Mures County Monitoring Report

''Men Heart Association'' Social Care Home for the Elderly, Sângeorgiu de Mureş

proiect derulat de:
CENTRUL DE RESURSE JURIDICE

în parteneriat cu:
MINISTERUL PUBLIC

On February 29, 2024, representatives of the Centre for Legal Resources (CLR) paid an unannounced monitoring visit to the Men Heart Association Residential Social care home for the Elderly in Sângeorgiu de Mureş, Mures County.

Access was granted based on the collaboration agreement concluded by CLR with the Monitoring Council for the implementation of the Convention on the Rights of Persons with Disabilities (Law no. 8 of 2016). The monitoring team consisted of [redacted] (manager of the "Advocate for dignity" program), [redacted] (legal expert, psychologist), [redacted] (psychologist specialized in clinical psychology), [redacted] (specialist in pediatric psychiatry) and [redacted] (psychologist specialized in clinical psychology).

Around 07:40 A.M., the CLR team arrived at the headquarters of the Men Heart Association in Sângeorgiu de Mureş, Transilvaniei Street no. 185, Mureş County. The visit of the monitoring team lasted until 11:50.

The social care home is located near the city of Targu Mures, on the northeastern border, in the direction of Reghin. It has been operating here for 10 years, after previously operating in Sărmaș, where it had a much smaller location, accommodating only 10 (ten) persons. The last renovation of the operating license took place in 2022, according to statements of the social care home's coordinator.

When the CLR team arrived, the gate of the social care home was open and the team could enter without problems. The head of the social care home was present there. Due to organizational issues regarding the collection of medical tests from some residents, we were asked to wait about 20-30 minutes before starting discussions with the head of the social care home. The discussions were held with the coordinator of the social care home, with the chef of the social care home who mentioned that he carries out administrative responsibilities, with the care staff and with the residents.

Building structure and living space, living conditions

The building is a house with ground floor and two floors. It has a courtyard where the beneficiaries sometimes spend their free time and where there is also a pavilion. The institution has 13 salons on the ground floor and the two floors. On the ground floor there are 2- and 4-bed lounges and on the two floors there are 3-bed lounges. Each salon has its own bathroom, consisting of shower, toilet bowl, sink, hygienic and sanitary materials.

The total capacity of the social care home is 43 places and at the time of the visit there were 40/41 residents. The social care home is described as being deep cleaned, twice a day, according to the residents, but on arrival, on the morning of the monitoring visit, there was a smell of urine.

In the access area of the social care home, a number of official documents are exhibited such as *"Operating license", "Accreditation certificate", "Sanitary authorization for operation", "Fire safety authorization".* Also, the visiting schedule of the social care home is displayed (Monday – Friday 07:00 – 20:00; Saturday – Sunday 08:00 – 20:00).

The social care home has both a kitchenette, equipped with sink, table and storage furniture for dishes, and a spacious kitchen, equipped with stove, hood, industrial sinks and other equipment necessary for preparing meals and snacks. Main meals are brought by a caterer. There is also a dining room, which is not used for eating meals, with residents dining in lounges or common areas equipped with table, chairs, sofa and armchairs in the hallways of the two floors.

The social care home also has an office, a personal sleeping place, a treatment room, staff toilets and other facilities.

According to the individual reports of the staff *(consisting of two nurses and the coordinator of the social care home),* the diet of the beneficiaries in the social care home involves 5 (five) meals per day, of which 3 (three) main meals and 2 (two) snacks.

The catering contract between the social care home for the elderly and **Hotel Alesia Corunca** provides for the daily delivery of cooked food around **12:00**, as well as the periodic delivery of cold food.

The staff from the ground floor kitchen of the social care home takes care of portioning the food. At the time of the monitoring visit, lunch was delivered by the catering company at 12:08 based on the menu previously decided upon at the social care home. Even if a weekly food schedule was provided to the monitoring team by the social care home, it remains unclear whether it refers to the

period during which the monitoring visit took place or to a subsequent one. We were not told if there are also persons with intolerance to certain foods who require a different menu.

According to the beneficiaries' statements, there are a number of complaints about the quality and distribution of food within the social care home. Some residents claim that the food is tasty, but complain about the insufficient quantity. For example, breakfast is served late, around 11:00 and lunch consists only of soup and bread.

There is dissatisfaction with the meal serving schedule, according to the statements of some beneficiaries, who mention that breakfast is scheduled around 11:00, lunch between 13:00 and 15:00, and dinner between 17:00 and 18:00.

According to the displayed schedule, breakfast is served from 08:00 to 10:00, lunch from 12:30 to 14:30 and dinner from 18:00 to 20:00. On the day of the monitoring visit, due to the CLR team and staff shortage at the social care home, breakfast was served around 11 am.

According to some beneficiaries, access to coffee is limited and tea is rarely offered. The consumption of alcohol and cigarettes is strictly prohibited.

Access to the community, **visits and communication with the exterior** are regulated according to a visiting schedule displayed at the entrance. Visits can take place in different locations within the care social care home *(wards, shared areas in the social care home's corridors, in the living room near the entrance or in the garden pavilion of the social care home's courtyard).* Opinions on these visits are varied. Some beneficiaries enjoy regular visits, while others receive visits less often due to distance or other reasons. In these situations, contact with the family is maintained through the phone.

Beneficiaries are restricted from accessing mobile phones due to neurological and mental disabilities they suffer from, according to staff statements. These restrictions were imposed in order to prevent situations where they accidentally call the emergency service, such as SMURD, causing the ambulance to come to the social care home without being necessary.

According to one beneficiary, it is allowed to go outdoors in spring and summer, after 17:00, for 2 hours, provided that the weather is nice.

Medical care, psychosocial aspects, personal hygiene

1. **HEALTH CARE**

Decisions to administer medications at the social care home are made with caution, thus residents receive sleeping pills only when absolutely necessary and recommended by the psychiatrist, according to staff statements and observations made at the time of the visit by the monitoring team.

Persons with severe mental disabilities are accommodated on the second floor and most residents receive psychiatric or neurological treatment (being diagnosed with schizophrenia, Parkinson's disease, unspecified dementias, sleep disorders, etc.).

According to the data provided and the observations during the visit, it can be assumed that most beneficiaries use diapers and they are changed **only in the morning and evening**, being managed by the management of the social care home and the medical staff, after the night period.

The social care home has medical staff, in collaboration with specialist doctors (psychiatrist and family doctor) and medical assistant to provide the necessary medical care to residents (an employee of the county hospital at the urology department, who comes, if necessary, to collect samples / analyzes and provide certain medical services such as changing urinary catheter, etc.).

The care home works with a pharmacy to manage monthly prescriptions issued by family doctors and psychiatrists, delivering medication to its residents. At first, the social care home covers the costs of medicines and then their families bear the costs. According to statements by the management of the social care home, they mention significant debts of families to the institution.

The residents' statements at the time of the visit highlighted disagreements regarding access to medicines, how they are administered and interaction with the family doctor. These findings highlight significant discrepancies in residents' perceptions of information provided by the social care home's staff, highlighting the need for a more thorough and transparent investigation to clarify the situation.

Excerpts from the beneficiaries' statements: "since the former nurse went on maternity leave, they receive fewer medicines and they are not administered as before – for them to see them, but literally just put them in their mouths."

"I don't know who the family doctor is, I've never seen them."

Some residents stated that they did not know who the family doctor was, they had never seen them, contrary to the statements of the social care home's staff, in that they carry out weekly visits to the unit - this aspect could not be verified, because the doctor does not mention such a visit in any of the documents available to the social care home.

According to the statements of the care staff, autonomous persons have the responsibility to receive the necessary medicines during a week and to self-administer them, while dependent residents are provided with administration by medical staff according to the indications prescribed by the family doctor. The staff monitors the administration of medicines to prevent situations where they could be thrown away or forgotten by residents, as there have been situations of this kind.

A physiotherapist/reflexologist visits residents twice a week to provide physical therapy interventions, working in residential premises and in their own office on the ground floor. There are statements from some beneficiaries that deny their participation in recovery sessions with this specialist.

A number of residents contracted scabies during the previous year following their transfer from the social care home in Bardesti. There are still residents affected by this infection that has not been completely resolved. There are discrepancies in the statements made by the employees of the social care home, some denying to know about this situation, while the coordinator of the social care home confirms the existence of the infection.

According to some residents, they are at a final stage of the disease and are treated with ointments based on marigold and sulfur. Instead, according to other residents, this problem has been reported for a long time and is a serious one, with some residents agreeing to have photographs taken to illustrate visible traces of the disease *(see annexes to this report).* However, there are persons who claim that they do not receive treatment for scabies. These findings highlight significant discrepancies in beneficiaries' perceptions of the information provided by the social care home's staff, highlighting the need for a more thorough and transparent investigation to clarify the situation.

According to staff statements, upon admission to the social care home, the beneficiaries' family signs **a consent agreement** in which they accept that during their stay in the institution, the hospitalized family member will be transferred to the family doctor and psychiatrist with whom the social care home collaborates. This agreement is justified by the need for rapid intervention in emergency situations, as well as the efficiency of issuing medical prescriptions for each resident.

2. PSYCHOSOCIAL ASPECTS

Residents' leisure activities: beneficiaries who do not have severe dementia interact in the wards or shared areas in the hallway, can go out in the courtyard of the social care home where there is a garden pavilion and some benches, or participate in various television programs.

There is a segment of residents who criticize the fact that they do not participate in organized activities, considering that their condition is deteriorating (according to statements *"they get dumb").* but they feel connected to that social care home that offers accessibility and is located close to their community.

Some beneficiaries express concern that non-movable beneficiaries are not moved or encouraged to leave the bed, remaining passive and uninvolved because there is no TV equipment in the bedrooms.

3. PERSONAL HYGIENE

From staff statements, in specific situations, such as finding elderly persons in a degraded and poor state of hygiene, including confused persons found on the street or abandoned alone in their homes for extended periods, an initial haircut may be necessary to remove tangled hair and dirt, as well as to facilitate access to the scalp for medical care if appropriate.

Apart from these cases, hair cutting and styling are done according to the expressed individual preferences, of the family or, in their absence, following the decision of the medical staff on the most

appropriate haircut for each beneficiary. However, **there are complaints from some beneficiaries about periodically cutting hair to short lengths without taking into account personal preferences.**

Also, some beneficiaries complain about the lack of permanent hot water for hygiene, having access to it every two weeks. There was also a lack of toothbrushes (*according to one resident, she brushes her teeth using a towel*), being provided only with soap for oral hygiene.

It should be noted that access to hot water for personal hygiene is a basic right of every individual and it is the responsibility of the nursing home to ensure this.

Admission to the social care home and documents

Usually, the beneficiary becomes a resident of the social care home following the requests of families/caregivers, who can live both in Romania and abroad. The residents come from various counties, including Mures, Cluj, Maramures, etc.

According to the coordinator of the social care home, given the efficient collaboration existing between the social care home, the SMURD service and the police, there are often situations in which the police identify elderly persons in a state of severe neglect (who live alone for a long time, without assistance, are disoriented on the streets, and face poor hygiene and health problems), thus requiring their admission to the social care home. Reception in the social care home generally takes place in emergency situations, when the family can no longer provide care for the elderly.

The staff of the social care home provided the CLR team with the requested documents according to the specific document management rules.

The documents for each beneficiary are organized as follows:

- **Personal file**
  - Social survey;
  - Application for admission to the social care home;
  - Decision on the settlement of the application for admission;
  - Relatives' promissory note;
  - Relatives' pledge in case of death;
  - Transfer agreement to collaborating doctors;
  - Service agreement.
- **Medical services file**
  - Individual needs evaluation/reassessment sheet;
  - Individualized assistance and care plan;
  - Assessment of the degree of dependence.
- **Medical record**

Social care home staff

According to the coordinator of the social care home, currently, 8 (eight) full-time employees work in the social care home, although initially there were 10 (ten), two persons being on maternity leave.

Management has great difficulty in identifying and hiring new staff. In addition to employees, the social care home benefits from the collaboration of contracted specialists, such as nurse, psychologist, psychiatrist, family doctor, social worker and reflexologist/physiotherapist.

Usually, 2-3 nurses are responsible for a shift in the context in which the psychologist interacts with residents twice a week. According to one beneficiary, the psychologist was present only at the time of her admission, asking her to count to 100.

Some beneficiaries mention the absence of activities carried out by the psychologist and only recognize the presence of the physiotherapist (reflexologist) twice a week. They are not aware of the presence of other specialists in the social care home and do not express their knowledge of the doctor in charge, stating that they have not met them personally.

According to the coordinator of the social care home, she instructs new employees (*caregivers, nurses*) not to push patients, not to shout and not to slam the door ("*We do not push the patients, we do not shout, we do not slam the door")* having an intense work schedule, being actively

present in the social care home and constantly interacting with beneficiaries, with very few rest periods in recent years.

Prohibition

After consulting the files during the monitoring visit, it was found that there are one or two residents in this social care home, and most of the service agreements between the social care home and the beneficiaries are signed by a member of the beneficiaries' family, not by them.

Also, given the conditions and symptoms of many residents, we believe it would be necessary to initiate procedures to order protective measures for some of them, even if one or two residents are banned.

A special situation noted by CLR members refers to the situation of Mr. E.S., 72 years old, beneficiary of the social care home for a period of one month who had been brought to the social care home at the recommendation of Sarmas City Hall, which drew up the documents for classification in the degree of disability (visual impairments).

The gentleman's ex-wife, H.B., came to take him over with a power of attorney signed by the social worker of Sarmas City Hall dated 28.02.2024, indicating a move to another locality, namely Jolotca, Harghita county where he will live with the D.S. family. This situation raises confusion for both the staff of the social care home and the CLR members, regarding the initial circumstances of his move to that social care home and the subsequent transfer.

Deaths

The announcement of deaths is not included in the reporting procedures of the Monitoring Board and staff are not aware of this omission because inspectors or AJPIS (County Agency for Payments and Social Inspection) staff have not trained them on this obligation.

There is an incident register in which only one case was reported, on July 10, 2017.

Legal situation. Incident legal framework

According to the documentation of CLR members on the legal situation of the social care home for the elderly Men Heart Association **(CUI 27707632)** regarding the accreditation and possession of an operating license, the following were identified:

- Decision No. 2843 dated 04.06.2016 regarding the issuance of the licensing certificate;
- Decision granting the license for social service temporary operation nr. LF/0001438.
- The license for relicensing the temporary operation of the social service no. LF/00010085 dated 16.06.2021.

The Men Heart Association **appears in the list *of licensed social care homes for the elderly on 11.03.2024 (social service code 8730 CR-V-I)*** issued by the Ministry of Labor, thus **showing that this residential social care home for the elderly operates under a valid provisional license.**

As regards contracts concluded with different suppliers, such as the catering company or collaboration contracts concluded with specialist doctors, they were not made available to the monitoring team.

The social care homes are obliged to communicate or make available to the institutions/structures responsible for monitoring and controlling the observance of human rights, the procedures for preventing and combating the abusive treatment of beneficiaries of social services and the prevention of torture, the requested information and to provide them with support in carrying out monitoring visits according to the law, according to art. 6 para. (1) letter d) of Government Decision nr. 797/2017.

Law no. 292/2011 on social assistance, with subsequent amendments and completions, provides in art. 92: "*In order to identify and respond as adequately as possible to the social needs of the elderly and the particular conditions in which they find themselves, social services are organized with priority at the level of local communities. Local public administration authorities are responsible for identifying and assessing the needs of the elderly, organizing, planning and ensuring the financing or co-financing of social services, public and private social service providers being responsible for providing them in compliance with quality standards,"* and in art. 97 para. (2) states: *"Local public administration authorities have the obligation to provide personal care services provided at home or in residential social care homes for solitary dependent elderly persons or whose family cannot provide their care".*

According to the law, the unit providing services dedicated to the elderly **is obliged to obtain a license or operating authorization from the competent authorities.** The lack of these documents can be considered a violation of current legislation.

Social service is defined in Art. 27 para. 1 of the Law on Social Assistance nr. 292 of 2011 as the activity or set of activities carried out to meet social needs, as well as special, individual, family or group needs, in order to overcome situations of difficulty, prevent and combat the risk of social exclusion, promote social inclusion and increase the quality of life.

The care of the person who requires help for more than 60 days to carry out the basic and instrumental activities of daily life is defined as long-term care *(Article 32 para. 2 of the Social Assistance Act No. 292 of 2011).*

Long-term care is provided at home, in residential social care homes, in day social care homes, at the domicile of the person providing the service and in the community *(Article 32(3) of the Social Assistance Act No. 292 of 2011).*

The beneficiaries of personal care services are the elderly, persons with disabilities and the chronically ill persons *(Article 36 para. 2 of the Law on Social Assistance no. 292 of 2011).*
Social service providers are individuals or legal persons, public or private law *(Article 37 para. 1 of the Social Assistance Law no. 292 of 2011).*

In order to achieve an efficient management, in the case of social assistance units, the responsibility for coordinating and managing the human and material resources related to that service may be delegated to the head of the unit *(Article 41 para. 4 of the Law on Social Assistance no. 292 of 2011).*

Law 448/2006 on the protection and promotion of the rights of persons with disabilities defines persons with disabilities as those persons who face restrictions in activities specific to daily life due to a physical, mental, sensory or intellectual disability.

This law stipulates that public authorities are obliged to take measures to ensure access for persons with disabilities to education, employment, medical services, transport, housing and public spaces. These measures include adapting buildings and infrastructure to facilitate access for persons with disabilities, implementing school and vocational integration programs, and providing specialised health and social care services.

The State has the obligation to provide the necessary resources for the integration and social inclusion of persons with disabilities, including training programs and financial support. The law stipulates that persons with disabilities have the right to a regular assessment of their needs and to the development of an individualized support plan, adapted to their specific needs.

Persons with disabilities benefit from tax incentives and tax exemptions for the purchase of medical equipment and housing adaptations to facilitate their access and mobility.

It also provides measures to protect against discrimination and marginalisation of persons with disabilities, promoting equal opportunities and respect for their fundamental rights.

Through Law 35/1997, the People's Advocate has the role of defending the rights and interests of elderly and persons with disabilities before authorities and institutions, ensuring that they benefit from protection and support against possible abuses or discrimination.

Also, according to the law, the Ombudsman may take legal action on behalf of elderly and persons with disabilities to protect their rights. They may also make recommendations and proposals for improving legislation and public policies relating to these categories of persons.

In this sense, we can exemplify the situations described by the beneficiaries of the social care home who:

- *reported that, since the former nurse went on maternity leave, they receive fewer medicines and these are not administered as before – for them to see them, but literally just put them in their mouths.";*
- *stated that they did not know who the family doctor was;*
- *declare that they do not receive treatment for scabies;*
- *mention, with fear of being heard by the social care home's staff, that non-movable persons are almost never lifted and removed from their beds;*
- *complained about the fact that they are all cut short, periodically, without regard to personal preferences;*
- *specify that there is not continous access to hot water for personal hygiene, but once every 2 weeks;*
- *complain that it is not enough, that they receive only a small breakfast and the lunch portion is served with soup and pieces of bread in bowls;*
- *report being allowed to go "outside" in spring and summer, after 5 p.m., if it's nice, for 2 hours.*

Recommendations

1. Identifying options (staff, program, involvement of volunteers to diversify the activities that residents carry out during their stay in the social care home. Lack of activity (physical, mental, socializing) contributes significantly to accelerating the degradation of physical, biological (metabolism, etc.), mental/psychological, neurological condition;
2. Identification of psychological and neuropsychological activities/programs for intellectual/mental stimulation;
3. Organizing activities that allow intensifying residents' group interactions, as well as intensifying residents' interactions with the community. The purpose of these activities is to maintain and strengthen social and general skills (essential aspects especially in the context of degenerative diseases) and general emotional and psychological stimulation;
4. Identifying solutions that allow residents to have access to their own mobile phones;
5. Organizing a program that guarantees systematic physical movement and daily contact with nature (fresh air, sun, plants, etc.);
6. Implementation of the procedure for announcing the Monitoring Board regarding the deaths occurring in the social care home;
7. Stricter organization of meal schedule;
8. Clarifying the administrative/legal aspects regarding the form of contracting services;
9. Rigorous psychological evaluation to understand the level of autonomy and lucidity of residents so that they benefit from adequate programs of stimulation and psychological intervention (emotional, cognitive) and to initiate, where appropriate and necessary, procedures for ordering protection measures;
10. Ordering urgent measures on the treatment of scabies of residents;
11. Paying proper attention to residents' personal hygiene measures – from changing diapers more often, to allowing bathing more frequently, etc.
12. Training of specialist staff on person-centred social services involving:
    A. Confidence in human potential;
    B. Involvement and contact with the beneficiary's family and friends;
    C. The fact that the individual manages a healthy lifestyle and remains active in the community;
    D. The fact that social networks and contact with persons in the community are maintained;