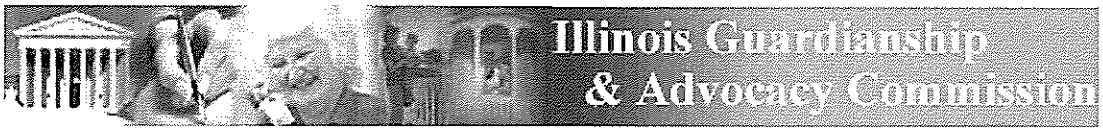

FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 19-090-9004
Seminary Village

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at the Seminary Village. Complaints alleged the following:

1. Inadequate guardian notification.
2. Inadequate internal incident investigation.

If found substantiated, the allegations would violate the Skilled Nursing and Intermediate Care Facilities regulations (77 Il Admin Code 300), the Nursing Home Care Act (210 ILCS 45/1) and the Probate Act of 1975 (755 ILCS).

Seminary Manor offers an Alzheimer's disease unit as well as short term rehabilitation, long term care, independent living and assisted living. The residents primarily live in the Galesburg, IL area but they receive inquiries within a 60 mile radius of the facility. They have 121 residents and a separate dementia unit with 21 residents. There are 220 staff members for the entire campus.

COMPLAINT STATEMENT

A resident had medical issues, but the guardian was only contacted intermittently about the issues. There was one occasion that the guardian was not contacted about a physical issue and was informed by another family member. Additionally, a resident's injury was discussed at a care plan meeting by the resident's family, but staff was unaware of the injury and stated they would perform an investigation. The investigation was never completed.

FINDINGS
Staff Interviews (10.31.2018)

Staff began the interview by explaining that if the resident has a guardian, the guardian is contacted. If a resident has a Power of Attorney (POA), and the resident does not want the POA contacted, and has established capacity to make decisions, then staff will not contact the POA. Staff explained that they comply with all regulations governing guardianships, POAs, and

investigation of incidents. Most of the time, when a resident has a POA, staff will only discuss the issues with the POA and not the entire family, which has led to complaints. Staff will contact the POA for an injury, medication change, etc. The residents participate in care plan meetings where goals are discussed. The quarterly care plan meetings include the coordinator, therapy staff, social services, patient and the family. Staff want the residents to return home successfully. The staff used an example where a POA requested a resident be sent to the emergency room, but the resident refused. In that instance, the staff followed the resident's wishes. They reported this situation to the Illinois Department of Public Health who agreed with the facility's actions. The facility will contact an emergency contact unless the resident requests not to contact. Staff explained there are few residents with guardians at the facility. Staff said that there is rarely a situation where they will not contact someone, and they have been told that they notify families too often. When family is contacted, staff document in the progress notes.

The staff contacts the same day for an incident and they contact for all incidents, unless the injury's origin is known. For example, if a resident had a bruise on their hand and staff know how the resident obtained the bruise. If the injury is unknown, they contact every time. Staff explained that they cannot claim that they have never missed contacting a family member. They have made mistakes before that led to trainings and in-services. The administration tracks trending issues and makes systemic changes. They have quality assurance at the facility and through their board. They change policy and practice based on trends and discoveries. Staff has quality assurance meetings every day excluding the weekends. They discuss whether investigations are complete, what was implemented because of the investigations, if family was notified, etc.

For investigations, staff must discover the root cause analysis. The facility is mandated to self-report to the Illinois Department of Public Health (IDPH) and staff explained that the better staff is with investigating, the better for the residents. They investigate to prevent other injuries with residents. An incident is defined as anything resulting in an injury, and the facility has two injury categories: witnessed injury and unwitnessed injury. At times, a resident will have a skin tear and the origin of the tear is unknown. There is an incident form that is used to get to the root cause. A bruise with no cause is reportable. When staff investigates, they interview staff, residents, roommates, and tablemates if the resident was in the dining room. They sometimes attempt to re-enact the situations. For example, with a skin tear, if someone self-propels and develops a tear on the arm, they investigate causes around the facility at the arm level of the tear, like a sharp corner. If an injury is witnessed, then the root cause is known. They will still interview others if the witness seems unreliable. If the situation is unwitnessed, that is when they conduct interviews with witnesses and reenactments. If there is abuse, they may need to interview residents who had similar staff issues but keep the residents confidential.

Guardians or POAs are not allowed to see the investigation results because the results are internal and not discoverable. Staff will verbalize the results to guardians or POAs. Any change in condition is investigated and the facility averages around one investigation per day. Not all the situations are reportable to the IDPH. Incidents that require a hospital visit are reportable and must be reported within 24 hours. The POAs are notified within 2 hours but staff said they have missed deadlines. Only certain staff contact the POA, and those are a nurse, social services, the Director of Nursing, or the administrator. The employee involved in the investigation is removed

from the care area. The perpetrator is not always staff, sometimes it is a roommate or visitor. They complete a background check for residents and have the right to deny admission. For example, they usually will not accept sex offenders. A full report must be completed and provided to the IDPH in 5 days. They never take the full five days and the POA is contacted when the investigation is occurring. If the situation is not reportable, they complete an internal investigation, which is documented and kept on file. The IDPH will audit those files. Staff explained that abuse is reported to guardians and POAs immediately and then after the investigation is complete.

FINDINGS (Including record review, mandates, and conclusion)

Complaint #1 - Inadequate guardian notification.

The HRA was provided redacted samples of incident reports which indicated that in each instance the medical doctor and resident representative (POA and emergency contact) were contacted. The HRA also reviewed the facility's "Accident and Incident Report" policy provided, where the objective states: "to document all accidents/incidents occurring to residents, visitors and employees." The "Resident" section of this form states the following: "1-provide any necessary emergency card. 2- Notify the nurse; who then must notify Physician and family."

The HRA also received the facility policy for reporting abuse and noted that, in the abuse reporting section, there is no mention of facility staff notifying a resident's power of attorney, guardian or emergency contact of the allegation of abuse. Within the abuse policy, under a section titled "Misappropriation of Resident Property" which states that the resident's representative will be notified of "... the alleged misappropriation or theft and the results of the facility's investigation of the incident." Also, in a section titled "Injuries of Unknown Sources" it reads "The shift nurse shall inform the resident's family and/or resident's representative of the injury."

The Probate Act of 1975 (755 ILCS 5/11a-23) reads "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. A reliant shall not be protected if the reliant has actual knowledge that the guardian, standby guardian, or short-term guardian is not entitled to act or that any particular action or inaction is contrary to the provisions of the law."

The Nursing Home Care Act (210 ILCS 45/1) defines a guardian as "... a person appointed as a guardian of the person or guardian of the estate, or both, of a resident under the "Probate Act of 1975". **The Act (201 ILCS 45/1-123)** also reads "§ 1-123. 'Resident's representative' means a person other than the owner not related to the resident, or an agent or employee of a facility not related to the resident, designated in writing by a resident to be his representative, or the resident's guardian."

The Skilled Care and Intermediate Care Nursing Facility Regulations (77 ILL. Adm. Code 300.3210) states "The facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings or related administrative matters arise." **The Skilled Care and Intermediate Care Nursing Regulations (77 IL Admin Code 300.3240)** states that "A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)." **The Nursing Home Care Act (210 ILCS 45/3-610)** reads "A facility administrator who becomes aware of abuse or neglect of a resident prohibited by Section 2-107 shall immediately report the matter by telephone and in writing to the resident's representative, and to the Department."

CONCLUSION:

While the facility has clear policy documenting the need for staff to contact a guardian or personal representative in instances concerning property and injuries of unknown origin, the section of the policy specific to allegations of abuse does not mention staff reporting allegations of abuse to a legal guardian, power of attorney, or resident representative. Additionally, the "Accidents and Incidents" policy only mentions contacting the residents "Family" but fails to mention contacting the legal guardian's power of attorney of the resident representative. The HRA recognizes that the progress notes do indicate that a POA is contacted, but the facility policies do not address the needs to contact resident representatives that are written in the Skilled Care and Intermediate Care Nursing Facility regulations (77 Il Admin Code 300.3210 & 300.3240) or the Nursing Home Care Act (210 ILCS 45/3-610). Because of this, the HRA finds this complaint **substantiated.** The HRA makes the following **recommendations:**

- The HRA recommends that the facility update their abuse reporting policy to reflect notification regulations (77 IL Admin Code 300.3210 & 300.3240, 210 ILCS 45/3-610). After policy has been updated facility staff should be trained in the new policy. The HRA requests evidence of the policy and training.

Complaint #2 - Inadequate internal incident investigation.

The HRA reviewed the facility policy focusing on Accident and Incident Reports. The procedure states: "a. Provide any necessary emergency care. b. Notify the nurse, who then notifies Physician and family. c. If there has been no apparent injury, follow-up must continue for 24 hrs-vital signs, responsiveness, general condition, etc. d. If there is apparent or suspected injury, follow-up must continue for at least 72 hours-vital signs, responsiveness, general condition, changes observed in injury site, etc, e. Documentation must be on form #NH-137 "Resident Accident and Incident Reports, as well as in the Nurse Notes." The policy also states that in all cases "There must be an exact description of the accident/incident" and states to include the location, time, date, witnesses and statements, level of consciousness, description of injury, description of emergency care provided, vital signs, and persons notified of the incident.

The HRA also received the facility policy for reporting abuse. The policy reads as follows: "B. Initial steps and reports of alleged abuse or neglect – 1. Facility employee or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to the facility Administrator or designee. If allegation involves the Administrator, then the facility employee or agent should immediately report the matter to the facility DON." Policy also states, "2. If the incident involves alleged abuse or neglect, the Administrator, or designee shall provide the Illinois Department of Public Health with initial notice of the alleged abuse or neglect by telefaxing to the Department a copy of a report of the incident completed as soon as possible, but not more than 24 hours after the incident becomes known ... 4. If the event that caused reasonable suspicion result in serious bodily injury, the report to IDPH and local law enforcement will be made immediately (no later than two hours after forming the suspicion). Otherwise it will be made within 24 hours after forming the suspicion.

The "Investigation" section of the abuse reporting policy states that the investigation will consist of interviews, including parties involved and witnesses and signed statements (which include the suspect, person making accusations, victim, and staff and residents who may have witnessed). The policy states the administrator will keep all copies of notes from interviews, supervise the investigation, and report the results of the investigation to the IDPH. The administrator is also responsible for protection from retaliation.

The HRA was also able to review several Grievance Reports provided which address concerns that were brought to the attention of facility staff by residents. The reports document how the facility addressed the grievance and/or used corrective action to improve the grievance. There is also a part of this form where it can be documented whether the grievance was substantiated. The Grievance Reports that were provided and reviewed involved resident complaints of a catheter not being flushed, a paper towel dispenser broken in the room, no washcloths, staff not shaving a resident, too long of a wait for a call light to be answered, and a resident stating she had a $100.00 bill stolen. Each grievance report reviewed, received a summary of the investigation that was made. There were also sections for findings and conclusions, an area noting if the grievance was substantiated, and lastly, a space for a corrective action plan.

The Grievance Procedure policy states that "... Upon receipt of a grievance, the Grievance Officer or designee shall complete an investigation of the concern as soon as possible and provide appropriate follow through as required. A written decision regarding the grievance shall be made available to the resident upon request. Contact information of independent entities with whom grievances may be filed, such as the pertinent State Agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program, or protection and advocacy systems hall be made available to the resident upon request. Immediate action shall be taken by the facility to ensure that further violations do not occur while the allegation is being investigated, including in-servicing and/or disciplinary action as required by facility policy and procedure. The Abuse Policy shall be followed for any grievance containing an allegation of abuse. The Grievance Log (NH-352) shall be maintained for three years."

The Nursing Home Care Act 210 ILCS 45/3-610. "Duty to report violations § 3-610. Duty to report violations. (a) A facility employee or agent who becomes aware of abuse or

neglect of a resident prohibited by Section 2-107 shall immediately report the matter to the Department and to the facility administrator. A facility administrator who becomes aware of abuse or neglect of a resident prohibited by Section 2-107 shall immediately report the matter by telephone and in writing to the resident's representative, and to the Department. Any person may report a violation of Section 2-107 to the Department. (b) A facility employee or agent who becomes aware of another facility employee or agent's theft or misappropriation of a resident's property must immediately report the matter to the facility administrator. A facility administrator who becomes aware of a facility employee or agent's theft or misappropriation of a resident's property must immediately report the matter by telephone and in writing to the resident's representative, to the Department, and to the local law enforcement agency. Neither a licensee nor its employees or agents may dismiss or otherwise retaliate against a facility employee or agent who reports the theft or misappropriation of a resident's property under this subsection."

77 Ill. Adm. Code 300.3240 Abuse and Neglect states "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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)"

The Skilled Care and Intermediate Care Nursing Facility Regulation (77 Ill. Adm. Code 300.690) states "a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident."

The Skilled Care and Intermediate Care Nursing Facility Regulation (77 Il. Admin Code 300.1880) "5) The facility shall maintain a file of all reports of serious incidents or accidents involving residents as required by Section 300.690 of this Part."

The Nursing Home Care Act 210 ILCS 45/3-206.01 states "(a) A facility shall not employ an individual as a nursing assistant, habilitation aide, home health aide, psychiatric services rehabilitation aide, or child care aide, or newly hired as an individual who may have access to a resident, a resident's living quarters, or a resident's personal, financial, or medical records, unless the facility has inquired of the Department's Health Care Worker Registry and the individual is listed on the Health Care Worker Registry as eligible to work for a health care employer."

Compliant #2 conclusion

After reviewing the provided policies and records, the facility is in compliance with the Skilled Care and Intermediate Care Nursing Facility Regulation (77 ILL. Adm. Code 300.690, 300.1880 and the Nursing Home Care Act 210 ILCS 45/2-107, 610(a), and 808.5) which deal with investigating incidents and abuse. Because of this, the HRA finds this complaint **unsubstantiated** but offers the following **suggestions:**

- Amend their Grievance Form and add a box to check in which staff ask the resident if they want their personal representative, guardian or power of attorney to be notified of the grievance issue.
- The Nursing Home Care Act 210 ILCS 45/3-610 states that "shall immediately report the matter to the Department and to the facility administrator" but the facility policy reads "shall provide the Illinois Department of Public Health with initial notice of the alleged abuse or neglect by telefaxing to the Department a copy of a report of the incident completed as soon as possible, but not more than 24 hours after the incident becomes known." The HRA **suggests** the facility update the reporting section of the policy to comply with the Act and educate staff on the reporting requirements.
- The HRA also suggests that the Procedure Section of Abuse Policy (part 4) which states; "A check of the OIG Exclusion list will also be conducted at least annually on all employees" should be amended to include having the Health Care Worker Registry reviewed per 210 ILCS 45/3-206.

RESPONSE

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

Seminary Manor

3/18/19

Illinois Guardianship and Advocacy Commission
401 Main St., Suite 620
Peoria IL 61602

Re: Response to HRA No. #19-090-9004

Dear: Meri Tucker, Chairsperson

Please find the attached Policy revision to reflect your recommendation to meet the notification regulations (77 IL Admin Code 300.3210 & 300.3240, 210 ILSC 45/3-610. Also attached is a copy of the in-service sheet as evidence of the policy and training.

IGAC also made three suggestions, but made clear that our policy and grievance form was already in regulatory compliance. At this time we will take those suggestions under advisement but will not be making any further changes to our forms or policies at this time.

If you have any questions please feel free to contact me.

Respectfully,

Tracy Owens Administrator

Tracy Owens

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