FOR IMMEDIATE RELEASE

East Central Regional Human Rights Authority
Palm Terrace
Report of Findings
Case #18-060-9002

Case summary: The HRA Substantiated all complaints and made recommendations. Palm Terrace responded and requested that the response be made public and, therefore, the responses can be found at the end of the report.

The East Central Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission voted to pursue an investigation of Palm Terrace in Mattoon, IL after receiving the following complaints of possible rights violations:

Complaints:

1. Allowed a consumer with a guardian to sign paperwork, specifically discharge paperwork in order to leave against medical advice.
2. Inappropriately discharging a consumer. Illinois Public Health discharge requirements were not met, including rationale for discharge, no written discharge notice/appeal rights, lack of discharge planning, and lack of opportunity to appeal.
3. Refused to allow a resident to return to the facility after a hospitalization because the consumer left 'against medical advice' even though the signed paperwork is invalid.
4. Informed the consumer's guardian that the consumer would be allowed back to the facility after the hospital stay but then denying the return without notifying the guardian.
5. Inappropriately informed social security that the consumer was "discharged to the community".

If the allegations are substantiated, they would violate protections under the Nursing Home Care Act, the Mental Health and Developmental Disabilities Code, the Illinois Probate Act and the Code of Federal Regulations.

Investigation

The HRA proceeded with the investigation after having received written authorization from the consumer's state appointed guardian that serves as plenary guardian, as appointed by the court. To pursue the matter, the HRA visited the facility and the program representatives were interviewed. Relevant practices, policies and sections of the consumer's record were reviewed.

According to the Peterson Health Care website, Palm Terrace of Mattoon is a 24-hour Skilled Nursing Care Facility offering Activities Programs, Hospice Care, Medical Transportation, Occupational Therapy, Pathways Rehabilitation Program, Physical Therapy, Respite Care, Speech/Language Pathology, and Wound Care Management.

Interviews:

On December 13, 2017, at 2:00 pm, the HRA met with Palm Terrace staff members, including: the Administrator, Director of Nursing, Regional Clinical Director, LPN/Care Plan Coordinator, and Regional Director. The meeting occurred at 100 Palm Ave Mattoon, IL 61938. The meeting began with introductions, a review of HRA procedures, and a review of the allegations being addressed in this investigation.

The staff provided some general information about the provider. Palm Terrace is a 176 bed Skilled Nursing Home specializing in both mental health and developmentally disabled consumers. Staff report providing services for the following "common diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management; psychiatric/mood disorders, heart, circulatory system, neurological system, vision, hearing, musculoskeletal system, neoplasm, metabolic disorders, respiratory system, genitourinary system, diseases of the blood, digestive system, integumentary system, and infectious disease." Consumers residing at Palm Terrace can come from any geographic area but residents are primarily from the state of Illinois. Staff report that training is provided in many areas upon hiring including, but not limited to, abuse and neglect, mental health, consumers with guardians, discharge planning, proper restraints, and the grievance process.

Consumers residing at Palm Terrace receive an explanation of the grievance process upon admission and then yearly trainings thereafter. Information about filing a grievance can be found in the admission packet. In the event of a complaint and/or grievance, consumers can discuss their concerns with any staff member. The staff member is to take the concern to the social service worker to start the resolution process. Grievance forms are filled out and taken to administration for follow up. Most consumers get additional reminders about the grievance process in therapy and at the monthly resident council meetings.

The consumer in the above listed complaints came to Palm Terrace with multiple mental health diagnoses that date back to youth, including schizophrenia. When the consumer was placed at Palm Terrace in November 2015 the consumer was under the care of a guardian and remained under the care of a guardian for the entire time she resided at Palm Terrace. Staff stated that despite all the diagnosed illnesses for this consumer, they felt that she was lucid enough to decrease down to one medication. Staff stated that the consumer had regular psychiatric evaluations to assess functioning. Over time, as the consumer's medication management improved so did her cognition. Staff stated that, "Unfortunately, the more she understood about her situation the less she wanted to be here (Palm Terrace)".

Staff reported that the consumer's care plan included services and mental health treatments, however, the consumer chose to participate minimally and only interacted with a few preferred staff members. Staff stated that the Mini Mental Health Exam (MMHE) was completed regularly

by the care plan coordinator and showed that the consumer was cognitively intact, however, she needed "more advanced care than we could provide to her". The HRA asked the Palm Terrace staff what care they believed that the consumer needed but staff reported that they did not know. At the time of the incident the consumer was refusing medications and would go outside and not come back in. Staff stated that they were aware that the consumer had a guardian but felt that the guardian "would not listen to us".

Palm Terrace staff report that they had been making efforts to locate alternate placement for the consumer. The staff had worked with the guardian to consent to over 45 referral packets for transfer to another facility. Staff believed that the consumer wanted to be closer to a family member in southern Illinois and focused primarily on providers that could meet the consumer's needs in that region. Staff report that while the guardian did provide consent and discussed possible placements the guardian did not believe that the facilities chosen would meet the consumer's needs and denied placement without any further explanation. Staff confirmed that one provider had come to visit/assess the consumer, however, the consumer had not gone to view any of the sites that were applied to and the process of discharge was not started. The consumer told staff that the consumer did not want to reside at Palm Terrace and her aggressive and combative behaviors increased because the consumer wanted to live elsewhere.

In the weeks leading up to the incident, the consumer's desire to leave Palm Terrace had increased. The consumer had reached out to both an attorney and an ombudsman for support. The consumer began leaving the unlocked building without notifying staff and she was "throwing fits and demanding to be taken to the ER". For three days prior to the incident, the consumer was taken to the emergency room at the local hospital as requested. At the hospital, the consumer reported that she did not want to return to Palm Terrace. Palm Terrace staff stated that her behavior at the hospital was excessive enough to "medicate her to the point of incoherence" before returning her to the Palm Terrace without admittance.

Staff reported that, on 6/28/2017, the consumer stated that she was going to leave Palm Terrace and then became verbally abusive to staff (vulgar and swearing). The director was called and the consumer asked for "AMA (Discharging Against Medical Advice) papers". Since this was the fourth day that the consumer had become enraged and demanded to leave, the director allowed the consumer to complete the paperwork despite knowing that the consumer had a guardian and could not legally be held responsible for the decision to leave the facility. Once the consumer left Palm Terrace property the staff followed her to the road. Once roadside, the consumer yelled into oncoming traffic that Palm Terrace was holding the consumer against her will. The police were called. The officer and the officer's supervisor determined that it would be best to take the consumer back to the hospital where she had been the three days prior for further evaluation. Staff stated that the consumer was then screened by the hospital and met the criteria to be admitted. The hospital contacted Palm Terrace who stated that they would take the consumer back but felt that doing so was "against the consumer's wishes". Palm Terrace remained in contact with the consumer and the guardian for a 10-day bed hold. Staff reported that they attempted to screen the consumer for readmission to Palm Terrace but the consumer refused to speak with the Palm Terrace staff. Ultimately, Palm Terrace felt that it would be best to honor the consumer's preference and not readmit her. The consumer was "discharged to the community." Staff reported that they discharged her to the community so that her social security

payments would not be stopped. It is Palm Terrace's experience that the consumer's social security payments are stopped if not "discharged to the community" until a new account and address are established. The HRA inquired about where the consumer is now and Palm Terrace stated that after several months at the hospital, the consumer was discharged to an alternate facility.

Policy/Records Reviews:

Palm Terrace provided the HRA with a copy of their discharge policy and the following records: Admissions paperwork and face sheet, AMA sheet dated 6/28/17, fax transmission for notice of discharge for social security, a Comprehensive assessment completed through admission process, Nursing notes, including nursing observation reports, from 6/2/2016 to 6/28/2017, Social service progress notes, Level of Functioning Exam 10/10/16, Physical Therapy plans for 2017, activity progress notes and assessments for 11/2016 to 3/2017, restraint assessments, psychotropic medication evaluations and documentation of medication disbursement, consents (including Do not resuscitate, medication consents, and emergency consents), hospital records for 10/14/16, 12/14/16, and 6/2/17, physician notes (including eye, dental, lab, dietary, and podiatry), and the care plan for 10/7/16 to 6/28/17. Also reviewed was Illinois Department of Public Health Complaint #1764526/IL95748- F152, F203, F206, F278 and Office of State Guardian records for the consumer dated 5/1/2017 to 1/14/18.

A release of Responsibility for Discharge Against Medical Advice dated 6/28/17 shows the consumer signed herself out of Palm Terrace against medical advice (AMA) with staff signatures approving the discharge. Cover sheets and case notes document the known presence of a guardian.

Illinois Department of Public Health Complaint #1764526/IL95748- F152, F203, F206, F278 verify that IDPH discharge requirements were not met. Office of State Guardian documentation does not include any written discharge information (including rationale for discharge, written discharge notice/appeal rights, or discharge planning). Palm Terrace did not provide any discharge paperwork to the HRA (except for the discharge statement for the social security administration).

There is no documentation from Palm Terrace verifying any case management/contact after the consumer was discharged. Office of State Guardian (OSG) documentation for 6/28/17 states Palm Terrace Administration is "refusing to take ward back". OSG documentation for 6/29/17 states the provider told OSG that the consumer did not want to be there. OSG proceeded to confirm that they were aware that the ward did not want to be in the placement but no notice had been given for discharge so the consumer needed to return. IDPH report page 3 states that Palm Terrace stated that the consumer "would not be allowed to return to (the facility) or any other (corporate) nursing home" and again that Palm Terrace "had notified the guardian that (the consumer) could not come back to (Palm Terrace) because (the consumer) was too difficult to manage and too difficult to find placement for".

Discharge notification written by Palm Terrace dated 6/28/17 (with a fax confirmation of 6/29/17) states the consumer was discharged "to the community". OSG case note dated 7/26/17

states, “(OSG) got a call from (social security) stating ward was missing. They received notice from Palm Terrace that ward was discharged to the community due to not returning from a medical appointment.”

Mandates Reviewed:

Nursing Home Care Act. 210 Ill. Comp. Stat. Ann. 45/2-111
§ 2-111. A resident may be discharged from a facility after he gives the administrator, a physician, or a nurse of the facility written notice of his desire to be discharged. If a guardian has been appointed for a resident or if the resident is a minor, the resident shall be discharged upon written consent of his guardian or if the resident is a minor, his parent unless there is a court order to the contrary. In such cases, upon the resident's discharge, the facility is relieved from any responsibility for the resident's care, safety or well-being.

Code of Federal Regulations for Long Term Care Facilities. 42 C.F.R. § 483.10
(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law
(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decision outside the representative's authority.
(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.
(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.

Probate Act. 755 Ill. Comp. Stat. Ann. 5/11a-23
(b) Every health care provider and other person (reliant) has the right to rely on any decision or direction made by the guardian, standby guardian, or short-term guardian that is not clearly contrary to the law, to the same extent and with the same effect as though the decision or direction had been made or given by the ward. Any person dealing with the guardian, standby guardian, or short-term guardian may presume in the absence of actual knowledge to the contrary that the acts of the guardian, standby guardian, or short-term guardian conform to the provisions of the law.

Nursing Home Care Act. 210 Ill. Comp. Stat. Ann. 45/3-405
§ 3-405. A copy of the notice required by Section 3-402 shall be placed in the resident's clinical record and a copy shall be transmitted to the Department, the resident, and the resident's representative.

Code of Federal Regulations. 42 C.F.R. § 483.15c
(c) Transfer and discharge—
(1) Facility requirements—

(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility (F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending
(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must—
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long–Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.
(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to

obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long–Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub.L. 106–402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

Nursing Home Care Act. 210 Ill. Comp. Stat. Ann. 45/3-418
§ 3-418. The Department shall prepare resident transfer or discharge plans to assure safe and orderly removals and protect residents' health, safety, welfare and rights. In nonemergencies, and where possible in emergencies, the Department shall design and implement such plans in advance of transfer or discharge

Code of Federal Regulations. 42 C.F.R. § 483.15e
(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.

Code of Federal Regulations 20 C.F.R. § 416.635
(d) Notify us of any event or change in your circumstances that will affect the amount of benefits you receive, your right to receive benefits, or how you receive them;
(g) Ensure that you are receiving treatment to the extent considered medically necessary and available for the condition that was the basis for providing

Conclusions

The Nursing Home Care Act (210 Ill. Comp. Stat. Ann. 45/2-111) states “If a guardian has been appointed for a resident or if the resident is a minor, the resident shall be discharged upon written consent of his guardian or if the resident is a minor, his parent unless there is a court order to the contrary”. Palm Terrace provided the HRA with the discharge sheet stating that the consumer was leaving against medical advice. This document was signed by the consumer and Palm Terrace Staff but not the guardian. Palm Terrace staff reported to the HRA that the resident wanted to leave the facility and was not locked into the building so the staff believed the consumer was going to leave regardless of paperwork. Palm Terrace staff were aware that the paperwork was invalid without the guardian’s signature. However, in follow-up contacts with the OSG and the facility, the HRA learned that the mental health unit is locked and this resident was considered to be in mental health care. The Code of Federal Regulations (42 C.F.R. § 483.15c(3)) specifies the notification requirements for discharge. No Palm Terrace documentation could be obtained to verify discharge notification. OSG case note documentation states that on 6/28/17 the guardian was notified that the consumer left the Palm Terrace facility

and was currently at the hospital. On 6/29/17 the guardian told the facility that the consumer needed to return to the facility upon hospital discharge. There is no notification that Palm Terrace discharged the consumer in the OSG file. Illinois Department of Public Health Complaint #1764526/IL95748- F152, F203, F206, F278 verifies that IDPH discharge requirements were not met and the following laws were violated: Code of Federal Regulations, 42 C.F.R. § 483.10, Rights Exercised by Representative and Code of Federal Regulations, 42 C.F.R. § 483.15c, Notice Requirements Before Transfer or Discharge. The Office of State Guardian documentation does not include any written discharge information (including rationale for discharge, written discharge notice/appeal rights, or discharge planning). Palm Terrace did not provide copies of any discharge paperwork to the HRA (except for the discharge statement for the social security administration).

The Code of Federal Regulations (42 C.F.R. § 483.15e) states that "A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident." Palm Terrace staff state that the consumer could return to Palm Terrace but that the consumer did not want to return. The OSG documentation on 6/28/17 states Palm Terrace Administration is "refusing to take ward back". OSG documentation for 6/29/17 states the provider told OSG that the consumer did not want to be there. OSG proceeded to confirm that they were aware that the ward did not want to be in the placement but no notice had been given for discharge so the consumer needed to return. IDPH report page 3 states that Palm Terrace stated that the consumer "would not be allowed to return to (the facility) or any other (corporate) nursing home" and again that Palm Terrace "had notified the guardian that (the consumer) could not come back to (Palm Terrace) because (the consumer) was too difficult to manage and too difficult to find placement for".

The Code of Federal Regulations (20 C.F.R. § 416.635 (d-g)) states "(d) Notify us of any event or change in your circumstances that will affect the amount of benefits you receive, your right to receive benefits, or how you receive them; (e) Submit to us, upon our request, a written report accounting for the benefits received on your behalf, and make all supporting records available for review if requested by us; (f) Notify us of any change in his or her circumstances that would affect performance of his/her payee responsibilities; and (g) Ensure that you are receiving treatment to the extent considered medically necessary and available for the condition that was the basis for providing benefits". Discharge notification written by Palm Terrace dated 6/28/17 (with a fax confirmation of 6/29/17) states the consumer was discharged "to the community". An OSG case note dated 7/26/17 states, "(OSG) got a call from (social security) stating ward was missing. They received notice from Palm Terrace that ward was discharged to the community due to not returning from a medical appointment." Palm Terrace stated that they discharged her to the community so that her social security payments would not be stopped. It is Palm Terrace's experience that the consumer's social security payments are stopped if not "discharged to the community" until a new account and address are established

After completing the interviews, records reviews, and assessing applicable mandates, there is evidence to support the complaint. The consumer displayed difficult behaviors and expressed a

desire to leave the facility. Palm Terrace stated they could not provide the needed services to the consumer and reported actively looking for alternate placement. Several transfer applications were placed and two facilities were located, however, Palm Terrace states that the guardian declined (755 Ill. Comp. Stat. Ann. 5/11a-23). While the HRA understands Palm Terrace's desire to support the consumer's preference to leave the facility, allowing the consumer to sign discharge paperwork without the guardian violates law and puts the consumer at risk. Since the discharge paperwork was not valid, Palm Terrace still held full responsibility for the care and well-being of the consumer. Palm Terrace assessed that the consumer had the capacity to refuse to return to Palm Terrace despite clinical assessments and court orders stating that the consumer was unable to make decisions. Further, the HRA received mixed reports as to whether or not the resident was on a locked unit; if she was on a locked unit, Palm Terrace more than facilitated her leave and the concern that she would have left anyway was invalid. The consumer's guardian clearly stated that the consumer was to return to Palm Terrace and Palm Terrace told the hospital that the consumer could not return. During the interview with Palm Terrace, staff repeatedly stated that the consumer would have been allowed to return to Palm Terrace, however the consumer did not want to return. The guardian stated that the consumer must return to Palm Terrace. No further discharge notification was provided. Since the consumer did not have the capacity to sign discharge papers and Palm Terrace was aware that the consumer was taken from their care to a hospital, the facility should have notified social security that the consumer had been admitted to the hospital. Per Code of Federal Regulations (42 C.F.R. § 483.15e) and Palm Terrace's Bed Hold Policy the consumer should not have been discharged during the bed hold period.

Based on the findings above the East Central Human Rights Authority concludes that the consumer's rights were violated and, therefore, all of the complaints are substantiated. On 8/8/27 the Illinois Department of Public Health corrective action plan addressed the deficiency in practice and required that staff complete the following in-service trainings:

1. Laws affecting residents at Palm Terrace that have been adjudicated as incompetent and are, therefore, under the care of a guardian and provide training on facility policy for discharge
2. Federal Guidelines regarding Involuntary Transfer/Discharge of a resident. In addition, the corrective action plan addressed the provider keeping in contact with guardians and to monitor ongoing quality assurance internally.

The corrective action plan also states that "all residents who are transferred and/or are being discharged will be reviewed during morning meetings to ensure proper documentation is completed and that all required parties have been notified, in writing for the reason for the discharge/transfer and the date of discharge/transfer". IDPH required Palm Terrace to provide the Bed Hold Guarantee Policy upon admission and at the time of Transfer or Leave of Absence and to follow the Transfer/Discharge Policy including the notification of guardians. The corrective action plan also addresses ongoing monitoring by an internal Quality Assurance process. The HRA believes that the corrective action plan addresses the substantiated complaints and recommends that Palm Terrace continue to follow the accepted corrective action plan.

Lastly, The HRA reviewed the care plan for the consumer. The care plan addressed medical and psychiatric needs. Handwritten dates in the upper righthand corner indicated that the plan was reviewed at regular intervals during the consumer's stay at the facility. When interviewing the staff at Palm Terrace, the staff stated that the consumer's medication had been decreased when she arrived at the facility and that the decrease in medication had led to an improvement in the consumer's cognition. Staff believed that her increased cognition led her to not want to be placed at Palm Terrace. The consumer's care plan does not address the changes in her cognition or her expressed preference to be placed in another facility and does not reflect the work that was being done to locate additional placement. The HRA would make the following recommendations:

1. Care plans should be updated according to a consumer's current circumstances and preferences. Care plans should minimally meet the requirements per the Nursing Home Care Act (210 Ill. Comp. Stat. Ann. 45/3-202.2a) and the Mental Health Code (405 Ill. Comp. Stat. Ann. 5/3-209) and documentation should clearly reflect that reviews were completed when required.

2. Any time a consumer is identified as wanting to leave the facility the care plan should be updated to include the consumer's preference and the plan to address those preferences as well as the involvement of the guardian, if applicable. The plan should also document whether or not the consumer is on a locked or unlocked unit.

The HRA would like to thank the Palm Terrace staff for their cooperation with this investigation.

RESPONSE

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

Fax: (217)258-6642
Palm Terrace
OF MATTOON

1000 Palm Ave.
Mattoon, IL 61938
Phone: (217)234-7403

04/12/2018
RE: Human Rights Authority Case #18-060-9002

To Whom It May Concern:

I received a letter of determination from the Human Rights Authority and would like to comment on a few issues regarding this case on behalf of Palm Terrace.

First of all, I do understand the laws regarding guardianship. Palm Terrace would not and has not ever done anything deliberately to harm any resident. Our goal is to give our residents the best possible quality of life that can be provided. There were some statements made in the report that were untrue or taken out of context that I would like to address.

The consumer in question refused to take most of her medication and we being a nursing home cannot force medicine upon a resident. When we were asked by the HRA what care we believed she needed we meant that her mental illness was more advanced than what our facility was equipped to handle. I had spoken with [redacted] her appointed guardian, on how we were not helping the consumer's mental illness and guardianship was not either and [redacted] agreed.

The guardian was contacted numerous times and would not return phone calls or requests to come and visit with her. This would have been added to the report. The consumer requested to speak to [redacted] before this incident happened and she flatly refused to come and see her. This only agitated the consumer. If guardianship is "in charge" of these individuals, they should make effort to assist them in every aspect, not just ignore their requests to a point where their mental well-being is compromised.

Palm Terrace did not refuse to take the consumer back in to our facility. The consumer would not come back and the hospital told us they were not going to "drug her up again" just to make her come back. The hospital never asked Palm Terrace to pick her up—they listened to the consumer when she told them she did not wish to return to the facility. [redacted] did call and I told them the same thing at that time. The statement that [redacted] had documented and I quote, "would not be allowed to return to (the facility) or any other (corporate) nursing home" and "had notified the guardian the (the consumer) could not come

Palm Terrace
OF MATTOON

1000 Palm Ave.
Mattoon, IL 61938
Phone: (217)234-7403

back to (Palm Terrace) because (the consumer) was too difficult to find placement for" was NEVER made.

Also in the report the HRA received mixed reports as to whether or not the resident was on a locked unit. Palm Terrace does not have any locked units, rather secure units with door alarms only. The doors are NOT locked. Palm Terrace did not facilitate the resident leaving the building. She left on her own accord with staff in eyesight at all times until the police were involved. The facility cannot barricade the doors under the laws of IDPH.

In regard to the recommendations made by the HRA the facility's care plans are updated according to a resident's current circumstances and preferences. Discharge planning is also included as indicated. We did not include whether they are on a "locked unit" due to the fact that we do not have any locked units at Palm Terrace.

In closing, Palm Terrace continues to stand firm on the decisions that were made that day. Palm Terrace made several attempts to contact [redacted] to no avail and strongly feels [redacted] failed this resident and did not respect her wishes.

Respectfully Submitted,

Julie A. Haskins, L.N.H.A.

Julie Haskins
Administrator
Palm Terrace
1000 Palm Ave
Mattoon IL 61938
Phone: 217-234-7403

Laura Hart, IGAC

June 1, 2018

Re: Human Rights Authority Case #18-060-9002

Dear Ms. Hart:

In response to the letter sent on May 23, 2018, Palm Terrace has inserviced all Social workers, PSRC's and Care Plan coordinators to meet requirements. The Care Plan shall be updated according to the resident's current circumstances and preferences for discharge planning. Inservicing was also completed to include the guardian in this process and staff is to document any and all conversations with the resident's guardian. We did not include on the care plan as to whether or not the resident is on a locked or unlocked unit due to the fact that Palm Terrace is not a locked facility. Thank you for your time in this matter.

If any further information is needed please contact me at 217-234-7403.

Sincerely Yours,

Julie A. Haskins,L.N.H.A.