FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
RIVIERA CARE CENTER —11-040-9002
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary—— The Authority did not substantiate the complaint as presented; the public record on this case is recorded below. A provider response is not included in the public record.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA), the investigative division of the Illinois Guardianship and Advocacy Commission has completed its investigation into allegations concerning Riviera Care Center. The complaint stated that a resident was denied the right to choose his own physicians. Additionally, the complaint alleged that the resident requested to be transferred to another nursing home, but the facility's process is too slow. 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, Department of Health and Human Services' (CMS) Requirements for Long Term Care Facilities (42 C.F.R. 483).

Riviera Care Center provides 24-hour skilled nursing care and offers a range of programs including rehabilitation services. The 200-bed facility located in Chicago Heights reportedly has about 164 residents.

METHODOLOGY

To investigate this complaint, a site visit was conducted. The facility's Corporate Counsel, the Assistant Administrator, the Director of Nursing, the Assistant Director of Nursing and the Director of Psychiatric Rehabilitation Services were interviewed. The complaint was discussed with the resident who gave consent to review his record. Relevant policies were also reviewed.

COMPLAINT STATEMENT

According to the complaint, the resident wanted to continue receiving care from his private psychiatrist and general medical physician but the Director and the Assistant Director of Nursing said that he had to choose a physician recommended by the facility. Although his three private physicians are located in the same office building only continuity of care with his neurosurgeon was allowed. It was further alleged that the resident requested to be transferred to

another living arrangement because Riviera Care Center does not offer physical rehabilitation, but the facility's process is too slow.

FINDINGS

The resident's record indicated that he was admitted to Riviera Care Center from an acute care hospital on June 16th, 2010. He was diagnosed with Schizoaffective Disorder, Depression, Hypertension and prostate problems. His history included obesity, migraine headaches, substance abuse and multiple surgeries on his back. The discharging hospital recommended that the resident should continue receiving physical and occupational therapy, pain management and psychiatric care. The resident's face sheet, completed by the facility, documented that the psychiatrist and general medical physician involved in his care were those associated with the facility. There was no documentation that the resident requested to continue receiving care from his private physicians as reported in the complaint.

The admitting physician's orders indicated that medications for the resident's psychiatric and physical problems were prescribed. His medication regimen included Norco, Tramadol and Dilavdid every four to six hours as needed (PRN) for his back pain. A pain assessment should be done on every shift and as needed. Also, the nursing staff were instructed to schedule a follow-up visit with a certain physician (neurosurgeon) due to the resident's back surgery. On June 17th, social services wrote that the resident was oriented times three. His insight concerning his mental illness was fair. He was able to articulate his care needs very well. He reported having recent surgery on his back. Medication Administration Records (MARs) indicated that Tramadol was discontinued on that same day. His initial care plan included goals concerning psychotropic medication, his behavior and psychosocial well-being. A psychiatric evaluation was completed on June 21st.

Progress notes detailed that the resident's adjustment to the facility was difficult. On June 21st, the resident was escorted around the neighborhood on a therapeutic walk because he was upset. He talked about his feelings concerning the facility and his peers. According to an assessment, the resident wanted to return to the community at discharge, but his length of stay at the facility could not be determined. On June 23rd, the resident was recommended for "The Money Follows the Person" (MFP) transitional independent living program. The Director of Psychiatric Rehabilitation Services also wrote that the resident needed to be interviewed and assessed by the MFP staff. On that same day, the resident signed a form to release personal information to the agency that manages the MFP program. There was no more information concerning the referral found in the resident's record.

Entries indicated the resident was seen by the assigned general medical physician on June 23rd. A History and Physical form documented a diagnosis of spinal stenosis. This is a narrowing of the spinal cord that causes pressure on the spinal cord. His assessment, completed on June 29th, indicated that he reported having excruciating and daily back pain during the last

seven days. On July 9th, the resident was seen by the neurosurgeon mentioned above and was referred to another physician for pain management. There was no documentation that he was seen as recommended by the neurosurgeon, but pain care for spinal stenosis was added to his plan of care. MARs showed that he was assessed for pain as ordered, and that pain medication was seldom administered.

Entries further documented that the resident packed his belongings on July 14th because he did not want to continue living at the facility. It was recorded that the resident changed his mind about leaving, unpacked his items, and the nursing staff were informed about his "agitation." On that same day, the resident was not allowed to attend his community day program because he was considered a flight risk. Two days later, the resident grabbed his peer by the neck, and staff intervention was needed. On July 20th, the resident refused to see any physician associated with the facility. Also, he refused medication, medical exams, testing and other necessary treatment. On July 23rd, the resident was discharged from the facility after he signed a leave against medical advice form.

When the complaint was discussed with Riviera Care Center administration, the HRA was told that residents are informed of their rights upon admission. The nursing staff interviewed said that residents can choose their own physician if they do not want to receive care from those recommended by the facility. Upon questioning, a staff person said that none of the facility's present residents have chosen their own physician but some of the previous residents chose this option. A nurse said that the resident involved in the complaint was very independent. His back pain was addressed, and he was seen by a physician in the community for consultation. He reportedly refused medication for his back pain most of the time. He sometimes would refuse to have his blood pressure taken before medication for hypertension was administered.

The Director of Psychiatric Rehabilitation Services said that the resident requested a transfer about three weeks after he was admitted to the facility. He reportedly wanted to be more independent. He wanted to step down to a lesser level of care such as a Community Integrated Living Arrangement (CILA) or live independently in an apartment setting. According to the staff person, the resident was not happy when he was informed that the MFP program admission process usually takes about three to six months. She said that the resident refused to be transferred to another nursing home, which takes about three to four days. The investigation team was informed that the facility sends the receiving agency the following information: a copy of the resident's face sheet, physician's orders, and nursing and social services notes.

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 Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities and Sections 45/2-104 of the NHCA and 300.3220 of the Illinois Administrative Code,

> A resident shall be permitted to retain the services of his or her own personal physician at his or her own expense or under an individual or group plan of health insurance, or under any public or private assistance program providing such coverage.... Every resident shall be permitted to participate in the planning of his of her total care and medical treatment to the extent that his or her condition permits....

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.

The Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities and Sections 45/2-111 of the NHCA and 300.3300 (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.

Section 300.4030 (f) of the Illinois 77 Administrative Code states that whenever possible, residents shall be offered some choice among rehabilitation interventions that will address specific Individualized Treatment Plan objectives using techniques suited to individual needs.

In regard to first complaint, there was no documentation found in the record that the resident requested to continue receiving care from his private psychiatrist and general medical

physician. His face sheet documented that a psychiatrist and general medical physician associated with Riviera Care Center were assigned to provide care upon his admission to the facility on June 16th, 2010. He was seen by his assigned physicians on June 21st and 23rd respectively. On July 20th, a note recorded that the resident refused to see any physician associated with the facility. The July 20th note does not support the staffs' assertion that residents can chose their own physician if they do not want to receive care from those recommended by the facility. The Authority reminds the facility that the above Sections clearly give residents the right to make decisions about their healthcare including choice of personal physician. The HRA is pleased that the resident was allowed to see his choice of neurosurgeon.

The Authority found no clear evidence that the resident was denied the right to choose his own physicians, although his refusal on the 20th to see facility physicians is an indication that he likely expressed something about that. Without clearer evidence, no violations of Section 45/2-104 of the NHCA, CMS' Section 483.15 (b) and the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities concerning the right to participate in one's care were found. However, we are concerned that none of the facility's current residents have chosen their own physician.

In regard to the second complaint, the resident's stay at the facility was very short although his discharge potential was determined to be uncertain. The HRA is unclear whether the resident needed physical therapy because of back pain, but services were based on his care plan. On June 23rd, the resident signed a form to release personal information to the MFP program for treatment planning, discharge and/or aftercare. According to the Director of Psychiatric Rehabilitation Services, the resident was not willing to wait to see if he would be accepted in the MFP. He also refused to be transferred to another nursing home. A leave against medical advice form indicated that the resident was discharged from the facility under this status on July 23rd, 2010.

The HRA does not substantiate the complaint that the resident requested to be transferred to another nursing home, but the facility's process is too slow. No violations of CMS's Sections 483.20 (b) (1) (xvi) and 483.25 or Section 45/2-111 of the NHCA were found.

SUGESTIONS

1. The facility should review "Residents' Rights for People in Long Term Care Facilities" with its staff.

2. The facility's intake staff person should ensure that new residents understand his or her rights to the best of their ability. If a guardian has been appointed that person must also be informed of the residents' rights. The above rights information should also be communicated at least annually.

3. Include in policy provisions for providing residents who choose to leave against medical advice with resource information to make needed contacts.

4. Evaluate practice of restricting residents to the facility with the resident's the right to leave. If not a safety risk and if discharge is imminent, such a restriction may not be appropriate.