Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008304	A. BUILDING: _____ B. WING _____	C 10/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TERRACE OF MCHENRY REHAB	803 ROYAL DRIVE MCHENRY, IL 60050

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S 000	Initial Comments Complaint Investigation Survey 1815647/IL105341	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.3210a) 300.3210o) 300.3240a) 300.3300j) 300.3300k) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.3210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law based on their status as a resident of a facility. o) The facility shall also immediately notify the resident's family, guardian, representative,	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Section 300.3300 Transfer or Discharge j) 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 or discharge shall include the facility administrator or other appropriate facility representative as the administrator's designee. 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 a part of the resident's clinical record. (Section 3-408 of the Act) k) The facility shall offer the resident counseling services before the transfer or discharge of the resident. These Regulations were not met as evidence by: Based on interview and record review the facility failed to allow a resident to remain in the facility. The facility also failed to have care and services arranged for the welfare of a resident prior to	S9999		

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discharge. The facility also failed to provide medically related social services by not ensuring social services participated in identifying, planning and providing for individual discharge needs of the residents. These failures resulted in R1 being discharged from the facility on 8/23/2018 to a community center that does not provide housing and R3 signing R3's self out against medical advice(AMA) from the facility on 7/27/2018 with no housing address to discharge to.

This applies to 2 of 5 residents (R1, R3) reviewed for medically related social services and discharge in a sample of 35.

The findings include:

1. R1's EMR (Electronic Medical Record) shows that R1 was admitted to the facility on 6/27/17 with diagnoses including Chronic Obstructive Pulmonary Disease, Respiratory Failure, Alcohol Abuse and Major Depression.

On 8/28/18, V1 (Administrator) stated, "On 8/21/18 (R1) fell and started bleeding but he refused to go to the hospital. The doctor told us to monitor him. We suspected him of being intoxicated. We don't know if he had any alcohol (no evidence found) not sure if someone brought some in to him or if he went out and got some. Staff never actually saw him drinking. We tried to get him to sign a behavioral contract and he refused to sign it. He said just let me go. He said he wanted to leave so we set up a taxi to the Firehouse Shelter."

R1's Incident Report dated 8/21/18 states, "Around 2:00AM (R1) was asking for a Band-Aid for his chin, prompted what happened , he said he fell in the toilet and claimed hitting his chin on

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the sink. About 3cm shallow cut observed in his right chin and also a bruise to his right shoulder. Minimal bleeding was noted. Resident is on Coumadin (anticoagulant) 15mg. Prompted to call (V13- R1's physician) and ordered to send the resident to ER for eval and treatment... Resident refused to come with (Ambulance) personnel and even refused to sign the refusal form... Resident recalled that he fell because he felt light headed and hit his chin on the sink." The Notes at the end of this same document written by V19 (Restorative Nurse) dated 8/24/18 (The day after R1 was discharged from the facility) state, "Resident was asking nurse for a band aid and stated that he fell while washing himself up he felt dizzy and slipped hitting his chin on the sink. Nurse called MD and tried to send resident to the ER, resident refused. Resident smelled like alcohol and staff suspected he was intoxicated which contributed to his fall. Resident put on 15 min check."

R1's EMR shows a Resident Behavior and Conduct Contract dated 6/18/18 signed by resident. This form states: Behavior to improve: Going out on pass and buying alcohol- drinking alcohol at the facility. There are no progress notes in R1's EMR showing that this behavior occurred before or after this contract was signed.

R1's Care Plan dated 7/31/18 states, "Resident demonstrates socially inappropriate behaviors as evidenced by being sexually inappropriate with staff. R1's Care Plan dated 7/10/18 states, "(R1) has a history of substance abuse. His drug of choice is alcohol. His last instance was July 2018."

R1's Behavior Assessment dated 7/31/18 states, "Resident became inappropriate with staff

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member, he grabbed the staff member by the hips while the staff member was bending down. Resident was suspected of drinking."

R1's Minimum Data Set of 8/17/18 shows that R1 had some verbal behaviors (1-3 days of assessment period). This same assessment shows that these behaviors had no impact on resident or others.

R1's Progress Notes throughout his stay at the facility do not document any social service involvement with R1.

On 10/10/18 at 1:00PM V31 (RN) stated, "(R1) came out and asked me for a Band-Aid. He said he fell and bumped his chin. He said he tried to stop the bleeding; there was a streak of blood in his sink. I assessed his chin and gave him a Band-Aid. He kept saying it was no big deal. I did not notice (R1) to be drinking. If I thought he was drinking, I would have put it in my notes. He did not smell like alcohol. I am not aware of (R1) ever drinking or being drunk while in the facility."

On 10/10/18 at 1:20PM V3 (Social Service) stated, "V1 came to me and told me that R1 had had these behaviors so I did the behavior assessment. Then that prompted the initiation of the care plan."

On 10/10/18 at 1:50PM V3 stated, "I try to do the bulk of the discharge planning for most residents. I set up the services. For (R1) I was not really involved. He and I did not have a good rapport. He never wanted anything to do with me. I think it was because whenever he was caught drinking, I was the one that had to talk to him. I only did that a couple of times. V1 was working with him more and she would come and check my work. I didn't

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have have much to do with R3. In terms of his discharge, V1 did that." V3 continued, "V1, V12 (Memory Care Unit Director) and a Social worker from another facility were doing social services while I was new. They should have been documenting in the medical record whenever they were involved with the residents."

On 10/10/18 at 2:00PM, V19 stated, "I got the information (Resident smelled like alcohol and staff suspected he was intoxicated which contributed to his fall) from what V31 wrote or else what he told me. I'm not sure where else I would have gotten it." V19 stated she knew of R1 drinking through hearsay but stated that she had never actually seen him drinking. V19 also stated she was not aware of R1 having any behaviors and stated that R1 was very quiet and interacted very little with the staff or other residents.

R1's Progress Notes dated from 6/27/17- 8/23/18 do not document any behaviors of R1 drinking alcohol in the facility, being drunk in the facility or displaying socially inappropriate behaviors with staff.

On 10/10/18 at 2:50PM V32 (Care Plan Coordinator/ RN) stated, "I'm sorry but we were unable to find any documentation in the progress notes that (R1) was drinking in the facility. The only thing we have is the risk management assessment (incident report) but that was written after he was discharged and the behavior contract showing his behavior dated 6/8/18."

On 10/11/18 at 11:00AM, V1 stated, "R1 was alert and oriented and he was the one who didn't want to participate in the discharge planning. He said said fine, get me out of here. V3 would go and talk to him and he would say, do whatever. My

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definition of a safe discharge- making sure what they have when they go home. If they don't have a home then we would look for some place for them to go or talk to the family or look for another appropriate setting. R1 going back to live in his care would not be appropriate, I'm not sure how R1 was supposed to get his PT/INR done. I'm not sure if I ever had any contact with the Firehouse Shelter."

R1's Progress Notes written by the Nurse Practitioner dated 11/27/17 states, "He reports that he has been in detox a few times. His last drink was early August. He reports he has been sleeping well with adequate (oral) intake. Staff deny aggressive behaviors, no s/s of anxiety."

R1's Progress Notes written by a Nurse Practitioner dated 4/23/18 states, "Care discussed with nursing staff. Nursing staff denies any concerns or changes."

R1's Progress Notes written by the Nurse Practitioner dated 5/30/18 states, "He reports that he has been in detox a few times. His last drink was early August. He reports he has been sleeping well with adequate (oral) intake. Staff deny aggressive behaviors, no s/s of anxiety... Staff and social work notes reviewed."

R1's Physician's Order Sheet shows an order dated 8/22/18 states, "Discharge home with Home Health."

R1's Progress Notes written by V3(Social Worker) dated 8/23/18 state, "When attempting to do discharge paperwork with resident he became non-complaint and non-responsive to this writer. He did not want to tell writer who his PCP is and did not want to be involved in making

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S9999	Continued From page 7 discharge plans." R1's Nurse's Noted dated 8/23/18 state, "Resident discharged to Firehouse Center in Woodstock. Resident verbalized understanding of discharge medications. Left via taxi at 1200 noon, gave all meds except Tramadol {Analgesic} which he says he doesn't need. " On 8/28/18 at 11:00AM V3 (Social Service) stated, "I was not too involved. The discharge came from {V1- Administrator}. I tried to do discharge paperwork with (R1) but he was not very cooperative with making discharge plans. He went to the Old Firehouse, it is a homeless shelter. People live there and they offer free services. I called and left a voicemail for them. Never spoke to anyone but I have sent people there before. They have transitional programs and are staffed from 8:00AM-3:00PM but they are open 24 hours a day. They help people find housing." On 8/28/18 at 1:40PM V11 (R1's daughter) stated, "My dad called me the day before and told me that he was being discharged for walking in the halls, smoking and drinking. When I went to talk to them the next day they said I was only the emergency contact. I told them that they called me two days before when he fell but I guess him leaving the facility is not an emergency. They said they tried to get him to sign a behavior contract and he refused. He does not recall being given a choice. He should have been given 30 days. He won't get his social security check until October so that 30 days would have been nice and at least allowed us some time to make arrangements for him. I don't think he wanted to leave knowing that he had no place to go. He thought the Firehouse was a place he could stay.	S9999		

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I paid my brother to drive him to Rockford because someone told him if he goes to the hospital there another facility would take him. He is at {local} Motel tonight. I had his car towed so that gave him $100. He has enough money to stay one more night. He can't stay with me, we have tried that before and it didn't work. He will be homeless as he was before. He was just lucky enough to stay at {facility} for the past year."

A written statement by V1 dated 8/24/18 (typed and presented to surveyor on 8/29/18 and not part of R1's EMR) states, "Daughter came to facility asking what happened to her father and why he had been discharged from the facility. I explained that resident had a fall and staff reported that he had been drinking. I let her know that we were not trying to kick (R1) out of the facility but we were trying to work with him and have him sign a behavior contract. I explained that on the behavior contract it addressed his drinking, smoking, sexual inappropriateness with staff and going into resident's room without knocking but that (R1) had refused to sign the behavior contract. (R1) was the one that stated to just get me out of here; I explained that he was alert and oriented and that he was his own decision maker."

On 8/28/18 at 2:00PM, V9 (Registered Nurse) stated, "(R1) went to the Woodstock Firehouse Center- Homeless Shelter. They (V1 and V2) tried to make a contract with him and he refused to sign it so they discharged him. He said, I just want to go. I wasn't there for the conversation. I did touch base with him and sent him with his medication {Current med list shows resident receiving the following medications: Coumadin (Anticoagulant) 14mg, DuoNeb (Bronchodilator) 0.5-2.5mg/ml, Folic Acid (Supplement) 1mg,

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Multivitamin (Supplement), Sertraline (Antidepressant) 50mg, Thiamine (Supplement) 100mg}. He needs a PT/INR (blood test) who was going to meet up with him to do that? I write the order but social service sets it up. He has respiratory issues and can run into trouble easily. I don't think he could live at home with his daughter. Several residents go to the gas station to get alcohol. On one incident they said he was drunk. I didn't think he was drunk... He left in a Uber or something, or taxi, (V1) set up his ride..."

On 8/28/18 at 12:00PM V4 (Old Firehouse employee) stated, "We are not a homeless shelter. Our day service is open 9:00AM- 3:00PM Monday through Friday. There is nowhere to sleep here. (R1) yes, I know him. He came here and claimed he was told by {facility} that there were places to sleep here. He came in asking where the beds are at. He was told this was a shelter. I told him no. I reached out to another facility in the area. (R1) spoke to someone there. This person said that (R1) was not a good fit for their facility but said he could go to {another facility in a city 30 miles from here} if he went to the hospital in {that city}. He went all the way to {city} and that fell apart, {facility} would not accept him because of what {current facility} said about him. He was here {Firehouse} yesterday. He has no phone. I don't know where he went after he left here. I tried my best to get him somewhere to go. He was scared. He said that {facility} never worked on getting him housing or anything. Never got him on any listings for housing."

On 8/29/18 at 12:35PM, V6 (Ombudsman) stated, "I was completely unaware of this. Even if he wanted to leave the facility he has to leave to a place that provides his level of care. If they are paying for an Uber and determining the

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destination, the destination better be a place that the resident can live and have some type of existence. A resident can leave on their own accord but the facility has to have determined that the destination is appropriate for them."

On 8/30/18 at 12:15PM V13 (Physician) stated, "(R1) was there long term. He has bad COPD (Chronic Obstructive Pulmonary Disease) and he is pretty weak and having some difficulty with ambulation." V13 was asked if he was aware that R1 had been discharged from the facility. V13 stated, "I was told he no longer needed skilled care and he was getting along well. All of his needs were pretty much custodial." V13 was asked if he thought it was safe for R1 to be discharged from the facility with no place to live. V13 stated, "I empathize for that but I don't really know what the requirements of the facility are in terms of that. I told them as long as he has his regular medications; he is chronically ill, and if he is only using the facility as a means of housing then it was okay for him to be discharged." V13 was asked why Home Health Services were ordered if R1 only required custodial care. V13 stated, "We pretty much use home health as a transition to minimize the risk of re-hospitalization. Almost all residents that are discharged from long term care are referred to home health." V13 was asked if he was aware of R1 having any behaviors while in the facility and if any type of rehab services had been offered to R1. V13 stated, "Yes I had heard that he was intoxicated and the RNs were quite upset about that. There were no other behaviors that I am aware of. I think the nurses had talked to him about rehab but the first step would be for him to acknowledge that he had a problem and he was not at that point."

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The facility policy entitled Discharge or Transfer, Involuntary dated 11/2017 states, "The facility must provide sufficient preparation and orientation to the residents to ensure safe and orderly discharge. This must be documented in the resident's record." This same policy states, "The facility shall assist the resident in arranging alternative living arrangements. All assistance will be documented in the resident's record."

The facility Social Service Director job description dated 1/2015 states, "Initiate, facilitate and/or participate in the written discharge plan which states the resident's specific need to be in the facility or if the resident is expected to be able to function in a more independent setting. The discharge plan should include consultation with other disciplines, the family and of course the resident.

2. The electronic medical record for R3 lists his diagnoses to include: hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, suicidal ideations, major depressive disorder, alcohol abuse with intoxication, and alcohol dependence with withdrawal delirium.

The minimum data set for R3 dated July 2, 2018 shows, he has severe cognitive impairment.

The facility's care conference review form for R3 dated June 26, 2018 shows, "R3 was present and his friend, was phone conferenced in. Therapy will be ending Friday, due to insurance. Explained to R3 that we need to do a couple more things before figuring out the next step after therapy. Plans are to do a neuro/psych eval to determine if R3 has decisional capabilities. Once

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that eval is done then we can make further plans."

The progress notes by nurse practitioner for R3 dated July 23, 2018 show, "63 year old male seen on 500 unit, lying in bed. He was alert, in NAD (No apparent distress), with calm demeanor. With interview, he repeatedly asked "I don't know what is going on". He has significant impairment with short- term memory loss. Resident had moderate flight of ideas with loose associations. His orientation was to self only, with difficulty answer some questions. He stated he was in a hospital in local city, uncertain of year, POTUS (President of the United States) was Obama. He stated several times he wants to go home, reporting he feels depressed..."

The last progress noted for R3 dated July 27, 2018 shows, "Resident alert, oriented x3 and wanted to sign AMA (against medical advice), resident signed AMA papers and pick up by his friend." (Friend not listed in electronic medical record under contacts).

The facility's against medical advice form: release from responsibility for discharge for R3 dated July 27, 2018 shows, R3 signed the form.

On August 29, 2018 at 11:33 AM, V1 Administrator stated, R3 was here for about a month or so. "He was the one who wanted to leave the facility. A couple of times he was trying to walk out and the receptionist tried to stop him. He was very persistent on leaving the facility. We were working on getting a neuropsych (consult) on him. He wasn't necessarily able to verbally communicate his needs. He was a gentlemen who was homeless. He ended up going to a local city. His friend picked him up that day. We had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008304	A. BUILDING: _____ B. WING _____	C 10/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TERRACE OF MCHENRY REHAB	803 ROYAL DRIVE MCHENRY, IL 60050

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13	S9999		

conversation with him and tried to educate him on the importance of trying to stay here. The doctor stated, if he was alert and oriented then he is his own decision maker. He did have some confusion."

On October 10, 2018 at 1:02 PM, V30 R3's Medical Doctor stated, "at times R3 was lucid and at times he was confused. Psych was following him and give us advice on if he was able to live in the community or not."

The psychological evaluation for R3 dated July 22 & 24, 2018 shows, "Test results indicate R3 presents with symptoms indicating moderate-sever cognitive deficits... After careful consideration of the results of this assessment, a diagnosis of Unspecified Moderate Neurocognitive Disorder has been assigned. For R3, this is characterized by the development of multiple cognitive deficits manifested by memory impairment and moderate-severe disturbance in cognitive functioning. As is often consistent with many individuals with dementia, it appears R3 may not have a realistic understanding of his deficits and may underestimate his needs when outside of a nursing home setting. R3 also has a history of alcohol abuse, alcohol dependence, recurrent major depression and a history of suicidal ideations that may further hinder his abilities to truly understand his cognitive impairments."

(A)