FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
JOLIET TERRACE NURSING CENTER—16-040-9008
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.]

IINTRODUCTION

The South Suburban Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission has completed its investigation into allegations concerning Joliet Terrace Nursing Center. The complaint alleged that: 1) a resident was terminated from the nursing facility without adequate cause and notice, 2) the resident's personal property was not returned, 3) the resident was denied medical care, and, 4) the resident's right to confidentiality was breached by the staff. If substantiated, these allegations would violate the Nursing Home Care Act (210 ILCS 45/2 and 45/3 et seq.), the Illinois Administrative Code (Standards for Skilled Nursing and Intermediate Care Facilities) (77 Ill. Admin. Code Part 300) and the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.).

This 120-bed intermediate care facility located in Joliet reportedly had about 97 residents when the complaint was discussed with the staff at the site visit. The majority of facility's residents have been diagnosed with a mental illness.

METHODOLOGY

To pursue the investigation, the complaint was discussed with the Facility Administrator and the Director of Psychiatric Rehabilitation Services. The resident's peer was interviewed privately at the facility. Sections of the resident's record were reviewed with consent. Relevant facility policies were also reviewed.

COMPLAINT STATEMENT

The complaint stated that the resident was discharged for filing a complaint with the facility's Corporate Office about peers using illicit drugs on the premises. It was reported that the local police came to the facility and told the resident that he had to leave the premises after he had filed the internal complaint with its Corporate Office. He reportedly was not allowed to take his belongings and was later informed that the staff had disposed of his items. The complaint stated that the resident's medical needs were neglected during his stay at the facility. Additionally, the complaint stated that the resident's right to confidentiality was breached by the facility's staff.

FINDINGS

<u>Information from the record, interviews and program policy</u>

The record documented that the resident has a history of criminal behavior but was considered appropriate for admission to the facility on June 4th, 2015. He was transferred to the

facility from a community hospital. He was diagnosed with Major Depression with Psychotic Symptoms, Post-Traumatic Stress Disorder, Diabetes Mellitus and Irritable Bowel Syndrome. The physician's admitting orders included Prozac, Seroquel and other medication for his psychiatric problems. Levaquin and Flagyl for a perianal cyst and other medication for his physical condition and laboratory tests were ordered. The resident's care plan stated that he was ambulatory and was able to make his needs known. It included many interventions such as psychotropic medication, diabetic management, substance abuse treatment, behavioral management and structural programming. A signed inventory sheet of the resident's belongings, completed during the intake process, documented as follows: 1) a wallet, 2) a checkbook, 3) one green/black shirt, 4) one pair of black pants, 5) one pair of shoes, and, 6) two pairs of socks. There was no indication of any other items acquired during his stay at the facility found in his record.

For June, the nursing notes detailed that the resident was compliant with medication. He denied any pain or discomfort from the perianal cyst with the exception of a note written on the 7th. On that day, he reported some drainage from the perianal area, but it was not visible upon assessment. He was seen by the primary physician, the psychiatrist, and eye doctor on that same month. Prozac was increased and changes to his medication for diabetes were made. For July, the resident was seen by the podiatrist, the primary physician, the psychiatrist, and an audiologist. Keflex for cellulitis in the resident's lower left leg was prescribed. He reported having diarrhea and Imodium was ordered. On that same month, the social services notes documented that the resident reported having mood swings, but he was feeling better since the medication change. He said that he was "frustrated" because he had not been able to obtain his belongings back from a former girlfriend. The facility policy on loaning and borrowing from peers was explained. The staff person reportedly called the resident's former girlfriend twice and left messages about his belongings. However, there was no indication that she had returned the staff's person calls. For August, the psychiatrist was informed that the resident wanted a mood stabilizing medication and that he was not sleeping well at night. Seroquel was increased on that same day. It was recorded that the resident vacillated about the effectiveness of the medication change.

For September, the progress notes indicated that the resident had a gastrointestinal consultation for adnominal pain on the 3rd. The nurse documented that the same medication was continued and that she was waiting for an endoscopy procedure to be scheduled. A social services note documented that the resident said that he was feeling better and that his anxiety level had decreased. He was encouraged to tell the staff about any changes in his mood or thoughts. It was recorded that monitoring would be continued and that assistance would be provided as needed. On the 14th, the resident voiced concerns about his medication at his care plan meeting and reportedly believed that his diagnosis should have been Bipolar Disorder. However, he had been seen by the psychiatrist. And, there was no mention of a Bipolar Disorder in his discharge papers from the transferring hospital. According to the progress note, the facility's interdisciplinary team assured the resident that his concerns above would be addressed, and he was satisfied overall with the staff's response. It was recorded that social services would follow up with him.

For September, the progress notes documented that the resident was provided with a copy of the "Resident Incentive Contingency Management Plan" on the 15th. He was reportedly reminded to use the facility's concern/complaint form. He was told where to find the grievance form and what to do with the form upon completion. On the 18th, it was recorded that the local

police came to the facility with a warrant to take custody of the resident. He was reportedly escorted out of the facility by the police. Later, the resident's probation officer told the Administrator that the resident had scheduled court dates and legal problems prior to being placed at the facility. There was no indication that the resident came back to the facility after he was removed by the police. He was discharged from the facility on the 26th. Three days later, the Administrator left a phone message for the resident's probation officer concerning his belongings. There was no more documentation concerning this issue found in his record.

The staff interviewed told the HRA that the resident might have lived with a family member or a friend prior to his admission to the facility. At the HRA's public meeting in closed session, the Director of Psychiatric Rehabilitation Services said that the resident was removed from the facility by the local police due to several outstanding warrants. A 10-day bed hold was done. She said that the resident never called or returned to the facility. At the site visit, the investigation team was informed that the resident's items were placed in a social services staff person's office. His probation officer reportedly never called the facility back concerning his items. The HRA was informed that the resident eventually picked up his belongings. Again, we note that this was not documented in the resident's record. On questioning, the Administrator said that the staff should have documented that the resident had picked up his belongings. She said that all belongings should be documented when they are returned. The investigation team was informed that the facility had developed a new form entitled "Relinquish of Belongings" in March of 2016. The form requires documentation of the items and the number of boxes returned and the person's name who receives them. We were told that the newly developed form was in response to a situation involving another resident.

The resident's peer told the HRA that the resident had belongings and that he had acquired many of them from donations given to the facility. She said that he had asked her to keep some of his items in her room. However, she had refused because she did not want her room to be cluttered. She confirmed that the resident came back to the facility for his belongings after he was removed by the police. She was not able to remember the exact month but said that it was hot outside when he came back. She explained that the resident was not allowed to come inside the facility to get his items. A security employee reportedly came outside and gave him two suitcases that contained his belongings. She reportedly saw at least three pairs of pants and other items when he opened the suitcases. She recalled that the resident said that his gym shoes were missing. She said that the police were called and that the resident was told not to come back to the facility. The investigation team was informed that he returned several times and that his roommate gave him back his gym shoes.

The staff did not remember any complaints about the lack of medical care or confidentiality during the resident's stay at the facility. The HRA was informed that the resident told the staff that his medication was not working and sometimes he said just the opposite. His medication was changed many times and his assigned physician was working with him concerning this issue. According to the staff, the resident believed that he should have been diagnosed with Bipolar Disorder versus Major Depression. He was removed from the facility before an endoscopy procedure could be scheduled. Additionally, the Administrator said that the facility takes confidentiality very seriously and that residents usually slide grievance forms upon completion under her office door. She said that the resident did not file a written grievance during his stay at the facility. The HRA notes that it did not receive specific information about the medical and confidentiality complaints. Subsequently, the Illinois Department of Public Health had followed up with the medical issue.

The Illinois Council on Long Term Care Standardized Admission Packet signed by the resident states that the facility conducts care planning meetings at regular intervals in order to develop the interdisciplinary approach to delivery of care. These meetings are used to discuss any changes in the resident's condition. The facility encourages the resident and family members to participate in the care planning process.

The Illinois Council on Long Term Care Standardized Admission Packet includes a "Notification of Policy Regarding Personal Property" stating that the facility understands the value and importance of everyone's personal property. It includes procedures for investigating lost personal property such as reporting the missing item to the Charge Nurse, the Administrator or designee. According to the policy, the resident, family member or authorized representative should remove all clothing and personal property from the facility within 14 days after the person is transferred or discharged. All property will be considered abandoned after 14 days and the facility will dispose of the items. The policy disclaims any liability for lost or damaged personal property unless placed in the facility secured area for safekeeping of money and valuables. Inventory requirements are not included.

Joliet Terrace Nursing Center's belongings policy is more lenient than the Illinois Council on Long Term Care standards above. It states that the facility protects the personal effects of a resident who has been transferred or discharged from the facility. The policy includes procedures as follows: 1) the resident's personal effects will be inventoried and stored until the individual has returned, 2) the resident, family or guardian will be informed to take the resident's belongings with them or to pick up items within 30 days, 3) the facility will donate or dispose of items that are not picked up within the timeframe above, and, 4) the staff are directed to document step 2 and 3 in the resident's record.

The Illinois Long Term Care Standardized Admission Packet "Notice of Privacy Practices" state that the facility is required by law to keep identifying medical information private. It describes how residents' medical information may be disclosed and how they can get access to this information. According to the notice, the provider may use and disclose medical information for treatment, payment, health care operations and other situations. Residents have a right to restrict or limit the medical information used or disclosed.

CONCLUSION

Section 45/3-401 of the Nursing Home Care Act (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.

Pursuant to the NHCA Section 45/2-103 and 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.

Section 45/2-104 (a) of the NHCA and 300.3220 (d) of the Illinois Administrative Code states that,

> Every resident shall be permitted to participate in the planning of his or her total care and medical treatment to the extent that his or her condition permits.

Section 5/2-102 of the Code states that,

> A resident of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan.

Section 45/2-105 of the NHCA and 300.3220 (k) of the Illinois Administrative Code states that,

> A resident shall be permitted respect and privacy in his medical and personal care program. Every resident's case discussion, consultation, examination and treatment shall be confidential and shall be conducted discreetly, and those persons not directly involved in the resident's care must have his permission to be present.

The complaint stated that: 1) a resident was terminated from the nursing facility without adequate cause and notice, 2) the resident's personal property was not returned, 3) the resident was denied medical care, and, 4) the resident's right to confidentiality was breached by the staff. It was recorded that the police presented to the facility with a warrant to take custody of the resident. He was escorted out of the facility by the police on September 18th, 2015. The staff initially reported that the resident never returned to the facility after he was removed by the police. Later, the HRA was informed that the resident came back for his belongings and was given two suitcases that contained his items. The HRA noticed that the resident's record contained an inventory sheet with only a few items listed on the form. The HRA found no documentation of the items returned to him during the record review. The HRA further notes that specific information about the medical and the confidentiality issue and belongings were not provided. However, the resident's record documented that medical care was provided as ordered by the assigned primary physician and the psychiatrist. He was also seen by a Gastroenterologist, the eye doctor, and a podiatrist during his stay at the facility. The staff was

unable to recall any complaints about the lack of medical care or an alleged breach in confidentiality during his stay at the facility.

The Authority is unable to substantiate the complaint as presented above. No clear violation of Sections 45/2-104 (a), 45/2-105 and 45/3-401 of the NHCA and, 300.3220 (d) and 300.3220 (k) of the Illinois Administrative and, 5/2-102 of the Code were found. However, the HRA finds that the staff lacked accountability for the items removed from the resident's room for safekeeping and supposedly released to him. This violates Sections 45/2-103 of the NHCA and 300.3210 of the Illinois Administrative Code and 5/2-104 (c) of the Code and the facility's policy.

RECOMMEDNATIONS

1. Ensure that resident's items are safeguarded and returned pursuant to Sections 45/2-103 of the NHCA and 300.3210 of the Illinois Administrative Code and 5/2-104 (c) of the Code and the program policy.

2. Follow facility policy regarding documentation of residents' personal belongings when they are discharged from the facility.

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

COMMENT

The Authority is pleased that the facility has developed a new form entitled "Relinquish of Belongings" to protect resident's items left at the facility.