan has an intervention which reads, "Toilet/change brief when wet and upon rising, at hs and after meals." The second care plan deals more with the goal of the resident being free of infection due to incontinence but states to change the resident if urine is noted. An Illinois Department of Public Health survey dated 10/16/2015 indicates the facility was cited for failure to use sanitizing solution in sanitizing buckets, when used to clean food preparation services and utensils. The issue was resolved with an approved plan of correction.

The Skilled Nursing and Intermediate Care Facilities Code reads "a) Every facility shall have an effective plan for housekeeping including sufficient staff, appropriate equipment, and adequate supplies. Each facility shall: (B) 1) Keep the building in a clean, safe, and orderly condition. This includes all rooms, corridors, attics, basements, and storage areas. (B) 2) Keep floors clean, as nonslip as possible, and free from tripping hazards including throw or scatter rugs" (77 Il Admin Code 300.2220). The Centers for Medicare and Medicaid Services reads "(h) Other environmental conditions. The facility must provide a safe, functional, sanitary, and

comfortable environment for the residents, staff and the public" (42 CFR 483.70). The Code also states that "All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible." (77 Il Admin Code 300.1210).

Complaint #1 - Conclusion

The HRA reviewed procedure, policy and observed the facility and saw no indication of unsanitary conditions or issues with urinary incidents. Because of this, the HRA finds the complaint **unsubstantiated** but offers the following **suggestions:**

- The facility stated that they do not save completed housekeeping checklists and the HRA would suggest keeping them for a period as a quality assurance measure.

Complaint #2 - Staff is demeaning towards residents and routinely yell at them.

The HRA reviewed the facility Abuse Prevention Program Policy which states that "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 proceeds to provide ways in which they will prevent abuse such as conducting pre-employment screening of employees, training employees, establishing a culture that promotes sensitivity, and filing accurate and timely investigative reports. The policy defines terms relating to abuse and defines "Verbal Abuse" as "the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, or saying things to frighten the resident, such as telling a resident that he/she will never be able to see his/her family again." The policy then provides a detailed description of each step taken to prevent abuse as described earlier in the policy and above, such as how pre-employment screening is conducted, how to establish a sensitive environment, and investigations of complaints.

The HRA reviewed resident council meeting minutes from 9/2015 – 12/2015 and saw no evidence of residents stating that staff are demeaning or routinely yell at them documented in the meeting minutes. The HRA was provided in-service attendance sheets for 9/25/2015 and the title of the in-service was "Sensitivity 1." Along with that, there is a handout which reads "You Are This Long-Term Care Facility" and part of this handout states the following: "Yours are the voices people hear when they walk the halls and when they try to sleep and when they try to forget their problems" and "Yours is the intelligence and caring that people hope they'll find here. If you're noisy, so is this facility. If you're rude so is this facility. If you're wonderful --- So is this facility." The HRA also reviewed an in-service training regarding abuse and neglect on 9/10/2015 which has a handout with that in-service as well. That handout has an illegible title due to the copy, but the first paragraph reads "Peterson Health Care has always maintained the

highest standards of resident care. Therefore, in all dealings with the public and with each other, all Company employees are expected to respect the dignity of each Individual. With this foregoing in mind, the Company has developed polices and rules for the benefit of us all." The next paragraph is also illegible but the last sentence reads "… similarly egregious actions is taken by you, it will result in disciplinary action up to and including termination" and then actions are listed that include improper treatment of a resident and "using obscene, abusive, threatening, or profane language or gestures and/or any conduct intended to mistreat, harass or cause physical harm to a resident, employee, visitor or other person." The HRA reviewed pages provided from the employee handbook which also appears to have these exact statements and rules illustrated. Another in-service on 8/10/2015 is titled "Customer Service" and covered "Peterson Pet Peeves, Vital Reminders, Ten Commandments of Caring" and "Our Mission, Our Vision, Our Philosophy" and "Phone Etiquette." The HRA also reviewed Illinois Department of Public Health reports on complaints in the facility for 2015 and saw no evidence of findings that staff were demeaning towards residents. The HRA requested grievances or incident reports regarding staff and were notified they have no grievances or incidents regarding staff treatment.

The Centers for Medicare and Medicaid Services requirements reads "(c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (1) The facility must— (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;" (42 CFR 483.13) The requirements also read "(a) Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality" (42 CFR 483.15).

Complaint #2 - Conclusion

The HRA saw no evidence that staff are demeaning towards residents or routinely yell at residents; the allegations are found to be **unsubstantiated.** The HRA is concerned about the comment made by the VP of Business Development during the interview that the police would sometimes come to the facility "for entertainment." This comment seemed to suggest that facility residents are a spectacle and the HRA **strongly suggests** that steps are taken to assure that this attitude towards the residents is not the culture of the facility. The HRA also suggests inviting the local police to disability sensitivity training/in-services.

Complaint #3 - Inadequate resident safety, including residents not properly clothed for outdoor weather and resident was in physical altercation with staff.

The HRA reviewed the initial notification form regarding the incident to the Illinois Department of Public health which was sent via email from the facility administrator. In the description, it reads "Allegation of physical abuse of resident by an employee (resident alleges employee bumped him in a purposeful manner) while wiping the dining room table." The facility attached a Final Five Day Report, completed by the agency, regarding the incident, which had no findings of abuse. The report documented the investigation which started with the report from the resident who said that he brought a wash cloth and soap into the dining room because "he knew his table would not be clean, as usual" and he was told that he was not allowed to wash tables. The report then reads "E1 [staff] then came over and pushed me out of the way

to clean the table. E1 came up from behind me and reached over me to wash the table" and the resident said it seemed "purposeful, abusive." According to the report, the staff member said "don't be mad at me about the table, as I can go home, there is your clean table." The resident asked that the police are contacted. Another witness interview states that the resident was "shoulder moved" and the staff said "don't get mad cause I can go home." The resident who witnessed followed the staff into the kitchen to ask why he said that and the staff member took his hairnet off and cursed the job. Another witness stated that he/she did not see a push but did see the resident yelling while the staff cleaned the table. Staff said something about finishing preparing the meals and then going home and the second resident witness threw an ice bucket across the dining room. The fourth resident witness stated that they saw the first resident wiping the table and then staff came over and wiped the table down. The witness could not hear exactly what was said but thinks staff may have said something about being stuck here and going home. Also, the staff member refused to allow the resident to clean the table. The eight employees interviewed had no reports of the staff member physically abusing or touching the resident in any way but the report did say that several employees reported the staff member saying something about being able to go home in the presence of the staff and cursing the job while in the kitchen. The staff involved stated that he did go out to wipe down the table and it was the second time he had wiped that area. He said that the resident was moving around and cussing and he reached over and around him to wipe the table and there was nothing on it, so he went back to the kitchen while the resident followed him and yelled in his face. Staff said the second resident did come into the kitchen and other staff walked him out. The staff member explained that he did say he could go home but meant he wanted to go back in the kitchen and finish work and then go home and did not want to argue about the table. The staff did say that he cursed the job while in the kitchen. They watched video footage and saw no indication of abuse and the staff member wiped the table without incidence. The police also reviewed the report and said there was no indication of abuse.

The HRA requested to see the video of the incident and was told that video self-erases after 60 days and was gone on 3/2/2016. The HRA also contacted the El Paso Police Department for a copy of the report taken and were told that the police did go to the facility and determined that El Paso Health Care was handling the issue and were told that if there was any more information or if they needed the police department to take a report, the Administrator would contact them. They never received a call and therefore do not have a report, only a log entry about meeting with the Administrator and the resident who claimed there was an assault.

In the previous complaint, it was stated that the HRA reviewed an Abuse Prevention Program Policy which affirms that the facility should be free from abuse and also illustrates how the facility protects the residents from abuse. That policy defines "Abuse" as "… any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Abuse is the *willful* infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental, and psychological well-being. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm, pain or mental anguish." The policy defines "Physical Abuse" as "… hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment." As stated in the last complaint, the policy provides a detailed description of each step taken to prevent abuse including a "Resident Protection Investigation Procedure" form and a form about choosing an investigation path based

on the type of possible abuse. The policy then illustrates the investigation procedures, such as a review of initial written reports, interviewing the person reporting the incident, reviewing medical records, etc. The policy illustrates the interview process and completing the final investigation report. The abuse investigation policy also indicates what actions to take for each investigation path, such as what to do in a situation of possible physical abuse, possible sexual abuse, possible verbal or mental abuse, theft or possible neglect. The abuse prevention program also states in its internal reporting requirements and identification of allegations section that when an employee is accused of abuse, they will be removed from resident contact immediately until the results of the investigation have been reviewed.

As stated in the previous complaint, the HRA reviewed an in-service on 9/10/2015 regarding abuse and neglect with an attachment listing offenses that would result in disciplinary action. One of the items on the list is "Creating or contributing to an unsafe working condition; Violation of or disregard for safety rules or safety practices." This is also echoed in the facility handbook pages that were provided. Another in-service is dated 8/25/2015 and it is the August Safety Meeting. There is a handout with the meeting that illustrates the main safety points, which include safety statistics related to resident behavior, Petersen Health Care policy review, and training materials to be reviewed by the safety team, which are the employee training brochure and an in-service guide. The committee actions detailed in the report mostly deal with the safety statistics and resident behavior. Two other handouts deal with resident behavior. Another in-service, dated 7/10/2015 addressed the types of abuse.

The facility handbook also has a section on reporting suspected resident abuse and neglect which reads "Petersen Health Care strongly supports resident's rights and protections. Therefore, we will not tolerate the physical, verbal, or emotional/psychological abuse of a resident, or neglect of resident care duties related to the safety, health and/or physical comfort of the resident."

The HRA reviewed the facility smoking policy which reads "It is the policy of Petersen Health Care that at no time may staff, residents, or guests smoke inside of the facilities. A smoking area outside of the facility will be designated by the Administration. Resident smoking is allowed only between the hours of 6:00 am and 10:00 pm. This also includes electronic cigarettes." The policy states that "Suspending or delaying of smoking time may occur in the event of inclimate weather makes it unsafe for residents or staff to venture outside of the facility." The policy also reads "Provision of ashtrays of safe material and design in designated smoking areas will be ensured by the facility. A self-closing, metal container may be kept in the smoking area." The HRA reviewed a resident smoking assessment for the resident involved in this complaint which evaluates physical tasks a resident must be able to perform to be permitted to smoke independently and the assessment consists of items such as the ability to bend arm at elbow while bringing the hand to the mouth and back, demonstrating safety measures for handling cigarettes and the ability to touch thumb to each finger on each hand. The assessment does not mention residents not properly being clothed but does state "The resident agrees to abide by the smoking policy, understands that a change in condition may necessitate an assessment, impact on the status of participating in the smoking procedures and result in discontinuance or modification of smoking procedures. Resident agrees to smoke only in attendance of staff, approved family member or volunteer." The form also states "Resident exhibits a clear understanding of the smoking policy as it has been explained, and in writing as evidenced by accurately answering questions related to designated smoking areas, storage and

use of smoking materials, consequences of non-compliance and responsibilities of the resident to prevent other residents from obtaining smoking materials."

The HRA reviewed a winter weather smoking policy that was updated January 5, 2015 which reads "Residents must be dressed appropriately to go out to smoke during winter weather: Must wear a coat, hat, mittens/gloves and shoes/boots." The policy also states that "If a resident is not dressed appropriately when the temperature is less than 32 degrees F, he/she will not be permitted to go outside to smoke, for their own safety." The policy also states that if the temperature is zero degrees or less, the residents cannot exceed 5 minutes outside, they can only smoke one hall at a time and doors will not be held open and they will not be able to smoke between 7am and 8:30pm because air temperature is coldest during these hours.

The Skilled Nursing and Intermediate Care Facility regulations read "a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.* (A, B) (Section 2-107 of the Act)" (77 Il Admin Code 300.3240). The Nursing Home Care Act requires that "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.'" (210 ILCS 45/2-107)

The Centers for Medicare and Medicaid Services requirements state: "Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." (42 CFR 483.25) The requirements also read "(h) Environment. The facility must provide—(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible…." (42 CFR 483.15) Additionally, the requirements state that "The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public." (42 CFR 483.70)

Complaint #3 - Conclusion

The HRA did see evidence that resident safety is taken into consideration, that the facility will not allow residents to smoke in inclement weather and that residents must be properly dressed in cold temperatures. Additionally, the residents that the HRA viewed outdoors were dressed appropriately for the weather. The HRA saw no evidence that the resident was unsafe during the incident in the dining room in accordance with the facility investigation. Because there was no evidence that there is inadequate resident safety, the HRA finds this complaint **unsubstantiated.**