Illinois Guardianship & Advocacy Commission

FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
DORCHESTER SUPPORTIVE LIVING FACILITY 15-040-9002
HUMAN RIGHTS AUTHORITY- South Suburban Region

[Case Summary— The Authority did not substantiate the complaint as presented below, but we made corrective recommendations that were accepted by the service provider although the facility administration disagreed with the HRA's findings. The public record on this case is recorded below; the provider requested that its response be part of the public record.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA), the investigative division of the Illinois Guardianship & Advocacy Commission has completed its investigation into allegations concerning Dorchester Supportive Living Facility. The complaint stated that a resident was inappropriately discharged from her supportive living program. Additionally, the complaint alleged that the resident's personal property was not returned at discharge. If substantiated, these allegations would violate the Illinois Administrative Code for Supportive Living Facilities (89 Ill. Admin. Code Part 146 et seq.).

Located in Dolton, Dorchester Supportive Living Facility offers residents independent living options and daily supportive services. The 126-bed facility reportedly had 40 residents when the complaint was discussed with the facility staff.

METHODOLOGY

To pursue the investigation, the Facility Assistant Director of Operations and two Registered Nurses were interviewed. The complaint was discussed with the resident's son and her agent for Power of Attorney for Health Care. Sections of the resident's record and a copy of her Durable Power of Attorney for Health Care, dated March 17th, 2010, were reviewed with consent. This document appoints the resident's granddaughter, who lives in a nearby state, to make health care decisions for the individual if she is unable to make them. Relevant policies were also reviewed.

COMPLAINT STATEMENT #1

The complaint stated that the Facility Assistant Director of Operations told the resident's son that the individual had been transported to a local hospital for a mental health evaluation and to go pick her up because she could not return to her residential placement. Once there, the hospital's social worker told the family member that the resident could not be abruptly discharged from the facility, and she was transported back to her residence. On that next day, the family member was notified that the resident had been discharged from the facility and the same administrative staff person threatened to report him for abandonment if he did not pick her up.

FINDINGS

Information from the record, interviews and program policies

The HRA determined that the resident was admitted to Dorchester Supportive Living Facility with diagnoses of hypertension and dementia in 2011. A one-year "Lease Agreement" signed by the resident on October 15th, 2013 indicated that she would occupy a specific apartment unit within the facility under the Illinois Administrative Rules for Supportive Living Facilities (SLF). It stated that an initial services plan would be developed upon the commencement of her residency. The facility would provide assistance with activities of daily living, medication management and other services based on the resident's services plan. The services plan would be reviewed at least quarterly or more frequently if the resident's health status or family circumstances change. Residents must be capable of self-preservation. The resident's care plan, dated October 15th, 2013, included problem areas such as activities of daily living, urinary incontinence, and cognition. It documented that she needed to be reminded to take medication and social and recreational activities would be offered. There was no clear indication concerning the resident's capacity to make her own decisions or the need to include her POA in her care.

The nursing notes indicated that the resident was seen by a physician routinely from January to August 2014. A Quarterly Health Status Evaluation report, dated April 18th, 2014, documented that the resident was socially appropriate and compliant with medication. And, there were no recommendations or follow up services needed at the time. Two months later, a Computed Tomography (CT) Scan, completed during the resident's hospital stay for chest pains, showed age related atrophy with severe periventricular small vessel disease. For August 2014, the nursing entries documented that the resident had started to refuse medication. Her record contained two incident reports reflecting that her behavior was no longer appropriate at the facility. It documented that her physician and family were informed about the change in her behavior. However, there was no mention that the resident's agent for health care was specifically notified.

According to the first incident report, the resident was confused and was observed with a fork in the living room on August 14th, 2014. It was recorded that a staff person took the fork from the resident and then left the object unattended while providing care for another client. The resident "grabbed" the fork and the object was taken from her again. According to the incident report, the resident said that she had the fork because a peer had her purse and she wanted it back. The second incident report stated that the resident had pulled out a knife on a security employee at the facility on August 24th, 2014. She then went outside on the patio and initially refused to go back inside of the facility. Once inside, she was described as being angry, and she set off the security alarm system when she tried to go down the stairwell. A corresponding nursing note stated the resident was observed going out of the facility's exit doors at 11:30 p.m. She told a staff person that she had a "butter" knife in her purse and would stab him with the object. It was recorded that the resident's family came to the facility and took her home with them for the night upon notification.

On August 25th, 2014, a nurse wrote that the resident's family was notified that she had been transported to a hospital for a mental health evaluation. She was diagnosed with Dementia and was sent back to the facility on that same day. The investigation team found no documentation that the resident's family member was informed that she could not return to the

facility after having a mental health evaluation as stated in the complaint. However, her record contained a "Notice of Involuntary Discharge" form, dated August 25th, 2014, documenting as follows: 1) the resident needs mental health services to prevent harm to self or others, 2) the facility cannot meet the resident's needs with available support services, and, 3) the resident poses an immediate threat to self or others. The effective date of the discharge was August 25th. The three-part form contained a statement regarding the resident's right to request a hearing with the Illinois Department of Healthcare and Family Services (IDHFS) within ten days after receiving a copy of the notice. It also included the Department's address and toll free number for filing an appeal. There was no documentation of any discussion with the resident or her health care agent concerning the termination decision. We found no written evidence that a copy of the notice was provided. Also, her record lacked indication of phone calls or correspondences with her designated representative regarding her care. The resident's son told the HRA that the facility did not provide a copy of the notice. He said that the resident was admitted to a hospital's geriatric behavioral health unit after she was discharged from the facility.

According to the facility's staff interviewed, the resident was admitted to the SLF on October 15th, 2011. Her primary diagnosis was hypertension and dementia was secondary. She was provided with assistance with activities of daily living, urinary incontinence and medication reminders. She sometimes would refuse medication. The Facility Assistant Director of Operations, who reportedly has been employed with the facility since the new management took over in July 2014, said that the resident sometimes was friendly with a certain female peer. He reported that the resident had accused the same peer of stealing her belongings and sometimes would "bang" on her door at night. He said that the previous Administrator told him that the resident had been having conflicts with the same peer "for some time." The investigation team was informed that the resident had altercations with other peers at the facility and that her family believed that the incidents were "unfounded." A nurse reported that she had observed an incident between the resident and a female peer. She said that an incident report should be written when a resident threatens a peer. However, we found only one incident report suggesting that the resident had a fork because she wanted to get her purse back from a peer in her record.

The HRA was informed that a resident's care plan is updated only when there is a significant change in the person's health or behaviors. Family members are notified when residents are sent to the hospital. They are informed that residents can return to the facility post-hospital discharge. We were told that the resident's son went to the hospital upon notification that she had been transported for a mental health evaluation. He called the facility and asked if the resident could return after the mental health assessment. She was allowed to return to the facility for only one day. The Facility Assistant Director of Operations said that the resident is a "wanderer" and requires 1:1 staff support. However, her services plan does not support this. He said that the facility was no longer able to meet the resident's needs because the program does not offer the service above. The facility does not have a special program for Alzheimer and related disorders. Her family was given information concerning other facilities. The resident reportedly was given a copy of the involuntary discharge notice and a copy was mailed to her agent of health care. However, we found no evidence to support this in the records provided. The investigation team was not able to verify whether or not the resident's health care agent received a copy of the notice because her phone number is disconnected. The administrative staff person denied threatening to report the resident's family member for abandonment if he did not pick up her on the discharge day as stated in the complaint.

Dorchester SLF lease agreement includes criteria for termination of lease and its discharge policy. It states that the facility will provide assistance so that residents can remain in their homes for long as it is safe to do so. It outlines conditions under which the lease agreement might be terminated by either party. The facility's policy mirrors the Illinois Administrative Rule 146 that requires a written 30-day notice of termination of lease and discharge when the facility can no longer meet a resident's needs. A request for a hearing shall stay the discharge decision, except in an emergency discharge. The facility will ensure a safe and orderly discharge to protect the health, safety and rights of the resident.

The facility's policy on grievances states that all residents will be given a copy of its complaint procedures. These procedures will be thoroughly explained to them. Per the policy, the facility's procedures provide a process for reviewing grievances through administrative means but it does not waive the right to judicial proceedings. Any resident or applicant who believes that he or she had been adversely affected by an act or a facility employee failure to act may request an administrative hearing to resolve their complaints. Any grievance concerning an eviction or termination of tenancy involving threats to harm other residents or employees shall be excluded from the grievance process.

CONCLUSION

According to the 89 Illinois Administrative Code Section 146.245,

> d) The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.
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> h) The SLF manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in a resident's mental or physical status is observed by staff. Except in life-threatening situations, such reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and the resident's designated representative immediately. The SLF staff shall be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities.

According to Section 146.250 (c) (14), all residents have the right to be treated at all times with courtesy, respect and full recognition of personal dignity and individuality.

According to termination criteria under the Section 146.255,

> a) If a resident does not meet the terms for occupancy as stated in the resident contract, the SLF shall not commence involuntary

discharge until the SLF has discussed the reasons for involuntary discharge with the resident and his or her designated representative. Documentation of the discussion shall be placed in the resident's record.

b) The SLF shall provide a resident with a 30-day written notice of proposed involuntary discharge unless such a delay might jeopardize the health, safety, and well-being of the resident or others. A copy of the notice required by this subsection (b) shall be placed in the resident's record and a copy shall be transmitted to the resident and the resident's designated representative. The notice shall be on a form prescribed by the Department and shall contain all of the following: 1) The stated reason for the proposed discharge, 2) The effective date of the proposed 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 discharge.

c) The SLF shall prepare plans to ensure safe and orderly involuntary discharge and protect resident health, safety, welfare and rights.

d) A resident may be involuntarily discharged only if one or more of the following occurs: 1) The resident poses an immediate threat to self or others, 2) The resident needs mental health services, 3) The resident has breached his or her contract, 4) The SLF has had its certification terminated, suspended, not renewed, or has voluntarily surrendered its certification, 5) The SLF cannot meet the resident's needs with available support services, 6) The resident has received proper notice of failure to pay from the SLF, or 7) The resident exceeds the SLF's policy for what constitutes a temporary absence from the SLF.

e) The notice required under subsection (b) of this Section shall not apply in either of the following instances; however, a notice and right to appeal information must still be provided: 1) when an emergency discharge is mandated by the resident's health care or mental health needs as documented in the resident's record. The SLF may consult with the attending physician for additional support on the emergency discharge or 2) when the discharge is mandated to ensure the physical safety of the resident and other residents as documented in the resident record.

> i) The SLF shall offer relocation assistance to residents involuntarily discharged under this Section, including information on available alternative placements. A resident or his or her designated representative shall be involved in planning the discharge and shall choose among the available alternative placements. Where an emergency makes prior resident involvement impossible, the SLF may arrange for a temporary placement until a final placement can be arranged. The SLF may offer assistance in relocating from a temporary to a final placement.

The Authority does not substantiate the complaint stating that a resident was inappropriately discharged from her supportive living program. The resident was discharged from the SLF on August 25th, 2014 under emergency circumstances, which does not require a 30-day notice, if the individual is unsafe to self and others under Section 146.255 (e). The notice contained a written statement of the resident's right to appeal the termination decision as required by the Section. The Facility Assistant Director of Operations reported that the resident and her agent of health care were given a copy of the notice. However, we found no evidence to support this. The HRA found no clear violations of termination criteria under the Illinois Administrative Sections above or program policy. However, the facility violates the resident's right to a supportive service plan. According to the staff, the resident had wandering and aggressive tendencies issues. However, her services plan does not support a change in her behavior as required by Section 146.245 (d) and the program lease agreement. Also, the resident's record does indicate that her agent of health care was notified about the change in her behavior as required under Section 146.245 (h).

RECOMMENDATIONS

1. Follow the Illinois Administrative Code, Section 145.245 (d) and the program lease agreement and update services plans when there is a change in a resident's behavior.
2. Follow the Illinois Administrative Code, Section 145.245 (h) and notify a resident's designated agent when there is a change in a resident's behavior.

SUGGESTIONS

1. Although the facility's staff reported that the resident had altercations with several peers, this was not found in her record. Document behavioral incidents to support problems between residents and the steps taken to resolve them.
2. The Authority must caution the facility about the lack of documentation in the resident's record regarding decisional capacity, contacts with significant others and the discharge notice. We suggest that proper documentation should be discussed with the staff.

COMPLAINT STATEMENT #2

The complaint alleged that the resident's belongings were not returned and that the facility continued to spend her Illinois Link Card (food stamps) after she was discharged from her program.

FINDINGS

Information from the record, interviews and program policies

On August 26th, 2014, a nursing entry stated that the resident's family took most of her belongings when they picked her up at the facility. According to the note, the resident's family said that they were going to come back for her other items. On that next day, the resident's son

called the facility and requested another copy of her medical card because the document had been misplaced. Whether or not the facility provided the document or the disposition of her other belongings were not mentioned in her record. We found no indication of phone calls or correspondences between the facility and her designated representative regarding her care in her record. We also found no mention that she had a Link Card (food stamps) as stated in the complaint.

According to the facility staff, the apartment unit previously occupied by the resident is locked and some of her items are still in the apartment. Her family reportedly was informed that her items needed to be picked up within 30 days after she was discharge from the facility or that a fee would be charged to remove them. However, they have not contacted the facility about picking up her belongings. The investigation team was informed that Medicaid-eligible residents are required to give their food stamps to the facility under the Rules for SLF. We were told that the resident's Link Card was never used because the facility is still in the process of getting approval to become the designated food stamps agent.

Dorchester's lease agreement states that the facility is not liable for damage or loss of resident's belongings. The facility may store or dispose of a resident's items and storage fees will apply if the person's belongings are not claimed within 30 days of the resident's apartment being vacated or one's death. Also, the lease agreement states that meals will be furnished and that the facility will be the designated service vendor for Medicaid-residents eligible for food stamps and will debit food stamp dollars from their accounts.

CONCLUSION

According to the 89 Illinois Administrative Code, Section 146.205,

> Room and Board" means the housing, utilities and meals provided under the resident contract. Unless otherwise specified in the resident contract, room and board does not include phone or cable charges.
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> Services" means the personal and health care related services provided by an SLF.

According to Section 146.225,

> b) The payment rate received by the SLF from the Department for services, with the exception of meals, provided in accordance with Section 146.230 shall constitute the full and complete charge for services rendered. Additional payment, other than patient credits authorized by the Department, may not be accepted. Meals are included in the room and board amount paid by the resident.

The Authority does not substantiate the complaint stating that the resident's personal property was not returned at discharge. According to a nursing note, the resident's family took some her belongings on August 26th after she was discharged from the facility. Her family reportedly told the nurse that they would come back for her other items. However, the Facility Assistant Director of Operations reported that the resident's remaining items are still her apartment. We were also informed that the facility is in the process of getting approval to be the designated service provider for Medicaid residents eligible for food stamps and that the resident's Link Card (food stamps) was never used. The HRA finds no violations of the program policy on resident's belongings or the Illinois Administrative Section above.

SUGGESTION

1. The facility should notify the resident’s family that her belongings are still at the facility and waive the storage fee.

RESPONSE

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

SENIOR LIVING / BUSINESS & BANQUET CENTER
1515 E. 154th Street Dolton, IL 60409 (708)841-5560 FAX (708)201-7038

RESPONSE TO FINDINGS
DORCHESTER SUPPORTIVE LIVING FACILITY 15-040-9002
HUMAN RIGHTS AUTHORITY – South Suburban Region

RESPONSE TO RECOMMENDATIONS:

1. The Authority stated "the facility violated the resident's right to a supportive service plan. According to the staff, the resident had a wandering and aggressive tendencies issues. However, her services plan does not support a change in her behavior as required by Section 146.245 (d) and the program lease agreement".

   The facility disagrees with the above statement. According to the nurses notes and an incident report on the evening of 8/24/2014 Mrs. Shorter had tried leaving the building, upon being approached by a staff member, threatened to stab the individual with a knife (this being the second time Mrs. Shorter either threatened or attempted to stab an employee or resident with a dangerous object). Two more staff members tried to persuade Mrs. Shorter to return into the building but she angrily refused. Upon returning into building Mrs. Shorter then tried exiting the building again through an emergency exit door setting off the alarms. Medical Doctor and family were notified. At 11:30p family arrived and took Mrs. Shorter home with them. Nurses notes for the day of 8/25/2014 state that Mrs. Shorter was sent out to the hospital for evaluation (with discharge paperwork), family was notified. Per our nurses notes resident returned from the hospital with the evening of 8/25/2014. This overnight stay was with the agreement from the family that they would return 8/26/2014 to pick up resident as she was involuntarily discharged from the facility on an emergency basis.

   As clearly documented in the nurse's notes, the timeframe in which these incidences took place that ultimately lead for us to issue an emergency involuntary discharge there would not have been a need to update Mrs. Shorter's service plan. If Mrs. Shorter was to remain a resident within the facility, then as required by the administrative code the service plan would have been updated.

2. The residents designated agent had been contacted on multiple occasions. Per the documentation that the facility has, Mrs. Shorter's designated agent was her son Anthony Shorter. The first incident since new management was brought into the building was 8/14/2014. Mrs. Shorter's son Anthony Shorter (resident's designated agent) was contacted immediately by facility administration. Mr. Shorter informed us that he would be into the building to discuss the incident. Mr. Shorter arrived to the facility after business hours after an altercation between Mr. Shorter and the reporting CNA. Mr.

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1515 E. 154th Street Dolton, IL 60409 (708)841-5560 FAX (708)201-7038

Shorter meet with administration where Mrs. Shorter's recent behavior was discussed. He was informed that this behavior was not tolerated and was grounds for immediate dismissal. He informed administration that mom has always been a person to make threats but "wouldn't hurt a fly". After a brief discussion about the dangers etc… Mr. Shorter said he would be talking with the rest of the family and getting back to us to discuss the further plans. That following day administration was contacted by the Daughter Elaine Shorter to discuss the incident as well. The second and final incident on 8/24/15 both the facilities nurses notes and incident report shows that the resident's designated agent was contacted immediately following the incident. In both incidents leading to the emergency discharge of Mrs. Shorter, the administrative code 145.245 (h) was followed and the residents designated agent was made aware of the resident's behavior.

After a detailed review of the two recommendations presented by the Authority and an even further review of Mrs. Shorter's file and incident reports leading up to Mrs. Shorter's discharge. We were not able to find where staff did not follow the Administrative Code, Section 146.245 (d) and Section 146.245 (h). However, in light of the circumstances we did hold an in-service to go over service plans and when they should be updated, proper protocols for reporting and to whom to report such incidents, and proper documentation. Along with the recommendations all suggestions made by the Authority have been reviewed, noted, and or incorporated into our procedures. The Dorchester Supportive Living Facility will continue to strive to provide excellent care to all of or our residents while upholding the Illinois Administrative Code part 146.