



FOR IMMEDIATE RELEASE

North Suburban Regional Human Rights Authority
Report of Findings
HRA #16-100-9002
Wood Glen Pavilion

In August 2015, the North Suburban Regional Human Rights Authority opened an investigation of possible rights violations regarding Wood Glen Pavilion. Wood Glen Pavilion is an extended-stay nursing care center to seniors with varying levels of disabilities. The complaint accepted for investigation was that a resident in the home does not have access to a call button; it was stated that this resident requires help during the late evening/early morning hours and he must repeatedly yell for staff assistance. Residents receiving services at Wood Glen Pavilion are protected by the Nursing Home Care Act (210 ILCS 45/100 et. seq.).

Method of Investigation

The HRA reviewed the resident's most recent comprehensive treatment care plan, with consent. An on-site visit was conducted in October 2015, at which time the HRA discussed the allegations with the facility's Administrator, the Director of Nursing (DON) and the facility's Social Worker. The resident whose rights were alleged to have been violated was interviewed twice by HRA representatives.

Findings

At the site visit, facility personnel stated that the resident in question has lived at the Pavilion for over twenty years and that he and his family members have always been very happy with his care. It was offered that the resident does have good and bad days; he can be very friendly and cooperative or very surly. At times, the resident might request that staff members provide a change of clothing right after that task had been completed. The resident's care plan did note that the resident has a history of ineffective coping skills, as he becomes easily frustrated when staff members do not meet his demands immediately. However, the care plan noted that he has not shown any of these behaviors in the last quarter. Facility personnel stated that the resident has some impaired physical mobility due to his Multiple Sclerosis and as the need arises, they will provide adaptive devices. It was offered that the resident's roommate and the roommate's guardian had complained often about the staff members constantly coming in and out of the room to take care of the resident's needs. It was stated that the roommate has been moved to another room.

The facility's Answering the Call Light Policy states (to summarize) that it is used to respond to the resident's request and needs and to provide a sense of security to the resident. The policy states that some residents may not be able to use their call light. Staff members are to check these residents frequently and listen for cries of help. The resident's call light is a safety device and is a means for the resident to summon assistance. Staff is to answer the call as soon as practical.

The first time the HRA met with the resident, he was in bed and did not want to talk. It was observed that the call light was within reach. The second time the HRA met with the resident, he was sitting in his wheelchair and fully engaged in the conversation. The call light button was attached to his shirt. When asked, the resident was able to use the call light and a staff member promptly replied. The resident did say that he was happy living at Wood Glen and that he had no problems with the staff members responding to his needs.

Conclusion

Pursuant to the Illinois Nursing Home Care Act, Section 2-107, "An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident." Based on the information obtained and observed, it is concluded that the resident does have access to and is able to effectively use the call light; the allegation is unsubstantiated.