FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
APERION CARE OF MIDLOTHIAN— 16-040-9006 and 16-040-9010
HUMAN RIGHTS AUTHORITY– South Suburban Region

[Case Summary— The Authority made corrective recommendations that were accepted by the service provider. The public record on this case is recorded below; the provider did not request that its response should 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 has completed its investigation into allegations concerning Aperion Care of Midlothian. In case #16-040-9006 and 16-040-9010, the complaints alleged as follows: 1) the staff opened a resident's mail many times without his consent, 2) the resident was inappropriately discharged from the facility, and, 3) the facility failed to safeguard the resident's property.

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, Department of Health and Human Services' (CMS) Requirements for Long Term Care Facilities (42 C.F.R. 483.10 [i] [1]), the Illinois Administrative Code for Skilled Nursing and Intermediate Care Facilities (77 Ill. Admin. Code 300.3210) and the Mental Health and Developmental Disabilities Code Section 5 /2-104 (c).

This 91-bed intermediate care facility located in Midlothian reportedly had about 86 residents when the complaint was discussed with the staff at the site visit. This facility primarily serves people with a mental illness diagnoses.

METHODOLOGY

The complaint was discussed with the Facility Administrator and the Regional Director in closed session at the South Suburban Regional Authority public meeting. A site visit was conducted at which time the newly assigned Facility Administrator, the Director of Social Services and a Psychiatric Rehabilitation Counselor (PRSC) were interviewed. The complaint was discussed with the resident and sections of his record were reviewed with consent. Relevant facility policies were also reviewed.

COMPLAINTS SUMMARY

In case #16-040-9006, the complaint specifically stated the staff opened the resident's mail from an attorney twice without his consent. It was reported that the resident had called the local police on September 1st, 2015 about the staff opening his mail from an attorney. He wanted to be discharged from the facility against medical advice but was hospitalized for calling the police on that same day. Later, he was returned to the facility upon his discharge from the hospital and called the police on October 10th, 2015 because the staff had opened his mail from the Social Security Administration. It was reported that the Facility's Director of Social Services would not allow the resident to talk to the police to make a report when they arrived at the facility. It was reported that the resident was hospitalized because of aggression toward his roommate on that same month. However, the complaint disputes this. It was reported that the resident wanted to return to the facility when he was discharged from the hospital. However, a facility staff person told his sister that he would not be accepted back at the facility. In case #16-040-9010, the complaint stated that the resident's belongings were not returned after he was discharged from the facility. It was reported that the resident's clothing, shoes and especially his black diabetic shoes, Rocawear jacket, Pelle jacket, and other items were not returned.

After reviewing the resident's record, the HRA determined that the resident was placed at the facility on August 19th, 2014. His diagnoses include Major Depression, Schizoaffective Disorder, Blindness, Constriction of Hands, and other physical medical problems. His record contained a copy of the Illinois Department on Long Term Care "Authorization to Inspect and Open Official Correspondence." The form includes a statement that the resident understands his right to receive personal mail that is unopened. But to avoid lost or misplaced mail, the resident authorizes the facility to inspect, open and remove the contents of the following, and that the person will be informed of issues deemed necessary: Social Security, Pension and Veteran's Administration Checks, Correspondences from the Illinois Department of Human Services and the Illinois Department of Healthcare and Family Services, the Social Security Administration, Medicare and medical bills. It was written on the form that the resident gave verbal consent because he is not able to sign the document. The form was signed by a staff person on August 27th, 2014.

The progress notes documented that the resident was angry because the staff had opened his mail and that he was hospitalized at least twice. On September 1st, 2015, the Director of Social Services wrote that the resident was verbally aggressive and refused medication. He called 911 and said that he had been abused and that his rights were violated. He had refused to talk to the police upon their arrival to the facility and said that he wanted to go the police station. On that same day, a nursing note indicated that the resident was sent to a local hospital for an evaluation and took some of his belongings with him. His record lacked property inventory sheets or any mention of the items that he took to the hospital. He was discharged back to the facility from the hospital. On September 25th, the resident was reportedly angry because he believed that the staff had opened his mail. He was informed that the postal services had delivered the letter to the facility with a piece of tape on it to keep it closed. The Director of Social Services wrote that the resident would be given his mail now when two staff members were present.

On October 10th, 2015, the resident was reportedly angry because a letter from the Social Security Administration was given to him without an envelope. According to the progress note,

the Director of Social Services told the resident that the letter was opened by mistake because it was addressed to him and in care of the facility. She reportedly apologized and read the letter to him. She offered to have a staff person to escort him to the Social Security Administration to obtain the information needed and to verify the "authenticity" of the letter. However, the resident remained upset and wanted to call the police to make a report about his mail being opened. Also, it was recorded that the resident had requested to talk to the Administrator concerning this issue and was informed that he would be returning to the facility on Monday.

On October 23rd, 2015, a nursing note indicated that the resident was agitated and physically aggressive towards a female staff person. He reportedly stood up from his wheelchair and tried to provoke a fight with her. He was approached by a social services staff person and was asked to voice his concerns. It was recorded that the resident remained agitated because the night nurse said that he had harassed his roommate. He was non-compliant with Seroquel that had been prescribed during a previous psychiatric hospitalization. He was transported to a local hospital for a psychiatric evaluation as ordered by his psychiatrist. He reportedly took some personal hygiene items to the hospital with him. There was no documentation that the resident had returned to the facility or discharge information found in his record. However, a social services note indicated that he is no longer a client of the facility. According to the social services note, a staff person from the resident's new home had called the facility about his belongings on December 4th, 2015. Three days later, the resident's new staff person was informed that his items had been located. His staff person reportedly said that he would call the facility when he was ready to pick up the resident's belongings. His record lacked indication that the staff person had called the facility back or that his items were returned to him.

Regarding the complaint about mail, Aperion Care's previous Administrator told the HRA that the resident is very intelligent and was placed at the facility more than a year ago. He said that the resident had voiced concerns about the staff opening his mail on three occasions. The Administrator explained that he had opened a letter addressed to the resident from the Social Security Administration. He gave the letter to the resident and told him that the staff would not open his mail again. However, he later inadvertently opened another letter addressed to the resident and the individual would not accept his apology. Also, the Administrator reported that the resident had received a letter from an attorney with a small tear in the envelope. He reported that the staff did not open the letter but the resident was really upset and that the staff was not able to put him at ease. According to the Administrator, some of the facility staff do not want to work with the resident because he has made it known that he has pending law suits against providers.

The staff interviewed explained that the facility's receptionist sorts the mail in two stacks. One stack is for official mail and the second stack is for residents' mail. The activity staff person usually delivers the mail to residents around 4 p.m. and asks them to sign a sheet of paper stating that they did receive their mail. The staff said that the resident can write but his handwriting is not legible. However, he would refuse to sign for his mail. The Director of Social Services recalled that the facility's receptionist was sorting through the mail one day and noticed that two letters addressed to the resident had tape on the back and one of them had a tear on the corner. The HRA was informed that the postal service had delivered the letters in those conditions. The

resident had a cell phone and said that he wanted to call the police. However, he did not call the police to her knowledge.

Regarding the complaint about discharge, the Director of Social Services said that she was working on finding another nursing home for the resident before he was hospitalized in October of 2015. However, she did not send any referral packets to any other alternative placements because the resident never gave verbal consent or told her where to send them. The previous Administrator said that the facility's nursing staff stayed in contact with the hospital. He reported that the resident said that he did not want to return to Aperion Care upon his discharge from the hospital. Later, a hospital's employee said that the resident wanted to come back to the facility but the 10-day bed hold was up and the bed had been filled. The HRA was informed that the resident's sister was involved with him but the Director of Social Services and the PRSC had never talked to her. Also, the HRA was told that the Illinois Department of Public Health had investigated the complaint about the resident being discharged from the facility and found no violations.

Regarding the complaint about personal property, the newly assigned Administrator said that residents' belongings are inventoried at intake and updated during their stay at the facility. The Director of Social Services recalled that the resident was wearing a pair of jeans, a tee shirt, and his diabetic shoes when he was transported to the hospital in October of 2015. The HRA was informed that the resident would tell the staff what items he wanted to take to the hospital with him and that he feels the items' texture to identify them. The Administrator said that the staff do not inventory items that residents take with them to the hospital but their belongings left at the facility will be documented. According to the staff, they never saw the resident wearing a Rocawear jacket or any other designer jacket. The PRSC reported that the resident wore a gray winter coat with a hood during the winter months.

The Administrator told the HRA that the facility's driver dropped off the resident's belongings at his new home. He said that the person who opened the door upon arrival to home would not allow the driver to enter the home or see the resident. We were told that the resident's belongings were inventoried prior to taking them to his new home. However, the staff were not able to locate any of his property inventory sheets. An employee in the facility Human Resource Department told the investigation team that two bags were delivered to the resident's new home. One bag reportedly contained clothing and the other bag consisted of papers (letters). She said that the facility's driver did not get a receipt when he dropped off the resident's items.

The facility's admission policy states that the purpose of the policy is to facilitate a smooth transition to a health care environment. It states that comprehensive information will be gathered as a basis for completing an individualized care plan. The resident and his family will be informed about all of the facility's services. The staff are directed to document the resident's belongings on the "Personal Effects" form.

The facility's Discharge/Transfer policy states that the facility protects the personal effects of a resident who has been transferred or discharged from the program. It states that the resident's personal effects will be inventoried and stored until the individual has returned or his representative has picked them up. The person who picks up the resident's belongings will be

required to sign a release form for the resident's items. According to the policy, the staff are directed to document the disposal of the resident's belongings in his or her record.

CONCLUSION

According to the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities and Section 45/2-108 (a) of the NHCA, "Every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or visitation. The Administrator shall ensure that correspondence is conveniently received and mailed…."

Section 483.10 (i) (1) of CMS' Requirements for Long Term Care Facilities guarantees residents the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.

Section 45/2-111 of the NHCA states 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 45/3-401.1 (a) of the NHCA states that "A facility participating in the Medical Assistance Program is prohibited from failing or refusing to retain as a resident any person because he or she is a recipient of or an applicant for the Medical Assistance Program."

Section 45/3-401.1 (a-10)) of the NHCA states "…a recipient or applicant shall be considered a resident in the facility during any hospital stay totaling 10 days or less following a hospital admission. The Department of Healthcare and Family Services shall recoup funds from a facility when, as a result of the facility's refusal to readmit a recipient after hospitalization for 10 days or less, the recipient incurs hospital bills in an amount greater than the amount that would have been paid by that Department (formerly the Illinois Department of Public Aid) for care of the recipient in the facility…."

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

The Authority substantiates the complaint that the staff opened the resident's personal mail without his consent. The previous Administrator acknowleged that he had opened the resident's mail by mistake. This violates Section 45/2-108 (a) of the NHCA. We cannot substantiate the complanit that the resident's mail from the Social Security Administration was opened without consent. His record contained an authorization form inidicating that he verbally consented to allow the staff to inspect official corrersponderces addressed to him. The Administrator explained that he had opened a letter addressed to the resident from the Social Security Administration. He reportedly told the resident that the staff would not open his mail again after he had voiced concern about this issue.

The Authority cannot substantiate the complaint stating that the resident was inappropriately discharged from the facility. According to the previous Administrator, the resident did not want to return to the facility upon his discharge from the hospital. He said that a hospital's employee later told the facility that the resident wanted to come back but the 10-day bed hold was up and the bed had been filled. No clear violations of Section 45/2-111 of the NHCA were found.

The Authority substantiates the complaint stating that the facility failed to safeguard the resident's property. The HRA was not able to determine what items the resident had during his stay at the facility because his record lacked inventory sheets. However, the facility staff reported that he had belongings and that two bags were delivered to his new home. The staff lacked accountability for the items removed from his room for safekeeping and supposedly released to someone at his new home. This violates Sections 45/2-103 of the NHCA and 300.3210, Title 77, of the Illinois Administrative Code and 5/2-104 (c) of the Code and the facility's policy.

RECOMMENDATIONS

1. Follow the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities and Section 45/2-108 (a) of the NHCA.

2. Ensure that resident's items are safeguarded and returned pursuant to Section 45/2-103 of the NHCA, Section 5 /2-104 (c) of the Code and the program policy.

3. The facility shall follow its policy regarding documentation of residents' personal belongings when they are discharged or their items are removed from the facility's storage areas.

4. Provide staff documentation training regarding inventorying residents' property and disposition of items when individuals are hospitalized or discharged from the facility.

SUGGESTIONS

1. Consider reviewing the Authorization to Inspect and Open Official Correspondence form with the resident, guardian or legal representative annually.

2. The facility's administration should contact the resident and offer to replace some of the resident's missing items or make some monetary reimbursement to resolve this issue.

3. Document in the resident's record all discussions concerning the resident's desire to be discharged from the facility. Document all actual transfers, discharges and readmissions

4. Consider developing a separate and more detailed policy on resident's personal property.