FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
EMBASSY CARE CENTER—09-040-9003
HUMAN RIGHTS AUTHORITY- South Suburban Region

[Case Summary— The Authority made corrective recommendations regarding two of four allegations that were accepted by the service provider. The public record on this case is recorded below; the provider did not request that its response be included as part of the public record.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA), the investigative division of the Illinois Guardianship & Advocacy Commission, has completed its investigation into allegations concerning Embassy Care Center. The 171-bed skilled and intermediate care facility is located in Wilmington. The complaint stated the following: 1) A resident was not allowed to keep religious items in her room, 2) The facility failed to safeguard the resident's property, 3) The resident did not receive her monthly personal allowance, and, 4) The facility's psychiatrist did not see the resident for about four months.

If substantiated, these allegations would be violations of the Nursing Home Care Act (NHCA) (210 ILCS 45/2 et seq.), the Illinois Administrative Code for Skilled Nursing and Intermediate Care Facilities (77 Ill. Admin. Code Part 300) and the Centers for Medicare and Medicaid Services, (CMS) Conditions of Participation for Long Term Care Facilities (42 C.F.R. 483.25 and 483.40 [c]).

METHODOLOGY

To pursue the investigation, a site visit to Embassy Care Center was conducted on December 12th, 2008. The Facility Administrator, the Director of Social Services, the Director of Admissions, a representative of the facility ownership and a bookkeeper were interviewed. Sections of the adult resident's record were reviewed with consent. Relevant policies were also reviewed.

COMPLAINTS # 1 and 2 Property

According to the complaint, the resident was not allowed to keep religious items such as crosses on the wall in her room. Additionally, the complaint alleged that the resident's white fan and stuffed animals (3 lions, 3 bears and 1 tiger valued at $117.00) were not returned upon her discharge from the facility. The resident allegedly had the stuffed animals at intake, and they were placed in one box. Her items reportedly disappeared although they were locked in the facility's secured area.

FINDINGS

According to the record, the resident was admitted to the facility's behavioral health unit on January 11th, 2008. Two days later, the resident was observed showing peers how she had decorated her bed area with various items. A June 9th note written by the Director of Social Services was the first indication that the resident was hoarding items in her room. She was reportedly informed why she could not keep all of her property in her room, but her belongings were not removed at this time. Seven days later, the facility mounted shelving on the wall in the resident's room to accommodate some of her items. But, documentation on June 17th reflected that the resident created a hazardous situation by hanging items such as pictures on the wall up to the ceiling and objects on top of her light fixture. Although the resident reportedly took the items down, she had been asked to refrain from this kind of behavior a couple of times. According to the resident's care plan, goals and objectives were added to address this problem on that same day. The plan also documented that her items must be hung 18" below the ceiling. Three days later, the objects were back on top of the resident's light fixture, and she was upset because the staff removed them. As before, the resident was informed of the rules, but there was no description of the items removed from her room.

According to progress notes, the resident continued to disregard safety concerns and more items were eventually removed from her room. On June 30th, the resident put up a "privacy curtain" on the wall with thumb tacks (push pins) around her bed area. She was informed that thumb tacks were not allowed, and they were removed. Velcro was put on the curtain and the wall to assist the resident with privacy issues. But, she placed the curtain back up with thumb tacks six more times. On July 14th, the resident was also informed that she could not have throw rugs on the floor around her bed area. Documentation reflected that thumb tacks, throw rugs, and items on her wall and light fixture were also removed many times by the staff. A July 17th note stated that the resident was counseled again about safety issues, but she repeated the same hazardous behaviors four days later. She also had a storage bin on the floor. Her items were removed by the staff, and they were placed in a box for storage. The resident reportedly started yelling at the staff person, and redirections were ineffective. She then requested to be transferred to another nursing facility, but she later asked to be discharged to the community.

On August 21st, a nurse wrote that the resident was discharged with her belongings. An inventory log of the resident's belongings (the form was not dated) included clothing items and indicated that three boxes had been placed in storage. Five days later, the Director of Social Services received a call from the resident who reported that her fan and a stuffed animal were missing. She was informed that the staff would search for her property. The documentation stated that on September 3rd, the resident was informed that her fan had been found, and that the staff would continue looking for her other missing item.

Embassy Care Center's administration told the HRA that residents are allowed to have religious items in their rooms. According to the facility's staff, the Illinois Department of Public Health investigated the same complaint, and found no violations of rights. In response to the allegation, the facility reportedly inspected every room for religious items, and a copy of the list that included bibles and religious crosses was provided to the HRA. The facility's staff

explained that the resident was hoarding items in her room, and that she had little respect for her two roommates' personal space. They tried to provide more space for the resident's knick-knacks such as the wall shelving. According to the facility ownership representative, the shelving units were placed in the exact location requested by the resident, but this was too close to her light fixture. She repeatedly placed items that were too high on the shelves and on the wall; she hung items on top of her light fixture; and she put up a privacy curtain with thumb tacks, posing a hazardous situation. According to the staff, the resident frequently went out in the community to go shopping, but the facility had received reports alleging that she was shoplifting from nearby stores.

The Administrator said that the resident's belongings were not inventoried item-by-item prior to being packed and placed in the facility's storage area. The resident's inventory log documented that three boxes were placed in storage, but it was unclear what was in these boxes and when this was done. According to the Administrator, the three boxes were placed in storage some time after the resident was admitted to the facility. She said that the staff did not put the resident's items in the boxes and that maybe the note should have been clearer. The investigation team was informed that residents' property is stored in a large container outside in the back of the facility. We were told that only the Maintenance Manager and housekeeping staff have keys to the storage container.

According to the Director of Social Services, she personally packed up some of the resident's belongings that included stuffed cats upon her discharge from the facility. The resident reportedly left some of her belongings in the hallway when she was discharged. Contrary to the complaint, the staff person said that the resident reported that her white fan and a large brown stuffed animal were missing. Her fan was found, and the former resident picked up the item during the investigation. We are unable to reach the former resident to confirm this information. The facility ownership representative agreed with the HRA that residents' property should be inventoried and signed for at discharge, per the facility's policy.

Embassy Care Center's "Storage of Items in Resident's Room" policy states that personal items will be properly stored. No items shall be stored on floors in resident's rooms.

According to the facility's "Inventory of Resident's Possessions" policy, items such as push pins will be removed for the safety of all residents on the behavioral unit.

The facility's "Resident's Personal Belongings" policy states that all items will be listed on the resident's inventory log. Residents of family members who bring in other items should ask the social services department to add them on the list. The facility is not for responsible items, if they are not recorded on the individual's inventory form.

According to the facility’s “Notification of Policy Regarding Personal Property,” residents should ask the charge nurse to update their inventory record whenever they receive new clothing or other items. The facility shall not be liable for lost or damaged personal property unless the items are placed in its secured area for safekeeping.

The facility's discharge and transfer policy states that residents' personal items are inventoried upon their admission and checked periodically. At discharge, belongings are checked against the inventory control sheet; the resident or responsible party will sign and date the sheet as verification. The policy includes procedures for documenting the disposition of resident's belongings at discharge.

According to the facility's grievance procedures, complaints may be presented to any staff person who may resolve the issue immediately. The staff person should report the complaint to his/her supervisor or departmental supervisor as soon as possible, if unable to resolve. The departmental or supervising employee is responsible for completing the grievance form within 10 working days. The facility's social services department is responsible for notifying all appropriate individuals such as family members of the resolution. A supervising staff person shall inform the resident of the resolution and this should be documented on the grievance form. Social services shall notify the Administration and schedule a meeting with all involved parties, if the complaint is not satisfactory resolved.

CONCLUSION

Pursuant to the NHCA Section 45/2-103 and the Illinois Administrative Code Section 300.3210,

> The facility shall provide adequate storage for personal property of the resident …. provide a means of safeguarding small items of value for its residents in their rooms or in any other part of the facility so long as the residents have daily access to such valuables …. make reasonable efforts to prevent loss and theft of residents' property and may include, but are not limited to, staff training and monitoring, labeling property, and frequent property inventories …. Develop procedures for investigating complaints concerning theft of residents' property and shall promptly investigate all such complaints.

According to Section 45/2-109 of the NHCA, a resident shall be permitted the free exercise of religion.

The Administrative Code (77 Ill. Admin. 300.1210 [b] [6]) states that all necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible.

The Administrative Code (77 Ill. Admin. 300.2220 [a]) states that each facility shall:

> (1) Keep the building in a clean, safe, and orderly condition. This includes all rooms, corridors, attics, basements and storage areas.
>
> (2) Keep floors clean, as nonslip as possible, and free from tripping hazards including throw or scatter rugs.

The Authority cannot substantiate that rights were violated because the resident was not allowed to keep religious items in her room. Progress notes confirmed that some of the resident's belongings were removed from her room and placed in the facility's storage area because she repeatedly disregarded safety concerns, posing a hazardous condition. Some of the items removed were pictures, throw rugs and some might have been religious items as reported in the complaint. The HRA acknowledge the facility's requirement under the Administrative Code to keep a safe environment while at the same allowing residents to exercise religion and that there is no evidence this resident was not allowed to express hers by displaying her religious artifacts. However, because the facility failed to itemize her belongings, we are unsure as to whether she even had religious artifacts. The Authority finds no violations of the Sections.

The complaint that the facility failed to safeguard the resident's property is substantiated because the staff lacked accountability for the items removed from the resident's room for safekeeping. The resident's property log documented that three boxes were placed in storage, but these items were not inventoried. It was reported that the resident's fan and seven stuffed animals were not returned upon her discharge from the facility. But, the Director of Social Services said that the resident reported that her fan and one stuffed animal were missing. She also said that the resident picked up her fan during the investigation. The Authority finds that Embassy Care Center's efforts for safeguarding residents' property are inadequate because the facility did not know what the resident had or what they were storing. This violates Sections 45/2-103 and 300.3210. The resident's property also was not periodically inventoried or checked against her inventory sheet when she was discharged, which violates the facility's discharge and transfer policy.

RECOMMENDATIONS

1. The facility shall make reasonable efforts to prevent loss or theft of personal property and inventory items prior to storing them in accordance to Sections 45/2-103 and 300.3210.

2. The facility shall follow its discharge and transfer policy.

COMMENT

Although there was no inventory record of the resident's seven stuffed animals valued at $117.00, the alleged items were reportedly in one of three boxes placed in the facility's storage area. The facility had a responsibility to label and to inventory the resident's possessions prior to storing them. The facility's administration should contact the resident and make some monetary reimbursement to resolve this issue.

Embassy Care Center's policy states that the facility is not liable for personal property, if the items are not recorded on the resident's inventory form. However, there is no indication that residents, family members or guardians are informed about the policy. A copy of the inventory policy should be provided to them during the admission process.

COMPLAINT # 3 Personal Allowance

The complaint stated that the resident did not receive her monthly $30.00 allowed for personal use under Medicaid for February, March and April 2008.

The facility's bookkeeper told the HRA that the resident requested that her payee representative be changed to Embassy Care Center. She said that the facility did not receive the resident's Social Security Income check until May 8th, 2008. A copy of the check for $30.00 was found in record. A ledger and receipts documented that the facility gave the resident $30.00 on February 14th, May 8th, May 30th, July 1st and August 1st. The bookkeeper explained that the $30.00 given to the resident on February 14th might have been in anticipation of the check for the same amount dated on March 11th, 2008 from the transferring facility found in the record. According to the facility ownership representative, the resident was given money from petty cash until her Social Security Income check was received. The facility could not show any receipts to support this statement. The HRA is unclear whether Embassy Care Center pursued the missing payment with the previous facility.

CONCLUSION

Pursuant to Sections 45/2-201 (9) of the NHCA and the Illinois Administrative Code Section 300.3260 (k),

> The facility shall place any monthly allowance to which a resident is entitled in that resident's personal account, or give it to the resident, unless the facility has written authorization from the resident or the resident's guardian or if the resident is a minor, his parent, to handle it differently….

Based on the record and statements from the facility's staff, the Authority cannot substantiate that the resident did not receive her monthly personal allowance for three months. A receipt supports that the resident did receive her $30.00 allowance on February 14th, 2008. Embassy Care Center should contact the resident's previous payee regarding her allowance for March and April; she should be promptly informed of the outcome. The HRA finds no violations of the Section.

COMPLAINT # 4 Medical Care

According to the complaint, the resident was not seen by the facility's psychiatrist for about four months after she was transferred to the medical unit.

The nursing admission note completed on January 11th, 2008 stated that the resident was able to make her needs known. An initial psychiatric evaluation completed by the facility's psychiatrist on January 21st recorded diagnoses of Schizophrenia, Major Depression and some physical problems. She was prescribed daily dosages of Wellbutrin, Trazodone, Seroquel and Celexa. Medications for her physical problems were also ordered. There was no documentation that the facility's psychiatrist saw the resident in February or after the March 28th visit.

Physicians and nursing notes documented that the resident was seen by the facility's medical physician on January 25th, April 22nd, May 22nd, July 13th, July 15th and August 19th. She was seen by a physician in the community on March 3rd. She was taken to a local emergency room for back pain on July 26th. Nursing notes also reflected that the medical physician was called many times because the resident complained of pain, and orders were given. Her care plan was reviewed on April 20th and July 29th. There was no documentation of change in the resident's mental status.

According to Administrator, the resident was on the program's level three. Residents on level three are expected to inform the staff when they need to see the physician or need to make a medical appointment. The Administrator said that she does not believe that the resident requested to see the psychiatrist during her stay on the medical unit.

According to the facility's "Antipsychotic Medications Protocol," residents taking antipsychotic medication shall have their medications reviewed and documented approximately every six months by a physician….

CONCLUSION

CMS' Requirements for Long Term Care Facilities Section 483.25 and the Illinois Administrative Code 300.1210 (a) states that,

> 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 care.

According to CMS' Section 483.40 (c), the resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

The Administrative Code (77 Ill. Admin. 300.1210 [a]) states that, at least every three months, the Psychiatric Rehabilitation Services Coordinator (PRCS) shall document review of the resident's progress, assessment and treatment plans. If needed, the PRSC shall inform the appropriate Interdisciplinary Team (IDT) members of the change in the resident's condition. The appropriate IDT member will reassess the individual and update the resident's assessment, assuring the continued accuracy of the assessment.

The Authority cannot substantiate that rights were violated although the psychiatrist did not see the resident for about four months. The resident was seen monthly by a physician after her admission to the facility, except for February and June, according to nursing notes. This does not meet the requirements of Sections 483.25 and 483.40 (c). The facility also violates its policy because there was no indication that the resident's psychotropic medications were reviewed every six months. The HRA found no violation of Section 300.1210 (a).

RECOMMENDATIONS

1. Ensure that residents receive the necessary care and that they are seen by a physician pursuant to Sections 483.25 and 483.40 (c).

2. Embassy Care Center shall follow its Antipsychotic Medications Protocol policy.