FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
JOLIET TERRACE—– 12-040-9010
HUMAN RIGHTS AUTHORITY— South Suburban Region

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

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA) has completed its investigation into an allegation concerning Joliet Terrace. The complaint alleged that a resident was inappropriately discharged from the facility. If substantiated, this allegation would violate the Nursing Home Care (NHCA) (210 ILCS 45/3-401 et seq.), the Illinois Administrative Code for Skilled Nursing and Intermediate Care Facilities (77 Ill. Admin. Code 300.3300) and the Centers for Medicare and Medicaid Services, (CMS) Conditions of Participation for Long Term Care Facilities (42 CFR Part 483).

The 120-bed intermediate care facility located in Joliet reportedly had about 118 residents when the complaint was discussed with the facility staff.

METHODOLOGY

To pursue the investigation, a site visit was conducted at which time the Facility Administrator, the Director of Psychiatric Rehabilitation Services, the Director of Social Services and a Psychiatric Rehabilitation Counselor were interviewed. The complaint was discussed with the adult resident who maintains his legal rights. Sections of the resident's record were reviewed with written consent. Relevant facility policies were also reviewed.

COMPLAINT STATEMENT

According to the complaint, the resident was given a 30-day discharge notice on January 17th, 2012, and he was driven to the train station with all of his belongings. Once there, a staff person reportedly purchased a one-way ticket to Chicago for the resident, but he returned to the facility on that same day. He reportedly was escorted back to the train station by the police and was subsequently hospitalized for behavioral health reasons after he called 911.

FINDINGS

After reviewing the record, the HRA determined that the resident was transferred to the facility from a local community hospital on December 19th, 2011. He was diagnosed with Depression, Schizophrenia, Bipolar Disorder and some physical problems. He was prescribed psychotropic medications and other medications for his physical problems. He had been homeless for about two months prior to being hospitalized. He had previously received treatment for substance abuse in a neighboring state. His communication skills were good, and he was able to make his needs known. His anticipated length of stay was determined to be longer than 90 days during the intake process. The resident's face sheet, completed by the facility, documented that he had Medicaid funding, and a report written by the transferring hospital indicated that he had a pending case for disability benefits. On December 21st, a progress note stated that the resident was cooperative with medication and staff. He was assisted with making calls. He was given some clothing because he did not have any personal property at intake. The note stated that the resident's funding would run out at the beginning of the New Year. The HRA found no documentation of the staffs' efforts to assist the resident regarding this issue.

A "Notice Of Involuntary Transfer Or Discharge And Opportunity For Hearing" form, dated January 10th, documented that the resident had failed, after reasonable and appropriate notice, to pay for his stay at the facility. According to the notice, the resident lacked Medicare or Medicaid funding, and a determination had been made that he did not meet Social Security guidelines for disability. His proposed transfer or discharge date was February 8th, and his alternative living arrangements would be subsequently determined. The two-part form contained a statement regarding the resident's right to request a hearing with the Illinois Department of Public Health (IDPH) within ten days after receiving a copy of the notice. It documented that the resident was given a copy of the notice that contained his appeal rights on that same day. However, the complaint alleged that the resident was provided with a copy of the involuntary discharge notice on January 17th.

On January 10th, a progress note written by the Director of Social Services repeated that the resident was given a 30-day discharge notice because of non-payment for his stay. According to the note, the resident said that "they keep denying me" and that he had been trying to get help for six years. He said that he did not have any family or friends who could help him. It was noted that the resident had been observed with money and that the staff would assist him in finding an alternative placement as needed. On or around January 10th, the progress notes reflected that the resident was transported to a nearby hospital for a psychiatric evaluation because of threats to inflict physical harm on staff and peers. He was not hospitalized and returned to the facility on the same day.

On January 17th, the resident reportedly told the Director of Social Services that he no longer wanted to stay at the facility and that he needed $36.00 for a bus ticket to go back to the state where he had previously received substance abuse treatment. The staff person wrote that she refused to give him money as requested and that he had been soliciting money from others at the facility. According to the note, Joliet Terrace's policy does not permit residents to borrow or accept personal property from each other. Another note (the exact date is unclear) stated that the Director of Psychiatric Rehabilitation Services met with the resident regarding his plan to leave the facility. The staff person then escorted the resident to the train station and purchased two tickets (train and bus) for him. A "Discharge Summary" report stated the resident was

discharged to his family on January 19th, although the record indicated that they lived in a different state.

When the complaint was discussed with Joliet Terrace's staff, the HRA was informed that the resident was pleasant upon his admission to the facility and that he usually made calls on the staff's phone. He reportedly would leave messages for attorneys including those who specialize in Social Security Disability laws and was upset when his calls were not returned. According to the Director of Social Services, the hospital's social worker told her that the resident did not have funding for long-term nursing care. She explained that the resident only had general funding (i.e. Link Card) and that he had refused to sign an application for public aid. She reportedly gave the resident a copy of the discharge notice that contained information about the appeal process because of funding problems. She was willing to help the resident to apply for disability benefits, but he was only focused on leaving the facility. Again, there was no documentation concerning the staff person's efforts to assist the resident in securing funding for long-term care found in the record. According to the staff, the resident wanted to call his attorney after he was given a copy of the notice. He referred to the discharge notice as being "ridiculous." He said that he did not want to be placed on the streets; he did not want to go to a shelter and could not live with his girlfriend. He reportedly was allowed to use the staff's phone to find alternative placement.

The Director of Psychiatric Rehabilitation Services reported that the facility does not issue many 30-day discharge notices. The staff person asserted that the resident was discharged voluntarily from the facility because of his plan to move to another state. He confirmed that he escorted the resident to the train station as indicated in the record. He purchased a train ticket to Chicago and gave the individual $37.00 for a bus ticket to get to his final designation. According to the Facility Administrator, the Director of Psychiatric Rehabilitation Services told her that he gave the resident some money because he wanted to leave the facility. She explained that she was initially concerned that he would purchase alcoholic beverages and street drugs with the money but that the staff usually give residents money when needed. She said that a discharge staffing was not held because the staff were trying to help the resident to stay at the facility. According to the Facility Administrator, the resident came back to the facility to see a female peer about an hour after he was transported to the train station and tried to enter the building through a window. He reportedly was informed that he was not allowed on the premise. He was escorted from the facility by the police.

The HRA was informed that the Director of Social Services is responsible for discharge planning, but she was not involved in the resident's discharge from the facility on January 19th. We noticed that the resident was not given any medication upon his discharge from the facility and that there was no aftercare plan mentioned in the record. The Director of Social Services said that the resident did not appeal the discharge decision with the Department. One day, an Administrative Judge reportedly was reviewing other involuntary discharge cases at the facility, and the resident refused to have his case reviewed. There was no documentation of the staff person's assertion found in the record. Additionally, the staff person said that one resident had lived at the facility for about year before his funding was approved. And, three residents who had problems with funding were allowed to stay at the facility through the Christmas Season last year. She stated that residents will no longer be admitted to the facility pending funding.

The facility's "Involuntary Transfer" policy states that discharge can occur when the individual's medical needs cannot be met the facility, when the individual's behavior represents a serious danger to self or others, when the individual no longer benefits from services, when the individual fails to pay for his care, and when the facility ceases to operate. The policy includes procedures for transferring or discharging residents under non-emergency circumstances. It directs the facility as follows: 1) to notify the resident or legal representative about the reason for the decision and the proposed date of discharge according to the 30-day policy, 2) document the reason for the decision in the resident's record, 3) complete the 30-day notice form provided by the Department and include information about appeal rights and the Long-Term Care Ombudsman Office, 4) to ensure sufficient preparation and orientation for a safe transfer or discharge, 5) to carry out physician's orders regarding the transfer, and, 6) to complete a discharge summary.

CONCLUSION

According to Sections of the NHCA,

> A facility may involuntarily transfer or discharge a resident for the following reasons: 1) Medical reasons; 2) The resident's physical safety; 3) The physical safety of other residents, the facility staff or facility visitors; or 4) Late payment or nonpayment for the resident's stay. (210 ILCS 45/3-401).

> Involuntary transfer or discharge of a resident shall be preceded by discussion required under Section 3-408 and by a minimum notice of 21 days, except in one of the following instances: 1) when ordered by the resident's attending physician because of the individual's health needs; or 2) when mandated by the physical safety of other residents, the facility staff or facility visitors, as documented in the clinical record. The Department shall be notified prior to any such involuntary transfer or discharge. (210 ILCS 45/3-402).

> The notice required by Section 3-402 shall be on a form prescribed by the Department and shall contain all of the following: 1) The stated reason for the proposed transfer or discharge; 2) The effective date for the proposed transfer or discharge; 3) A complete statement regarding the resident's right to appeal; 4) A hearing request form, together with a postage paid, preaddressed envelope to the Department; and 5) The name, address, and telephone number of the person charged with the responsibility of supervising the transfer or discharge. (210 ILCS 45/3-403).

> A request for a hearing made under Section 3-403 shall stay a transfer pending a hearing or appeal of the decision, unless a

> condition, which would allow transfer or discharge in less than 21 days as described under Section 3-402 develops in the interim. (210 ILCS 45/3-404).
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> The planned involuntary transfer or discharge shall be discussed with the resident, the resident's representative and person or agency responsible for the resident's placement, maintenance, and care in the facility. The explanation and discussion of the reasons for involuntary transfer/discharge shall include the facility administrator or other appropriate facility representative. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made part of the resident's clinical record. (ILCS 210 45/3-408).

The provisions above are also guaranteed according to admission, transfer and discharge criteria in the 77 Ill Administrative Code 300.3300 and CMS' Section 42 CRF 483.12. The latter statute also provides for sufficient preparation and orientation for a safe transfer or discharge (42 CRF 483.12 [7]).

The HRA disagrees with the Director of Psychiatric Rehabilitation Services that the resident was voluntarily discharged from the facility. A form, dated January 10th, 2012, clearly documented that he was involuntarily discharged from the facility because of non-payment for his stay. Documentation indicated that the resident was given a copy of notice that contained his appeal rights on that same day. According to progress notes, the resident wanted to leave the facility after he was informed about the discharge decision. He reportedly chose to go back to the state where he had previously received substance abuse treatment. On or around January 19th, the resident was discharged from the facility without sufficient preparation such as medication and an aftercare plan. He was taken to the train station and returned to the facility on that same day. We do not discount the complaint that the resident was given a 30-day discharge notice on January 17th, and he was taken to the train station with all of his belonging, but we found little evidence of this. No violations of the transfer and discharge criteria under the Nursing Home Care Act and the 77 Ill Administrative Code were found.

The complaint alleging that a resident was inappropriately discharged from the facility is substantiated only in regards to the lack of sufficient preparation for a safe discharge. This violates CMS' Section 42 CRF 483.12 (7) and the facility's policy.

RECOMMENDATION

1. The facility shall follow CMS' Section 42 CFR 483.12 (7) and its policy and ensure that residents are provided with safe discharge plans.

SUGGESTION

1. Document staffs' efforts to assist residents in applying for long-term nursing care funding.