
**FOR IMMEDIATE RELEASE**

REPORT OF FINDINGS
RIVIERA CARE CENTER — 10-040-9015
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary— The Authority made corrective recommendations regarding one of three allegations that were accepted by the service provider. The public record on this case is recorded below; the provider's response is not included in the public record.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA) has completed its investigation into allegations concerning Riviera Care Center. According to the complaint, the facility failed to prevent the loss of the resident's property. The facility did not provide a resident's guardian with personal records upon her request. Additionally, the guardian requested that the resident should be transferred to another nursing facility, but the facility was slow in honoring her request. If substantiated, these allegations would be violations of the Nursing Home Care Act (NHCA) (210 ILCS 45/2 et seq.), the Centers for Medicare and Medicaid Services, (CMS) Conditions of Participation for Long Term Care Facilities (42 CFR Part 483) and the Illinois Administrative Code for Skilled Nursing and Intermediate Care Facilities (77 Ill. Admin. Code 300.3210 and 300.3300 [a]).

Riviera Care Center provides 24-hour skilled nursing care and offers a range of programs. The 200-bed facility located in Chicago Heights reportedly has about 162 residents, and all of them have been diagnosed with a mental illness.

METHODOLGY

To pursue the investigation, a site visit to Riviera Care Center was conducted. The Facility Corporate Counsel, the Facility Assistant Administrator, the Director of Psychiatric Rehabilitation Services, the Director of Environmental Services, a Certified Nursing Assistant and a staff person from medical records were interviewed. The complaint was discussed with the resident and guardian by telephone. Sections of the adult resident's record and a copy of his Guardianship Order, dated November 30th, 2009, were reviewed with consent. This order appoints guardianship over the resident's personal care and finances. Relevant policies were also reviewed.

COMPLAINT STATEMENT

The complaint stated that the lock on the resident's night stand was broken, and all of his belongings in his room were stolen while he was hospitalized in September 2009. A list of the resident's alleged missing items totaled $3982.00 to $4992.00 and many of them were brand name clothing. Included in the total was $600.00 for six wristwatches, $1000.00 to 2000.00 for pants with no descriptions, $320.00 for four shirts, $200.00 for four bottles of cologne, $48.00 for four compact discs, $240.00 for three pairs of pants, $510.00 for four outfits (clothing), $300.00 for three hooded sweatshirts, $200.00 for two jerseys, $100.00 for two tee-shirts, $100.00 for two pairs of jeans, $100.00 for two jackets, $60.00 for one jumpsuit, $20.00 to 30.00 for a radio and $84.00 for miscellaneous items such as soap, deodorant, shampoo, a hair comb, etc. An IPOD (a portable device used to play music files) and a beige knee length sweater were subsequently added to the list, but there was no monetary value reported for these items. An unidentified staff person supposedly told the guardian that a peer took the resident's radio, but the item was not retrieved before his peer was discharged from the facility. Another peer who still resides at the facility allegedly has the resident's IPOD. It was reported that the current and previous Administrator did not adequately address the guardian's concerns regarding the resident's missing items. The complaint alleged that the resident's guardian requested personal records concerning the eligible person, but they were not provided. And, the facility failed to comply with a court-order regarding this issue. A staff person reportedly told the guardian that the facility charges a fee for duplication of a record but refused to say how much the fee was. Additionally, the complaint stated that the facility was slow in honoring the guardian's request that the resident be transferred to another nursing home.

FINDINGS
Information from record, interviews and program policies

After reviewing the record, the HRA determined that the 19-year old resident was initially transferred to the facility from a hospital on May 22nd, 2008. He was diagnosed with Bipolar Disorder and Delusional Behavior. On the admission day, he was described as very upset and agitated because he wanted to live with his mother. The resident's mother and god-mother were informed about his admission to Riviera Care Center, and that he wanted to leave the facility. They reportedly told the social worker that he could not live with them. And, the resident said that he would be at the facility only for a few days. A "Discharge Plan Review" form, completed on that same day, indicated that his anticipated length of stay at the facility was more than 90 days. It stated that the resident had been placed at the facility because of non-compliance with mental health treatment and discharge potential was fair.

The resident was reportedly oriented times three during the intake process and signed many forms including a "Consent for Psychotropic Medication." The social worker wrote that the resident was "offered clothing items," but he chose to stay in his hospital gown and pants. The record does not clearly indicate whether the resident had property at intake. A form entitled "Patient's Clothes List" documented that the resident had nine pairs of socks, six pairs of underwear, three tee shirts, two red shirts, two pairs of blue shorts, 2 pairs of jeans, two tank tops, two pairs of shower shoes, one pair of sweat pants, and one pair of gym shoes. There was no mention of when or who completed the form or the facility's name on the document.

On May 23rd, a nurse wrote that the resident insisted on leaving the facility. Two days later, he was pacing up and down the corridors and loudly talking to himself. The resident reportedly said "If god [tells] me to kill, I will kill." Nursing entries indicated that the resident was aggressive toward others and non-compliant with medications. On June 6th, he was reevaluated by a physician, and new orders were given. It was documented that the resident verbally agreed to the recommended medications after the risks, benefits and right to refuse treatment were discussed. According to progress notes, the resident continued to refuse medications and was sometimes physically threatening when they were offered. On July 22nd, a social worker wrote that the resident did not believe that the facility was his home, and that he needed to comply with rules. He told the staff person that "he had signed himself in and could sign himself out to the streets." Entries further suggested that the resident engaged in physical altercations with peers and refused medical services.

According to the record, the resident's mother was very involved in his care. On March 11th, 2009, the resident, his mother and all members of the facility's Interdisciplinary Team (IDT) attended the quarterly care plan meeting. And, the resident requested to be discharged to a group home at the meeting. A corresponding nursing note stated that the resident was doing well and that there had been a recent reduction in medication. It was recorded that some half-way houses (boarding houses) and a named agency for outpatient services and medication would be called. On that next day, the resident and his mother reportedly met with the physician and agreed with the discharge plan. Progress notes detailed the facility's efforts to find another placement as requested by the resident. On March 16th, a referral packet for group home placement was sent to a named agency, and a discharge planning meeting was held later that month. At the meeting, the resident reportedly became verbally aggressive and his mother said that he could not come home on pass until his behavior improved. On April 23rd, a second referral packet was sent, and the receiving agency reported that there were no beds available. Four days later, a third referral packet was sent, and the receiving agency reported that a bed would be available in June. On that same day, the resident told the staff person that he was no longer interested in a Community Integrated Living Arrangement (CILA) placement after he was updated about the referral status. The resident said that he wanted to stay at the facility until he was able to get his own apartment. Two days later, he requested a CILA placement again. A discharge potential assessment form, completed on May 6th, 2009, stated that there were no discharge plans at the time.

On June 22nd, the receiving agency reported that there was a "freeze" on accepting new clients, and that the agency did not know how long it would last. The resident and his mother reportedly were informed about the placement referral status. There was evidence in the record that the resident was informed about the Leave Against Medical Advice option. On July 24th, the resident's mother reportedly needed a copy of his award letter because her lights had been turned off. He was told that he could sign the above form because he did not have a home pass. On August 25th, a discharge planning meeting was held as requested by the resident and his mother. It was recorded that the resident's mother "reluctantly" agreed to review possible discharge in 30 days after he acknowledged having behavioral problems and non-compliance with medication on the previous day. The facility's expectations for a successful discharge were explained. On September 3rd, the resident requested to be discharged to a CILA placement again and verbalized anger about being transferred to another nursing home. Although there was no clear documentation that the staff was working on discharging the resident to his mother's home, a

note written on September 24th stated that the resident's mother was present when he was informed that he would not be returning home as planned. Six days later, referral information was faxed to another nursing home with the resident's consent.

The record does not support that the resident was hospitalized in September 2009 as stated in the complaint. Documentation on October 3rd referenced that he presented with increased agitation and was subsequently hospitalized on that same day. According to the note, code yellow was called because the resident pushed a nurse down on the floor. He was administered PRN (as needed) medication but continued to yell and threatened staff with physical harm. There was no documentation regarding the disposition of the resident's property during his hospitalization. He was readmitted to the facility on the 12th. Two days later, he alleged that some personal items were missing but was only able to give a vague description of them. Then, he reportedly showed the staff person the same alleged missing items and said that he was disposing of them because of their condition. It was further recorded that the resident said that "the situation was now fine" after he was given some items from the laundry room. On November 18th, his mother reported that some items were still missing, and that they had been taken while he was hospitalized. According to the note, the resident denied his mother's assertion and called her a "liar." He said that most of his belongings were not labeled, and that he had thrown away some items because of their condition.

An order indicated that the resident's mother was appointed his legal guardian on November 30th. There was no written request from his guardian for a copy of the record or a court-order regarding this issue. Documentation on January 14th, 2010 indicated that the guardian requested that the resident be transferred to a specific nursing home. The guardian was asked to sign a release of information for sharing information with the requested nursing home, but there was no signed release found in the record. On January 18th, the resident was hospitalized because of psychosis and auditory hallucinations. His guardian was notified about the incident. Again, there was no documentation concerning the disposition of his personal belongings. According to the record, the resident did not return to the facility post-hospitalization.

In regard to property, the Director of Psychiatric Rehabilitation Services told the HRA that the "Patient's Clothing List" form found in the resident's record is the facility's form. She said that the form was completed at intake although there is no date on the document. The investigation team was informed that the Certified Nursing Assistant is responsible for inventorying property at intake and all belongings are inventoried before taken to the floor. According to the Director of Environmental Services, the resident had a night stand with a lock, and he had the only key. The complaint alleged that the lock was broken. The staff person reported that the resident did not want his items to be labeled, and that this would not be documented in the record. The investigation team was told that the guardian removed some of the resident's items from the facility when he was hospitalized. Later, she reported that some of the resident's belongings were missing. A search reportedly was done, but the staff were not sure what they were looking for. On questioning, the HRA was informed that the facility was not provided with a list of the resident's alleged missing items. The staff did not remember him having an IPOD or a radio as stated in the complaint. The resident's inventory sheet also does

not reflect these items. However, a nursing entry stated that the resident was alert and listening to music in bed on March 18th.

According to the staff interviewed, the resident's guardian did not file a written grievance with the facility concerning his alleged missing items. Riviera Care Center uses concern forms to track complaints and receives less that five completed forms monthly. The staff reported that the last complaint was about diabetic socks being missing. Property is inventoried and labeled prior to being packed and placed in storage when residents are hospitalized. A copy of the inventory record is placed in each bag. There are two storage rooms on each unit. The HRA was told that only the Environmental Services and nursing staff have keys to the storage areas. On March 25th, 2010, a bag of clothing was returned to the resident. The investigation team was informed that sometimes personal items might be in the laundry room during the resident's hospitalization and will be stored. During the investigation, the resident and guardian confirmed that some property was returned after he was discharged from the facility. The guardian said that the bag did not contain any jeans. And, the resident reported that his sweatshirts and one outfit were returned.

In regard to personal records, the staff person from medical records has been employed at the facility since June 2009. She said that the facility did not receive a request for the resident's record from the guardian. The Facility Corporate Counsel explained that a record request must be in writing. All requests are sent to the General Counsel's office to determine their appropriateness, and the facility has 30 days to respond to the request. The fee for duplicating the record is $0.40 per page and $1.00 per 25 sheets. Sometimes specific records are requested because the number of documents in a record might be substantial. Sometimes records are provided to individuals free of charge if they cannot pay the fee. The staff person who allegedly refused to tell the guardian how much the fee was to duplicate the resident's record is no longer employed by the facility.

In regard to discharge, the Director of Psychiatric Rehabilitation Services said that the facility was working on discharging the resident to his mother’s home, but she changed her mind. She said that finding another restrictive placement is easier than transferring a resident to an independent living arrangement. The Facility Corporate Counsel referenced that guardianship was granted on November 30th, 2009, and that the guardian requested a transfer to another nursing facility in January 2010. The resident was hospitalized days later and did not return to the facility.

According to Riviera Care Center's "Belongings" policy, the facility protects the personal effects of a resident upon his or her transfer or discharge from the facility. The policy states that the resident, family member or guardian will be notified to take the person's belongings upon transfer or discharge or pick them up within 30 days. It directs the staff to routinely check the storage area and to dispose of belongings if they are not picked up within 30 days after notification is given. The policy also states that for a resident who is temporarily transferred or discharged from the facility, items will be stored until the individual returns.

An "Authorization for Disclosure/Release of Health Information" form was provided to the HRA. According to the form, the facility may charge a reasonable fee for copying and

sending the person's health information records within [left blank] days upon written request. The person making the request will be informed about the fees, and the requested information will be sent after full payment is received. The facility's fee for copying a record per page is as follows: $0.75 up to 25 pages, $0.50 for pages 26 thru 50 and $0.25 for 51 pages or more. Also, it states that the facility charges a $20.00 handling cost and postage fees.

According to the facility's discharge planning and transfer policy, the facility will appropriately enable a resident to move to another setting after he or she gives notice to an administrative or social services representative. It states that social services will be primarily responsible for determining the resident's reasons for transfer to another setting. If there is an issue that can be resolved to enable the resident to remain comfortable in his or her current setting that it will be pursued. If the resident still desires a transfer, social services will request appropriate consent forms to share information with the desired facility. A physician's order will be requested as appropriate. The staff will help the resident to prepare for the upcoming transfer, which will be arranged within reasonable timeframes depending on the response from the receiving facility. For discharge planning purposes, each resident's discharge potential will be assessed upon admission, and a discharge plan will be developed by the Interdisciplinary Team as a component of the comprehensive care plan.

Riviera Care Center's Complaint and Concern Resolution policy states that all residents and family members will be informed about the complaint procedure upon admission to the facility. All staff and residents will be informed about the location of the complaint and concern forms. All complaints and concerns should be written on the appropriate form by the resident (if possible) or staff person. The completed form should be given to the Director of Psychiatric Rehabilitation Services who will forward it to the responsible department manager for follow up and the Administrator. All complaints and concerns raised in the Resident Council meeting will be addressed in the same manner. The person who initiates the form will be informed of the resolution, and this will be indicated on the document. All completed forms will be reviewed by the Administrator and kept in a binder in his or her office. And, they will be reviewed monthly during the facility's Quality Assurance and Performance Improvement meeting.

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.

Pursuant to the NHCA Section 45/2-103 and Section 300.3210 of the Illinois 77 Administrative Code,

> The facility shall provide adequate storage for personal property of the resident .... shall 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 …. 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 Section 45/2-104 (d) of the NHCA and CMS' Requirements for Long Term Care Facilities Section 483.10 (b) (2) (i) (ii),

> Every resident, resident's guardian, or parent if the resident is a minor shall be permitted to inspect and copy all of his clinical and other records concerning his care and maintenance kept by the facility or by his physician. The facility may charge a reasonable fee for duplication of a record.

The CMS' Section also allows record access within 24 hours excluding weekends and holidays upon an oral or written request. It allows those eligible to purchase at cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.

CMS' 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.

Pursuant to Section 45/2-111 of the NHCA and Section 300.3300 (a) of the Illinois 77 Administrative Code, 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.

This investigation revealed many problems with the facility's procedures for preventing loss of personal property. It is unclear whether the resident had belongings on his May 22nd, 2008 admission to the facility. An inventory form indicated that the resident had some clothing, shoes, socks and underwear during his stay at the facility. The facility's name does not appear on the form; there was no mention of when or who completed the form. The facility's staff told the HRA that the form in question was completed at intake. They said that property is inventoried prior to being placed in storage when residents are hospitalized. But the record lacked any indication that the resident's belongings were stored when he was hospitalized in October 2009 in accordance to Riviera Care Center's policy. In January 2010, the resident was hospitalized, and he did not return to the facility post-hospital discharge. As before, there was no mention of the disposition of his belongings in the record.

At the site visit, the staff reported that a bag containing the resident's property was returned after he was discharged from the facility. The staff were not able to account for the contents in the bag. They did not know what the resident had or what they were storing. The resident and the guardian said that the bag only contained a few clothing items. The Authority cannot substantiate the loss or theft of the items listed in the complaint. We find that Riviera Care Center's efforts for safeguarding residents' property are not reasonable because the facility's policy lacks procedures for inventorying property prior to storing the items. This violates Sections 45/2-103 and 300.3210 and the facility's policy.

The Authority cannot substantiate that the agency did not provide personal records to the resident's guardian. The HRA found no evidence to support that a record request was made. No violations of Sections 45/2-104 (d) or 483.10 (b) (2) (i) (ii) or the facility's policy were found.

The Authority does not substantiate the complaint that the guardian requested that the resident should be transferred to another nursing facility, but the facility was slow in honoring her request. Based on documentation found in the record, guardianship was granted on November 30th, 2009, and the facility was working on finding another placement for the resident prior to hospitalization in January 2010. He did not return to the facility upon his discharge from the hospital. No violations of Sections 45/2-111 or 300.3300 (a) or 483.20 (b) (1) (xvi) or the facility's policy were found.

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 Section 45/2-103 and Section 300.3210.

2. Ensure that residents' personal belongings are inventoried on a regular basis.

3. Riviera Care Center shall follow it policy and safeguard residents' personal property when they are temporarily transferred or discharged from the facility.

4. The facility shall include procedures for inventorying property prior to storing items in its policy.

SUGGESTIONS

1. Although there was no inventory record of the alleged missing items, the HRA suggests that the facility's administration should contact the guardian and offer some monetary reimbursement to resolve this issue.

2. Riviera Care Center should revise its resident's clothing list form and include the facility's name.