FOR IMMEDIATE RELEASE

FINAL REPORT OF FINDINGS
WOODSIDE EXTENDED CARE- 10-040-9004
HUMAN RIGHTS AUTHORITY- South Suburban Region

[Case Summary— The Authority made four corrective recommendations regarding the allegations, and the service provider accepted all of them. 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), a division of the Illinois Guardianship and Advocacy Commission opened this investigation concerning Woodside Extended Care in August 2009. The 112-bed skilled and intermediate care facility is located in Chicago Heights; about a quarter of its residents have mental illness diagnoses. According to the complaint, the facility refuses to honor a resident's request for discharge. Additionally, the complaint stated that the facility failed to prevent the loss of the resident's property. If substantiated, these allegations would violate the Nursing Home Care Act (NHCA) (210 ILCS 45/2-111), the Illinois Administrative Code for Skilled Nursing and Intermediate Care Facilities (77 Ill. Admin. Code 300.3300 [a] and 300.4030 [f]), the Centers for Medicare and Medicaid Services, Department of Health and Human Services' (CMS) Requirements for Long Term Care Facilities (42 C.F.R. 483) and the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/2-102 [a]).

METHODOLOGY

To pursue the investigation, on October 29th, 2009, the HRA conducted a site visit and discussed the allegations with the Facility Administrator, the Director of Nursing, the Intake Worker and a Psychiatric Rehabilitation Services Coordinator (PRSC). The HRA reviewed sections of the resident's record with her written consent. Relevant facility policies were reviewed. Additionally, the HRA was provided with two Woodside forms entitled, "Leaving Nursing Home Against Medical Advice" both signed by the resident that was not part of the record reviewed.

The resident is an adult who maintains her legal rights.

COMPLAINT STATEMENT

According to the complaint, the resident informed the facility's staff of her desire to be discharged, but her request was not honored. It was reported that the resident was hospitalized

because she tried to leave to the facility. Additionally, the complaint specifically stated that the facility's laundry room staff lost the resident's clothing valued at about $1500.00, but there was no specific description given of the alleged missing items.

FINDINGS

According to the record, the resident had been admitted to the facility many times, and she was readmitted on October 2nd, 2008. She was transferred from another facility because of non-compliance with psychotropic medications. She was diagnosed with Schizoaffective Disorder Bipolar Type, Chronic Obstructive Pulmonary Disease and Hypertension. Her history included substance abuse. She was prescribed psychotropic medications and other medications for her physical problems. The resident's Comprehensive Care Plan developed on that next day reflected only one goal to improve her social skills.

According to the October 11th social services admission note, there were no discharge plans at the time. The resident was described as often angry, inpatient and she blamed others for her situation. The staff person wrote that the resident could benefit from medication and therapy groups such as symptoms management, community reentry and substance abuse. An assessment completed on October 13th stated that the resident was alert and independent in most of her functional areas. Her cognitive skills were fairly good, but her insight was poor concerning her illness. She exhibited problems with decision making, verbal aggression and social skills. Discharge was not anticipated because the resident was not able to comply with post-discharge treatment. According to the assessment, the resident needed to accept treatment, learn symptoms management skills and always follow up with treatment. On October 15th goals regarding hypertension, substance abuse and possibly fall-related injuries were added to her care plan.

A psychiatric evaluation, completed on October 25th, documented that the resident had been admitted to the facility because she was unable to care for self. Her mood and affect were appropriate. She was oriented to person, place and things. Her memory, judgment and insight were intact and positive. Her general fund of knowledge and ability to understand were adequate. The resident's potential for discharge was reassessed on November 8th and December 1st, but there was no indication of progress. She was seen by the psychiatrist on December 13th.

A care plan staffing was held on January 13th, 2009. According to the meeting note, the resident was very cooperative on the admission day, but her mood had changed within the past ninety days. She chose not to attend her treatment staffing or meet with the Director of Social Services. She refused to attend the day program, the facility's skills therapy groups and other activities. She was verbally aggressive when she believed that her requests were not being met. As before, discharge was not anticipated at the time. Two days later goals such as refraining from verbal and physical abuse, complying with staffs' directions and better decision making ability were added to her care plan. On February 14th, the psychiatrist noted that the resident was alert and that she was complying with medication fairly well.

Nursing entries stated that the resident was observed hoarding personal items that belonged to her peers on March 10th. She reportedly locked her peers' belongings in her closet and refused to give them back when she allowed the staff to enter her room. It was documented

that the resident refused medications, she wandered from room to room, and she was verbally abusive. On the morning of March 11th she exhibited the same behaviors mentioned above with the exception of hoarding others' property. She later tried to leave the facility, and she was sent to a local hospital for an evaluation as ordered by her physician. The petition for emergency involuntary hospitalization prepared by the facility's nurse documented increased agitation, delusional and paranoid behaviors, threatening to elope and threatening behaviors towards others. Another note indicated that her family was notified about her hospitalization. Also, the resident's belongings were placed in the facility's storage area, but there was no personal property log found during the record review. The resident returned to the facility upon her hospital discharge on April 1st, and she had a physical altercation with her roommate six days later. She claimed that she was a nurse and refused medical treatment for minor scratches on her face. She continued to refuse medication overall, and her physician was alerted. On April 11th, the psychiatrist saw the resident, and he gave new orders.

In April, the resident's care plan indicated that goals regarding personal hygiene and complying with the facility's smoking policy were added. The resident refused to attend her treatment staffing on April 21st, but her goal outcomes were discussed with her after the meeting as requested. According to the meeting note, the resident continued to exhibit cognitive deficiencies in decision making and social skills. She was behaviorally and socially inappropriate (layered clothing) at times. Her progress in areas such as her mood and socializing with others was minimal. It stated that the resident had made repeated complaints, but there was no more information about them. She was informed about the importance of complying with her physician's orders, and there was no discharge anticipated at the time.

A nurse wrote that the resident was very delusional and psychotic on May 14th. She called the police, and she requested to be discharged from the facility against medical advice when they responded to her call. She could not be redirected, she refused medication, and her physician ordered a psychiatric evaluation. The petition for emergency involuntary hospitalization prepared by the facility's nurse repeated information documented in the nursing note and that she was verbally combative. On that same day the resident was hospitalized, but there was no documentation that her belongings were placed in the facility's storage area during her hospital stay that lasted until May 26th. A completed "Leaving Nursing Home Against Medical Advice" form was not found during the record review, but the HRA was provided with a completed form dated on "May 15th and Judge Wapner" (a television judge) was listed as a witness.

On June 13th, the psychiatrist wrote that the resident was preoccupied with the facility. Her thought process was described as illogical and delusional. She stated that, "I'm going back to school to become a teacher's psychologist." A July 3rd note stated that the resident would sometimes accuse the staff of stealing her clothing. Three days later, the staff person wrote that the resident's inappropriate behaviors included constantly changing her clothing. On July 23rd her care plan and discharge potential were reviewed. The note repeated information mentioned in the April 21st entry. The resident stated "I don't need that" when her refusal to comply with medication was discussed with her. The staff person wrote that she would continue to discuss medication with the resident, and that the issue would be addressed in skills training therapy groups. She also wrote that there was no family involvement at the time. According to the discharge

planning note, the resident was more appropriate for a structured living arrangement. There was no discharge plan in progress because she was unable to care for self. A goal stating that the resident will comply with her treatment and specifically medication was added to her care plan.

Documentation on August 14th indicated that the resident was transported to the hospital for an evaluation because she attacked a peer in a wheelchair. There was no indication that the resident was hospitalized. The resident presented with decreased agitation and aggression seven days later; she was provided with counseling and interventions to improve her quality of life. On August 25th, the resident requested to be discharged to the community Against Medical Advice (AMA). She signed the discharge form under this option, but she refused to leave the facility. She stated that, "I will hold on to this and leave when I get ready." The staff person wrote that the resident's discharge status and plans would continue to be assessed. On October 7th, the resident was alert, oriented and verbally responsive when she was discharged from the facility. The AMA discharge form dated on August 21st signed and stamped by a facility's staff person that was included with the complaint letter also had October 7th written on top of the form. According to the record, the resident was readmitted to the facility seven days later, and she was hospitalized because of physical aggression toward a staff person on December 11th. She returned to the facility on December 16th, and she was hospitalized on that next day. The record does not indicate that she returned to the facility upon her hospital discharge.

When the complaint about discharge was discussed with the facility's staff, the Director of Nursing (DON) said that the resident called her family daily. Her mother told the staff person that the resident could not return home. She reported that the phone conversation occurred around March, but the resident's written consent for sharing information with her family was not found in her record. The DON said that the resident was very delusional and psychotic on May 14th, and she called the police because she wanted to leave the facility AMA. According to the Facility Administrator, "the resident was out of control," but he tried to talk to her about her discharge plans and medications. He told the investigation team that residents who choose to leave the facility against medical advice need to be safe. They should be oriented and alert; they should have a plan that includes taking their medication with them. According to the Facility Administrator, the police said that the resident was not appropriate for the community. And, the resident's physician was called because the police asked him what he was planning on doing about her. Nursing notes indicated that the resident was hospitalized on that same day, and she returned on May 26th.

According to the DON, the resident was hospitalized for behavioral reasons in June after she signed the leaving against medical advice form. She was later observed waving the form around the facility. The record indicated that the resident was hospitalized in March, but there was no documentation that she required inpatient care in June. The HRA was informed that the resident signed many AMA discharge forms, but she kept them. According to the PRSC, the resident repeatedly requested to be discharged against medical advice, but she did not follow through with this option until October 7th. She then chose to return to the facility from the community, and she was subsequently hospitalized. The resident reportedly was planning on returning to the facility post-hospital discharge.

The complaint regarding the resident's missing clothing was discussed with the staff. According to the intake worker, the resident only had the clothing that she was wearing at intake. She was given clothing during her stay at the facility. The resident claimed that her designer clothing valued at $100,000 was missing shortly after her arrival. She said that the resident wore her peers' clothing without their permission, and she required much encouragement to take them off. Another staff person said that she overheard the resident saying that someone had stolen her clothing. And, she would also accuse the staff of taking her clothing if she thought that her items were not promptly returned from the laundry room. She reportedly never gave the staff a list of her alleged missing items. The HRA was also not provided with any specific information about them.

The HRA asked why there was no inventory log found in the resident's record. According to the staff, the facility's nursing assistants are responsible for inventorying residents' property, and inventory sheets are updated. The resident involved in the complaint would not allow the staff to update her belongings. She had a duffle bag and a purse when she was discharged on October 7th but refused to allow her items to be inventoried. The staff explained that property is inventoried when the discharge is planned. Residents are usually in a hurry to leave the facility under the AMA discharge option, and their belongings are not inventoried. Residents' belongings are not inventoried when hospitalized prior to storage. On questioning, the investigation team was informed that the storage area is located in the facility's basement, and that the laundry and maintenance staff have keys to this area.

According to the DON, the facility had only a few complaints about loss of property in 2009, and the facility's Missing Item Report" form is used for formal complaints. She explained that a search is done for the missing items. Residents' belongings are replaced if the items are documented on their property sheet, but they are not found. Residents are asked to sign the form when belongings are replaced. There were no written grievances found in the resident's record.

CONCLUSION

Woodside's "Voluntary Discharge Policy" states that a resident who has not been "declared incompetent" can request discharge from the facility at any time. If requested, the resident's competence (vital signs, mental status examination that includes the presence or absence of hallucinations and delusions, judgment, reasoning, awareness and community survival skills) will be assessed. The Facility Administrator and the physician will be informed of the request. The physician will determine whether the resident is mentally stable based on the staffs' assessment and all relevant known factors. An order will be entered in the resident's record if discharge is appropriate. The staff are directed to assist the resident with identifying another living arrangement of choice.

According to the policy, a resident who is determined to be mentally unstable for discharge will be informed of the physician's decision as well as family, if appropriate. The resident has the right to leave if he or she is oriented to time and place and lack mental or cognitive impairment. The AMA discharge option will be explained if the resident is capable of making this kind of decision. If the resident's decision making ability is considered to be impaired or the Administrator or Director of Nursing determines that there is a safety issue (for

example, extreme weather conditions or lack of shelter), the resident might not be allowed to leave the facility until it is safe. If the resident insists on leaving the facility, the person may be transferred to a hospital or administered medications as directed by the physician.

The facility's discharge planning policy states that a discharge plan will be developed by the interdisciplinary team (IDT) as a component of the comprehensive care plan. Residents who have strong discharge potential and/or strong supportive networks in favor of discharge are referred to the Social Services Department by the IDT or physician. Significant assessment information will be documented in the Summary Sheet, Social History, a Discharge Potential Assessment (if appropriate) and other assessment reports. The IDT is directed to give consideration to the resident or guardian's input regarding their request for inclusion. Therapeutic counseling interventions will be provided throughout the process, especially when a less structured environment is not appropriate but requested.

The facility's "Notification of Policy Regarding Personal Property" states that every resident should have at least six changes of clothing and at least two pairs of shoes in good condition. Residents should ask the charge nurse to update their inventory record any time they receive new clothing or other items. According to the policy, the facility understands the value and importance of a resident's personal property, but the loss of personal belongings is difficult to manage in a long-term care facility where many diverse residents live and employees work. The facility shall not be liable for lost or damaged personal property unless the items are placed in its secured area for safekeeping.

According to the facility's grievance policy, a resident or significant other may file a complaint concerning the resident's treatment, theft of property, a staff person, etc., without fear or reprisal in any form. The facility's grievance procedures direct that: 1) the complainant should obtain a grievance form from the nurses' station, 2) answer all questions on the report form, 3) the complainant should sign and date the form, and, 4) the completed form should be given to the Facility Administrator or social services. It states that the complainant will be orally informed about the investigation findings within ten working days. Complaints alleging abuse, harassment or mistreatment will be immediately investigated, and the complainant will receive an oral and written report of the facility's findings and/or corrective action plan within five working days. The complainant may meet with the Administrator or file a complaint with an outside agency if the person disagrees with the resolution. The complainant may request a copy of the investigation report from the facility's business office. The facility will assist the person in filing a grievance.

CONCLUSION

According to Section 45/2-101 of the NHCA, no resident shall be deprived of any right solely on account of his status as a resident of the facility. Section 45/2-111 of the Act and Section 330.3300 (a) of the 77 Administrative Code state that 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.

CMS' Requirements for Long Term Care Facilities Section 483.15 (b) guarantees a resident the right to self-determination and to make choices about aspects of his or her life in the facility that are significant to the resident.

Section 483.20 (b) (1) (xvi) states that the facility must conduct, initially and periodically, a comprehensive assessment of each resident's functional capacity. The assessment must include discharge potential.

According to Section 5/2-102 (a) of the Mental Health and Developmental Disabilities Code,

> Services shall be provided in the least restrictive environment, pursuant to an individual services plan…. In determining whether services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided.

The Code adds in Section 5/2-101 that no recipient shall be presumed legally disabled nor held legally disabled except as determined by a court.

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

> The facility shall …. 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 the record, the resident was admitted to the facility on October 8th, and her functional capacity was initially assessed three days later. She tried to leave the facility on March 11th, and she requested to be discharged against medical advice on May 14th. The facility's nursing staff prepared a petition (both times) for emergency involuntary hospitalization under Article VI of the Mental Health and Developmental Disabilities Code because of concerns about her mental stability. She was involuntarily hospitalized as permitted under the Code, and there was no evidence that she objected to returning to the facility on April 1st and May 26th respectively. Her functional capacity and potential for discharge were periodically assessed, but there were no discharge plans in progress because she could not care for herself. It appears that the resident's right to make choices about medication was adequately considered because was allowed to refuse medication.

The HRA believes that the resident was prevented from leaving the facility. A discharge planning note written on August 25th stated that the resident refused to leave the facility after signing the AMA discharge form. The AMA discharge form, dated on August 21st signed and

stamped by a facility's staff person, that was not part of the record reviewed but was included with the complaint letter contradicts the date of her request for discharge. The facility's staff reported that the resident signed many AMA form during her stay, but they were not found in her record. She was discharged AMA on October 7th and she was readmitted to the facility on October 14th. She was hospitalized on December 11th and the 17th. There was no evidence that she objected to returning to the facility on October 14th and December 16th. The last note found in her record was dated on the 17th.

The Authority reminds the facility of the Illinois Appellate Court, Fourth District ruling- In re Muellner- citing the Mental Health and Developmental Disabilities Code, Section 5/2-114 that defines a mental health facility as "any licensed private hospital, institution or facility… or section thereof, operated by the State… for the treatment of persons with mental illness and includes **all** hospitals, institutions, clinics, evaluation facilities, and mental health centers which provide treatment for such persons." The court ruled that a specialized behavioral health unit in a nursing home meets the definition of a mental health facility under the above Section. The court also ruled that a recipient cannot be admitted to a nursing home that primarily serves individuals with psychiatric needs or held against the recipient's objections without a court order obtained through the involuntary commitment process under Article VII of the Code.

The Authority substantiates that the facility refused to honor a resident's request for discharge. The facility's violates Sections 45/2-111 of the NHCA, and 330.3300 (a) of the Administrative Code, CMS' Requirements for Long Term Care Facilities 483.15 (b), 5/2-102 (a) of the Mental Health and Developmental Disabilities Code and facility's discharge planning policy. No violations of Section 483.20 (b) (1) (xvi) were found.

In response to the complaint regarding the resident's property, the staff said that the resident refused to allow her items to be inventoried at intake, periodically or when she was discharged from the facility. A nursing note suggests that the resident had some property because her belongings were placed in the facility's storage area when she was hospitalized on March 11th. The staff told the HRA that residents' belongings are not inventoried when hospitalized prior to storage. There was no personal property log found in her record. Another nursing note stated that the resident was hospitalized on May 14th, but there was no documentation that the staff secured her property during her hospital stay. The resident was hospitalized twice after she returned to the facility on October 7th. Although there was no indication that her property was placed in storage during these visits, the complaint was filed prior to them.

The Authority cannot substantiate that the facility lost the resident's property because there was no property sheet found in her record. The HRA finds that the facility's efforts for safeguarding residents' property are inadequate because the facility's policy lacks procedures for labeling and inventorying property prior to storing the items. This violates Sections 45/2-103 of the NHCA and 300.3210 of the Administrative Code. The staff lack accountability for the items removed from her room for safekeeping which violates the facility's policy.

RECOMMENDATIONS

1. Follow Sections 45/2-111 of the NHCA and 330.3300 (a) of the 77 Ill. Administrative Code concerning residents' right to discharge. Ensure proper documentation concerning discharge information in residents' records.

2. Always consider resident input in overall care planning and treatment pursuant to CMS' Requirements for Long Term Care Facilities 483.15 (b) and 5/2-102 (a) of the Mental Health and Developmental Disabilities Code.

3. To ensure that personal property is adequately safeguarded and accounted for the facility's staff should complete inventory forms whenever residents refuse to complete them independently under Sections 45/2-103 of the NHCA and 300.3210 of the 77 Ill. Administrative Code.

4. Provide the HRA with documentation of staff training.

COMMENTS

The Authority reminds the facility that only a judge can adjudicate a person to be incompetent based on clear and convincing evidence that he or she lacks sufficient understanding or capacity to make or communicate responsible decisions concerning their well-being. We respect Woodside's intentions to do sound discharge planning such as functional capacity assessments, but a person diagnosed with a mental illness cannot be held in a facility that provides mental health treatment over the person's objections without a court order. We caution that a person's right to self-determination and the right to move about freely absent dangerousness are to be respected, particularly for those who remain legally competent. Woodside should revise its Voluntary Discharge Policy stating that a resident's competence will be assessed upon their request for discharge because the facility lacks the authority to determine competency which is different from functional capacity assessments.

Additionally, there was no written authorization found from the resident to discuss her care with her family. The Authority must remind the facility that the Mental Health and Developmental Disabilities Confidentiality Act Section 110/2 defines communication as any … in connection with providing mental health … services to a recipient. We suggest that the facility follow Section 110/5 (a) of the Act stating that,

> Records and communications may be disclosed to someone other than those persons entitled listed in Section 4 of this Act only with the written consent of those persons who are entitled to inspect and copy a recipient record pursuant to Section 4 of this Act.