FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
RIVIERA CARE CENTER— 14-040-9007 & 14-040-9008
HUMAN RIGHTS AUTHORITY— South Suburban Region

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 complaints alleged that a resident was inappropriately discharged from the facility and that her belongings were not returned on the discharge day. It was also alleged that the resident was given medication daily against her wishes and in the absence of an emergency. 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), 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.5/100 et seq.).

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 had about 197 residents when the complaint was discussed with the facility staff and all of them have been diagnosed with a mental illness.

METHODOLOGY

To investigate the complaints, the facility's Corporate Counsel, the Administrator, the Director of Nursing and the Director of Psychiatric Rehabilitation Services were interviewed. The complaints were discussed with the resident's guardian who gave consent to review her record. Relevant policies were also reviewed.

The HRA was provided with a copy of the resident's Guardianship Order dated October 30th, 2013 that was not part of the record reviewed. This order appoints guardianship over the resident's personal care and finances. We note that the resident maintained her legal rights during her stay at the nursing.

COMPLAINTS SUMMARY

In case #14-040-9007, the complaint alleged that the resident was sent to the hospital for medication management and that the Administrator told the guardian that the resident could

return to the facility when she was discharged from the hospital. Later, a hospital employee told the guardian that the Administrator said that the resident would not be returning to the facility because of aggression toward the staff. In case #14-040-9008, the complaint alleged that the resident was not allowed to refuse medication during her stay at Riviera. She reportedly was forced to take medication daily in the absence of an emergency.

Information from record, interviews and program policies

According to the record, the resident was transferred to the facility from a psychiatric hospital on August 13th, 2013. She was diagnosed with Bipolar Disorder, Hypothyroidism, and other physical problems. She had been hospitalized because of suicidal ideations and non-compliancy with medication. The resident gave signed consent for the administration of Lithium Carbonate, Invega Sustenna 156 mg Intramuscular (IM) monthly, Elavil 75 mg orally at night, Invega 3 mg orally twice daily and Melatonin 4 mg orally at night. There was no recommended dosage range for Lithium Carbonate found on the consent form, but the Medication Administration Records (MARs) documented that 300 mg twice daily was prescribed. Her record also contained physician's orders for Levothyroxine and other medications for her physical problems.

According to the record, the resident's belongings were inventoried on the admission date, and her items were updated twice during her stay at the facility. Her belongings included: 1) a DVD player, 2) a radio, 3) a television, 4) one pair of gym shoes, 5) one pair of slippers, 6) one pair of eyeglasses, 7) two coats, 8) two pairs of pajamas, 9) two sweaters, 10) two brassieres, 11) four pairs of shorts, 12) four night gowns, 13) five suits, 14) six pairs of dress pants, 15) eight pairs of socks, 16) nine blouses, 17) nine pairs of panties, 18) nineteen pairs of jeans, 19) twenty eight shirts, and, 20) some miscellaneous items. The resident signed two of three inventory forms indicating that the items above were an accurate list of her belongings.

There were many entries found in the record documenting that the resident had exhibited inappropriate behaviors at the facility. On August 21st, the resident reportedly walked out of the facility; she was escorted back inside and said that "she just wants to leave." She was placed on 1:1 supervision and monitoring was continued as ordered by the physician. On that next day, a nurse wrote that the resident accepted all of her medications and a social services note referenced that the resident had been compliant with medication since she arrived at the facility. Also, the social services note documented that the resident had poor boundaries and was inappropriate with the staff. But there were no plans to discharge the resident at the time. On the 23rd, the resident refused her medications, and there were no indications that medications were given over her objections. On that same afternoon, the resident reportedly took a staff person's money out of the vending machine, and she had offered to have sex with him for money. It was recorded that the resident became upset and denied being sexually inappropriate with the staff person as mentioned above. Later, she ran out of the facility; she was escorted back inside and said that she was "bored". She was placed on 1:1 supervision again and the physician was notified. On the 24th, the resident's care plan was updated to include: 1) leaving the nursing facility without authorization, 2) making false allegations about the staff and peers, and, 3) being sexually inappropriate toward staff.

On September 7th, a note stated that the resident refused medication and told the nurse "I don't need them dude." As before, there were no indications that medications were given over her objections. On the 14th, it was recorded that the resident was being monitored for possible elopement; and she became frustrated and walked out of the facility without authorization. Two days later, the resident was described as being verbally aggressive toward staff, and she convinced a peer to give her a cup of coffee. Three days later, the resident accused a staff person of being verbally abusive toward her, and the resident's mother was informed. According to the note, the Administrator conducted an internal investigation into the allegation above.

On September 18th, a note stated that the resident ran out of the facility, and she was brought back inside by the staff. Prolixin 5 mg was administered, but this was not documented on the MARs. Also there was no indication concerning the method of administration, but the nursing entry stated that the resident voluntarily accepted the medication. Her record contained a consent form for the administration of Prolixin 5 mg orally or IM every six hours as needed. However, the form appeared to have been signed by someone other than the resident. On that next morning, the resident reportedly accepted her medications without any problems, and monitoring was continued. Later, she walked out of the facility without authorization and said "I am tired of my mom asking me if I want to leave here." Once inside, she started banging on the window at the nursing station, she repeatedly called a nurse a "bitch," redirections failed, and she tried to leave the facility again. On September 20th, it was recorded that the resident told the staff that she was planning on going outside and getting hit by a car. She ran out of the facility and was escorted back inside. Prolixin 5 mg orally was administered, but this was not documented on the MARs.

On September 23rd, the resident was described as being delusional, verbally aggressive toward others, and she tried to leave the facility many times. According to a physician's order, the resident was transferred to a local hospital for a psychiatric evaluation. A nursing note documented that her belongings were packed up and placed in the facility's storage area on that same day. A corresponding inventory form recorded: 1) a coat, 2) a bag with lots of clothing, 3) a television, 4) a DVD player, 5) two pairs of shoes, 6) two pillows, 7) three books, and, 8) six DVD movies. There was no indication that the resident returned from the hospital, and she was discharged from the facility on October 9th. Her record lacked a clear reason for this decision or notice. On October 9th and the 24th, two receipts indicated that some of the resident's belongings were returned to her while she was hospitalized. These items included: 1) a coat, 2) one sweat shirt, 3) one pair of pajamas, 4) two pairs of jeans, 5) two long sleeve tops, 6) five pairs of underwear, and, 7) five pairs of socks. The receipts were signed by the hospital's employee and one of them by the resident.

Riviera Care Center administration told the HRA that the resident was admitted to the nursing facility because she needed more structure. According to the staff interviewed, the resident was verbally aggressive toward the staff and peers. She reportedly "taunted" her peers and told one peer that she should kill herself. She was difficult to redirect. She would leave out of the fenced area around the patio and would taunt the staff to come and get her. She reportedly would become very agitated when she ran out of the nursing facility. Prolixin was administered to calm her. We were informed that the resident was compliant with all medication except for her thyroid medication. The Administrator further reported that she had conducted an internal

investigation because the resident had accused a staff person of being abusive toward her. She said that the resident was not allowed to return to the facility because of her inappropriate behaviors and that the resident's mother had been informed that this might happen. She reported that a phone conference was done at which time the termination decision was explained to the resident, her mother and a social worker at the hospital. According to the Administrator, the resident was discharged from the facility on October 9th, 2013, and the termination decision was not appealed with the Department to her knowledge.

The Administrator further explained that she had encouraged the resident's mother to pursue guardianship. She said that the resident's mother wrote a letter to the facility and requested that a staff member should bring the resident's items to the hospital. She reported that a staff person took a few of the resident's items to the hospital and some of her belongings were returned by mail and her new staff member picked up the rest of her belongings on November 14th, 2013. The Administrator reported that she had replaced the resident's security box, although some of the facility's residents told her that the individual had sold the item. She stated that she replaced the security box to resolve the issue. Her record lacked documentation concerning any missing or replacement items and that her new staff picked up some of her belongings.

According to the resident's mother, she was appointed as the temporary guardian in September, 2013, but she only provided the court order appointing her as the plenary guardian in October, 2013. She said that the resident told her that she routinely ran out of the facility because a male staff member sexually abused her every night. The Illinois Department of Public Health (IDPH), which is the licensing agency for nursing facilities, told the HRA that the IDPH was aware of the allegation above. According to the guardian, she had requested copies of the resident's inventory sheets, but the facility staff never provided them. She said that she provided the staff with a list of items that she had brought to the facility for the resident. She reported that she picked up some of the resident's belongings but was not sure if all of her items were returned.

According to the facility "Psychotropic Drug Therapy" policy, psychotropic medication shall not be prescribed or administered without the informed consent of the resident, the guardian or authorized representative. It states that informed consent is not required for reductions in dosages or the discontinuation of a specific medication. A person's informed consent might provide for a medication administration program of sequential increases in dosages or a combination of medications to establish the lowest effective dosage that will achieve the desired therapeutic outcome.

The facility "Medication Administration Policy" directs that the nursing staff should document all dosages of medication given on the medication administration record.

According to the facility "Medication and Treatment Refusal Policy," when medication or treatment is refused, the resident's record should include at the minimum: 1) the date and time, 2) the specific medication or treatment, and, 3) the reasons for the refusal and the physician's response. For example, the policy states that the Administrator and the attending physician must be informed if medication or treatment is refused at least two consecutive times for three days.

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The facility's admission, transfer and release policies on resident's belongings state that all items will be inventoried at intake and that property sheets will be updated when new items are acquired. Inventory sheets should be signed by the resident, family member or guardian. They will be informed that the facility is not responsible for items lost, stolen or kept at the person's bedside. Items will be inventoried and stored when a resident is transferred or discharged from the facility. The resident, family member or guardian will be notified that the facility might dispose of all items that are not picked up within 30 days after transfer or discharge. The resident or authorized person is required to sign a release form to ensure that all items are returned when a resident is discharged from the facility. All communications regarding a resident's belongings must be documented in the person's chart.

According to the facility "Discharge/Transfer of Resident" policy, a physician's order is required to discharge a resident. The policy also directs the staff on what to do if the resident desires to leave without a physician's order. The policy lacks criteria for a planned or involuntary discharge.

CONCLUSION

According to Section 45/2-104 (a) of the NHCA and Section 300.4040 (c) (3) of the Illinois Administrative Code, every resident shall be permitted to participate in the planning of his total care and medication treatment to the extent that his condition permits.

Also under Section 45/2-104 (c) of the NHCA,

> Every resident shall be permitted to refuse medical treatment and to know the consequences of such action, unless such refusal would be harmful to the health and safety of others and such harm is documented by a physician in the resident's clinical record. The resident's refusal shall free the facility from the obligation to provide the treatment.

And, Section 5/2-107 (a) of the Mental Health Code states,

> An adult recipient of services…must be informed of the recipient's right to refuse medication ….If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent harm to the recipient or others and no less restrictive alternative is available….psychotropic medication or electroconvulsive therapy may be given under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record.

According to Section 45/2-106.1 (b) of the Act,

> Psychotropic medication shall not be prescribed without the informed consent of the resident, the resident's guardian, or other authorized representative. "Psychotropic medication" means medication that is used for or listed as used for antipsychotic, antidepressant, antimanic, or antianxiety behavior modification or behavior management purposes in the latest editions of the American Medical Association Drug Evaluations or the Physician's Desk Reference.

Section 45/3-401 of the NHCA states that,

> 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.

Section 45/3-402 of the NHCA states that,

> 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

Section 45/3-403 of the NHCA states that,

> 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.

Section 45/3-404 of the NHCA states that,

> 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.

Section 45/3-408 of the NHCA states that,

> 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.

The provisions above are also guaranteed according to admission, transfer and discharge criteria in the Illinois Administrative Code (77 Ill Administrative Code 300.3300) and CMS' Conditions of Participation (Section 42 CRF 483.12).

According to the Mental Health and Developmental Disabilities Code Section 5 /2-104 (c),

> When a recipient is discharged from the mental health or developmental disabilities facility, all of his lawful personal property which is in the custody of the facility shall be returned to him.

Complaint #1

The complaint alleged that a resident was inappropriately discharged from the facility and that her belongings were not returned on the discharge day. The Administrator told the HRA that the resident was not accepted back from a psychiatric hospital stay because of aggression toward the staff and her eloping behaviors. It is unclear whether the resident's discharge from the facility was an emergency under Section 45/3-402 of the NHCA because there was no explanation for the termination decision found in her record. The Administrator reported that the termination decision was explained to the resident, her mother (guardian) and a hospital employee during a phone conference. However, this was not documented in the resident's record as required by Section 45/3-408 of the NHCA. The Authority was informed that the termination decision was not appealed with the Department to the Administrator's knowledge.

The HRA is unable to determine whether or not all of the resident's items were returned to her. The resident's record contained three inventory sheets, completed prior to her hospitalization, documenting that she had many items but only two of them were signed by the resident. This violates the facility policy stating that inventory sheets should be signed by the resident or responsible person. The Administrator told the HRA that she replaced the resident's security box, but there was no mention that the item was missing or replaced found in her record. She also said that the resident's new staff person picked up her remaining items, but her record does not support her assertion. This also violates the facility policy stating that a release form

must be signed when a resident's belongings are picked from the facility. According to the guardian, she had requested copies of the resident's inventory sheets, but the facility refused to provide them. She reported that she picked up some of the resident's belongings, but her record only supports that some of the items were sent to the hospital. She told the investigation team that she was not sure if all of the resident's items were returned.

The complaint is substantiated only in regards to the facility failure to follow the discharge criteria under Sections 45/3-402 and 45/3-408 of the NHCA, the Illinois Administrative Code (77 Ill Administrative Code 300.3300) and CMS' Section 483.12 (42 CFR 483.12). The Authority believes that it would be unreasonable to expect the facility to return all of belongings on the discharge day because she was in the hospital at the time. No violations of the Mental Health Code's Section 5/2-104 (c) were found.

COMMENT

The resident's mother (guardian) told the HRA that the facility refused to provide her with copies of the person's inventory sheets. The facility is reminded of the Mental Health and Developmental Disabilities Confidentiality Act, Section 110/4 stating that,

> The parent or guardian shall be entitled, upon request, to inspect and copy a recipient's record. Whenever access or modification is requested, the request and any other action taken thereon shall be noted in the recipient's record.

Complaint #2

The HRA does not substantiate the complaint stating that the resident was given medication daily against her wishes and in the absence of an emergency. However, the resident's record indicated that Prolixin as needed was administered twice after she walked out of the facility without authorization. According to a nursing note, the resident accepted the first dose of Prolixin, but there was no indication concerning the method of administration. Although the second dose reportedly was administered orally, the record lacked clear documentation that she voluntarily accepted the medication. The medication dosages administered were not listed on the medication records. This violates the facility medication administration policy. Additionally, the HRA noticed that the consent form for administration of Prolixin appeared to have been signed by someone other than the resident.

RECOMMENDATIONS

1. Document in the resident's record the reasons for termination decision pursuant to Sections 45/3-402 and 45/3-408 of the NHCA, the Illinois Administrative Code (77 Ill Administrative Code 300.3300) and CMS' Conditions of Participation (42 CFR 483.12) .

2. The facility shall follow its "Medication Administration Policy" and document all dosages of medication administered on the MARs.

3. Ensure that residents or authorized persons sign the individual's inventory sheets according to the facility policy.

4. Document in the resident's record when someone picks up the individual's belongings per the facility policy.

5. To ensure that residents/guardians have sufficient information to give informed medical consent, include medication dosages on medication consent forms.

SUGGESTIONS

1. Ensure that the resident's informed consent is obtained before administering medication.

2. Thoroughly document incidents that warrant prn or emergency medication.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

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CHICAGO HEIGHTS

December 29, 2014

Guardianship and Advocacy Commission

West Suburban Regional Office

P.O. Box 7009

Hines, IL 60141-7009

RE: HRA No. 14-040-9007 and 14-040-9008

The following is the facility response to report of The Regional Human Rights Authority investigation of complaint #14-040-9007 and #14-040-9008.

1. If a resident is involuntarily discharged from the facility, the reason for such discharge will be recorded in the resident's medical record. All Social Service staff have been in-serviced on this procedure. The Social Service Director will monitor to ensure compliance. The facility will continue to follow the IDPH guidelines regarding Involuntary Discharge of a resident. See Attached.

2. All medication administered will be documented on the MAR, per facility policy. Instances requiring PRN medication will also be documented on the MAR. All nursing staff have been in-serviced on this policy. The Director of Nursing will randomly audit to ensure resident MAR's to ensure compliance. See Attached.

3. All Resident Inventory sheets will be signed by the resident or the resident's representative, as able. All C.N.A staff have been in-serviced on the procedure. The Director of Nursing will monitor to ensure compliance with the procedure. See Attached.

4. When a resident's belongings are picked up from the facility, the facility will continue to obtain the name and signature of the individual picking up the belongings as well as the list of the belongings. This information is maintained by the Housekeeping Supervisor.

5. Informed consent, which includes appropriate dosage, will be obtained for administration of all psychotropic medications, per facility policy. All nursing staff have been in-serviced on this policy. The Director of Nursing will randomly audit Psychotropic consents to ensure compliance. See Attached.

Respectfully submitted by,

Heather Bassett

Heather Bassett, Administrator

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