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HUMAN RIGHTS AUTHORITY-NORTH SUBURBAN REGION

REPORT #20-100-9010
LAKE BEHAVIORAL HOSPITAL

Introduction
On October 1, 2019, the North Suburban Regional Human Rights Authority (HRA) began an investigation of possible rights violations regarding care for a recipient of adult inpatient services at Lake Behavioral Hospital (LBH). The specific complaints under investigation are the following: upon admission the patient was denied pain medication for 24 hours; the bathrooms were dirty; food services were inadequate (hot food was served cold); patient supervision was inadequate (other patients were not prevented from entering the recipient's room); telephones were not readily accessible to patients; staff did not provide the recipient with a five-day notice of discharge form upon request.

Investigation findings could substantiate violations of the following sections of the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5/):
- Adequate and humane care and services (sections 1-101.2): stating that mental health services must be *"reasonably calculated to result in a significant improvement of the condition of a recipient of services confined in an inpatient mental health facility"*
- Voluntary Admission (section 3-400(b)(2)): stating that a recipient of services may *"request discharge at any time. The request must be in writing. . ."*
- Communication under sections 2-103(a)(b)(c), stating: *"a recipient who resides in a mental health . . . facility shall be permitted unimpeded . . . communication by . . . telephone. . . The facility director shall ensure that . . . telephones are reasonably accessible. . . Reasonable times and places for the use of . . . may be established in writing. . .*

Lake Behavioral Hospital (LBH) is a 146-bed state-of-the-art hospital offering inpatient and outpatient mental health and substance use treatment for adolescents, adults, and senior adults. LBH has been operational since March 2018. At the time of the services being investigated in this report, LBH was in its old facility on a floor of Vista Medical Center East, with 46 beds in their adult inpatient unit.

The North Suburban Human Rights Authority thanks the administration of Lake Behavioral Hospital for their full cooperation in this investigation.

Method of Investigation
To proceed with this investigation, the HRA reviewed the recipient's clinical record (with

authorization) from Lake Behavioral Hospital (LBH). Due to North Suburban HRA personnel changes and subsequent COVID-19 protocols the HRA was not able to conduct a site visit between 2019-2021. The HRA obtained additional case information through a phone conversation and emails with LBH administrators. The HRA also reviewed relevant LBH policies provided by the hospital administrator.

Case Summary

The recipient was admitted to Lake Behavioral Hospital on September 4th at 11:15 pm. The record contains the application for voluntary admission signed by the recipient to indicate that they have read and understood The Rights of Voluntary Admittee listed on the application, including the right to request a five-day discharge in writing.

A "Demographic Information" form completed September 4th indicates that the recipient was *"complaining of intense pain".* An intake assessment indicates that the recipient has a medical history of Fibromyalgia and recent pelvic surgery. The Initial Nursing Assessment dated September 5th at 12:20am indicates that the recipient rated their pain at "20" on a Wong-Baker FACES pain rating scale of one to ten. The recipient's intake assessment documents that she could be considered a danger to herself, and that acute inpatient psychiatric care was necessary due to suicidal ideations and increased depression related to her chronic pain. A note in the record from September 5th at 1:15am indicates the recipient was given 650 mg of Tylenol for back pain complaints.

The patient was transferred to the adult inpatient unit on September 5th at 3:15am. A note in the record dated September 5th at 9pm indicates *"Pt signed 5-day stating, 'I don't belong here".* The record contains a Request for Discharge form signed by the recipient on Thursday September 5th at 8:50pm. There is no documentation in the record to inform when the recipient might have requested this discharge form. According to the record and confirmation from LBH administrators the recipient was discharged five business days later on Wednesday September 11th at 9am.

There is no documentation in the record regarding any phone restrictions, and there is no documentation regarding recipient complaints about inadequate staff supervision, unauthorized entry to the recipient's room, unhygienic bathroom facilities, or cold food. In January 2021, The HRA spoke with an LBH administrator about a potential site visit (still prohibited by COVID-19 protocols), as well as the complaint about food services, sanitation, and telephone availability. The hospital administrator disclosed that LBH has been housed in a new building since June 2020, but that at the time of the complaint the in-patient psychiatric unit was housed on a single floor at Vista Medical Center East. The administrator explained this was an older and small building which was not ideal for LBH's capacity. At the time of the services being investigated, food was sent in from an off-site cafeteria facility which could explain the complaint about cold food. The administrator also explained that the new LBH building has an on-site cafeteria and at least two phones on each of their inpatient units. In January 2023 a different LBH administrator confirmed that prior to June 2020, food services were delivered to the hospital three times per day by an outside vendor.

Policies
The HRA reviewed relevant Lake Behavioral Hospital Policies. LBH's Request for Discharge Against Medical Advice policy is well-aligned with the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5/). The procedure for discharge request includes *"Assessment or referral staff review in writing and verbally with the . . . patient . . . the patient's right to request discharge (Ref: 405 ILCS/5/3-400 and 5/3-502) . . . in writing."*

The provider's Schedule for Cleaning policy indicates that bathrooms are cleaned daily, but that *"cleaning is done according to the schedule or more frequently as necessary."* This policy seems to meet the standard for Adequate and Humane Care (405 ILCS 5/1-101.2). In response to a request for their phone policy, LBH furnished the HRA with their Open Adult Patient phone times which at the time of services being investigated were daily from 11am-12pm and 6pm-6:45pm.

Findings
This investigation found the complaint that Lake Behavioral Hospital denied the recipient pain medication for 24-hours upon admission to be ***unsubstantiated***. There was ***not enough evidence available*** around the issues of the dirty bathroom, food services, or patient supervision to substantiate a violation of ***adequate and humane care and services*** (405 ILCS 5/1). This investigation found the complaint that LBH violated the recipient's right to reasonably accessible phone communications under **405 ILCS 5/2-103(a)(b)(c)** to be ***substantiated***. This investigation found that the complaint the provider violated the recipient's right to be discharged under Voluntary Admission statute **405 ILCS 5/3-400(b)(2)** to be ***unsubstantiated***.

Analysis
This investigation found evidence that the patient was administered a high dose of Tylenol within a few hours of admission. However, due to the protracted length of this investigation, there is not currently enough evidence about the sanitary conditions, patient supervision, or issues with food services. The provider's move to a brand-new facility with on-site food services in June 2020 will have likely resolved some of those issues, and the HRA has no complaints of similar issues with LBH since then.

Regarding restricted access to telephones on the unit, the Illinois Mental Health and Developmental Disabilities Code states that: *"a recipient who resides in a mental health . . . facility shall be permitted unimpeded. . . communication by . . . telephone. . . The facility director shall ensure that . . . telephones are reasonably accessible. . . Reasonable times and places for the use of telephones and for visits may be established in writing by the facility director.* (405 ILCS 5/2-103(a)(b)(c))

Lake Behavioral Hospital's phone hours demonstrated that patient phone use was restricted to one hour and 45 minutes per day, which the HRA believes does not rise to the standard of *"reasonable access"* set by the Code. If availability of phones was an issue at the time this recipient received services, the hospital should have provided patients with an alternative to increase their telephone access.

This investigation did not find evidence that the provider violated the recipient's right to be discharged under Voluntary Admission statute 405 ILCS 5/3-400(b)(2). The case documentation shows that the recipient signed a Request for Discharge form on September 5th at 9pm, which was about 22 hours after admission. There is nothing in the record to indicate if, or when the recipient requested this form prior September 5th at 9pm. However, the HRA found evidence that the recipient had been made aware of their right to request discharge in writing, which does not specify that this request must be made on a special form. In any case, the recipient was released within five business days of September 5th, which would not have changed if the request for discharge was submitted earlier in the day.

Recommendations

1) Increase Open Adult patient phone time to a reasonable time frame. (The HRA ***suggests*** at least four hours per day)
   - Provide the HRA with proof of new Open Adult patient phone times.