



FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY – PEORIA REGION
REPORT OF FINDINGS

Case #24-090-9003
Carle Methodist Hospital

INTRODUCTION:

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations involving services at Carle Methodist Hospital. The allegations are as follows:

- 1. Inadequate treatment**
- 2. Patient rights violation**
- 3. Inhumane care**
- 4. Failure to provide timely medical care.**
- 5. Failure to complete inventory of personal items**

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-100) and other hospital regulations. The facility receives patients statewide, excluding Cook County. There are 23 to 25 staff members employed in the Emergency Department (ED), including nurses, mental health technicians, certified nursing assistants (CNA), a recreational therapist, and a psychiatrist. Staff estimated between 1500 - 2000 patients present to the emergency department with mental health needs yearly. The HRA also reviewed, with authorized written consent, the service recipient's record. Based on a review of the website, the hospital is accredited through the Centers for Medicare and Medicaid Services (CMS).

Complaint Statement

The complaint alleges a patient was transferred from a local hospital for behavioral health admission and they have no recollection of this process. Allegedly, when they admitted to the floor, they were wearing the wrong patient bracelet, did not receive the appropriate involuntary admission paperwork, and were yelled at by staff when the fire alarm was activated. The patient was admitted from 8/4/23-8/24/23. The allegation also states a patient received unknown medications resulting in bruising to their upper left arm, and that medications were given without informed consent or receiving a rights restriction

notice and possibly given while in a physical restraint during the patient's admission process. Further allegations state nursing staff refused to give the remote to the patient for an interim medical device for bladder control which requires skin to skin contact when used, to control the intensity of this device when using the restroom. Allegedly, the patient was hospitalized for behavioral health care for approximately 21 days and this care resulted in 17 instances of incontinence and staff blamed the patient for the situation and did not help address hygiene needs. Another allegation is that, prior to admission for behavioral health care a patient had experienced a fall that resulted in an injury. This injury was not properly diagnosed until the final week of the inpatient hospitalization. Allegedly, it was discovered that a patient had a fracture of their L5 vertebrae discovered after a CT scan was ordered and completed. The treatment team was reportedly delayed in ordering a CT scan. Lastly, the allegations state that due to unit staff not completing an inventory of personal belongings when transferred/admitted to the behavioral health unit, the patient lost personal items; particularly, a wedding ring and car keys which continue to be missing.

Interview with staff (12.05.2023)

Carle Methodist Healthcare has two inpatient units to treat patients with acute mental health needs. The recipient for this case was directly admitted to 6 West with 22 beds. A patient can be admitted to the unit on a voluntary or involuntary process. The floor employs Registered Nurses (RN) each shift with a lead nurse, 3 master's degree level Clinicians, a Discharge Coordinator, a Utilization Manager (for insurance processes), a Nurse Manager, Mental Health Technicians with a bachelor's level degree, and Certified Nursing Assistants. The average number of patients assigned to a nurse each shift is 1:8 or 1:7. The unit has three Psychiatrists. The unit also has Resident Physicians that rotate the unit. The unit has access to a tele-psychiatrist if needed. Only RNs and LPNs pass medications.

The Admission or Transfer process to the unit was summarized. A patient arrives to the floor. Their belongings go into a separate room during the admission. This is a separate inventory process. The patient can be present. No contraband is allowed on the unit. A patient could keep jewelry on depending on their precaution level and safety needs. If they are on suicide precautions, they would not wear jewelry, and an order would be needed for the suicide precaution. These decisions would all be made on a case-by-case basis. The HRA inquired about mental health patients that require a special medical device, such as in this circumstance. The treatment team would need to understand the purpose of the device by talking with the providers and then it would be evaluated. For example, insulin pumps, ostomy bags, breathing machines such as CPAPS or BIPAPS would be evaluated by respiratory. Also, there are evaluations for patients who use wheelchairs, and canes. The team also considers the level of need for each medical device and if they can meet the higher level of care needed on the mental health floor. An alternative would be considered. If a patient is refused a medical device due to suicide risk, it would be a rights restriction. For example, alternative treatment methods can be provided for insulin needs. Another example was a neurostimulator. The treatment team does not have a lot of experience with this type of device and would

require a decision to be made about usage. The provider would enter the order to manage whatever medical device can be supported by the mental health team on a case-by-case basis. This patient was using a bladder device with which the unit did not have experience. The remote to the device did not arrive with the patient upon admission and was brought to the unit by the husband a few days after admission.

The admission assessment is based off of whatever is ordered by the provider. A person is always medically cleared prior to admission for behavioral health care. Pain is assessed, and medications are ordered; there is also a visual assessment of pain and scaled pain assessment used by staff. If a patient reports pain, they are provided some type of medication or other options to manage pains such as with movement. The nurse would then follow-up after an hour of whatever treatment intervention was provided. Nursing would always report to the Medical Provider any patient reporting pain or discomfort. Staff on the behavioral health unit navigate patient pain complaints on a regular basis. Sometimes the complaints are somatic and part of a person's delusions or symptoms of their mental health diagnosis. The attending provider assesses the complaints and attempts to differentiate between physical pain and somatic complaints. The unit does not want unnecessary testing to be completed, however if it is ordered and found to be necessary to treat the whole patient, then the test could be ordered, and a quick response is usually had to facilitate the ordered testing.

If a physician orders a patient to not keep something on their person or is determined to be at-risk due to safety concerns, a rights notice would be completed and provided to the patient. This form would be used when personal property is removed from the patient, such as no shoes due to safety precautions. The unit provides clothing to their patients.

The HRA inquired about the first three allegations. The service recipient was a transfer to Carle Methodist 6W from another area hospital due to behavioral health care needs. The sending hospital started the involuntary admission process. The recipient arrived at the unit with the petition and two certificates completed on 8/4/23. Once a recipient arrives to the unit the provider will assess and determine if they are candidates for voluntary admission. The involuntary admission and voluntary admission process were discussed with recipient. Paperwork was reviewed and rights were discussed. She became a voluntary admission. The recipient had to understand decisional capacity, where they were, that the unit is locked, and that they are choosing to stay on a locked unit. The voluntary application was completed on 8/11/23 and witnessed by a clinician. This application also documents the recipient having their rights reviewed with them. The unit does have folders that are provided for patients to store paperwork.

The Unit Medical Director, who is a Medical Doctor in Psychiatry for 6W, has known the recipient from treatment ten years prior. Her presentation for this admission was worse than the Psychiatrist's experience with the recipient in the past. She was admitted with the diagnosis of Manic, Bipolar I and was medically cleared by the sending hospital. The 6W Treatment Team had a plan to proceed with the involuntary admission process and go to court. They did not end up going to court. The recipient's erratic behavior changed after medications were restarted. The chart does not document any evidence of the

recipient having the “wrong bracelet”. The recipient arrived at the unit from another hospital and would have had that bracelet on from the prior treatment. No complaints of the “wrong bracelet” were documented at discharge or in the summary of discharge. The recipient’s husband was very involved with the treatment process. He was part of the discharge and was who received the recipient when discharged. The Psychiatrist and Resident Psychiatrists had good and direct conversations with the husband. Family meetings were held with his involvement. There was a concern with Lyme disease and a medical issue with the medications that were ordered to treat this history of Lyme disease. More diagnostic testing was delayed due to the recipient’s other delusional thoughts and the timeline of what was being reported.

The fire alarm did go off during the inpatient admission. They are loud but they are necessary. The Behavioral Health Director did speak directly with the recipient, and she reported that staff hid in the bathroom and the recipient was worried about staff being scared. The unit is mandated to occasionally run fire drills. On 8/15/23 the alarm/drill was mentioned as going off “four times”. Someone did pull the fire alarm on a different floor. Internal protocol does require evacuation of patients if told to do so. Staff would not yell at a patient but might talk loud because of the noise level of the fire alarm. When the alarm goes off the patients go to the middle of the hallway. A patient could be redirected by staff and that staff could be speaking loudly over the sound of the fire alarm.

The recipient was never in a physical restraint. No orders were found in the chart. The 6W team states she could have been restrained in the ambulance, but they did not know that detail. The recipient did not receive any intramuscular emergency medications.

The recipient did require a remote for a medical bladder device called an Interstim. The unit staff were not familiar with this type of medical device. There was an order entered for Urology to consult on 8/14/23 due to the recipient verbalizing that this device was causing her pain. She was worried that it had been “knocked out of place”. The recipient was ordered for direct staff care 1:1 due to fall risk. She was incontinent while admitted. Staff assisted her with extra levels of care when this occurred. She had assistance from staff to use the toilet. The chart record documents the recipient being incontinent on 8/5/23 and staff helped change gowns. The recipient expressed pain and could minimally maneuver in bed. The Behavioral Health Director again met with her, and the recipient told her she could not feed herself. The Psychiatrist ordered an x-ray of the lumbar spine on 8/16/23. This was completed on 8/20/23; the reason for the x-ray was to check the Interstim device location and incidentally found the fracture. The orthopedic department became involved at this point recommending a brace and routine pain medication. Ibuprofen was provided routinely and as needed. The recipient was inconsistent with reporting. She claimed the sending hospital had dropped her and would tap her forehead saying she has a traumatic brain injury. She did have a lidocaine patch ordered. She did have some bruising that was assessed as being old and “pale in color” upon admission. She was assessed for pain each shift. If the recipient was sleeping, she would not be woken up. If she required scheduled pain medications, then she would have been given the medication. The recipient verbalized pain regularly twice a day and up to seven times

a day. The bladder stimulator was the “confounder” for the treatment team. The original thinking was this device was causing the pain and then the L5 vertebrae fracture was incidental and was close to the stem device. The recipient signed acknowledging her ordered medications and/or provided verbal understanding of her medications. On 8/20/23 a brace was ordered for the recipient to wear when up. This was not needed at nighttime. The fracture was stable. The recipient was to follow-up at the outpatient level.

The HRA inquired about the allegation regarding a property inventory, and the unit’s process for recordkeeping a patient’s personal items on an inventory sheet. A Personal Inventory was completed with the recipient. The hospital’s own Patient Advocacy Department was involved. The original inventory does not document a ring, purse or keys being on the unit. Rings would not be removed but could be put on inventory checklist which staff would sign. The hospital does have a safe that could be used for wedding rings or cash over \$30. The recipient had several inventory sheets completed on different days during her admission. Keys could be kept locked in a drawer behind the nurse’s station or other valuables. The recipient had a lot of concerns with her patient care experience.

The unit can be loud. The recipient required medical and behavioral health care. The sending hospital was responsible for medical clearance prior to the admission. The unit was involved with assessing and treatment, communicated regularly with the husband, and it was a teaching case due to a past diagnosis of dissociative identity disorder. The treatment team assessed somatic complaints daily and chronic pain was mentioned; fibromyalgia was mentioned, and Lyme Disease was mentioned. Staff explained that the treatment team did not ignore her concerns.

FINDINGS

COMPLAINTS #1- Inadequate Treatment and #2- Patient Rights Violation,

For clarity within the report, the HRA has combined the information found through the investigative process for allegations #1, and #2.

Involuntary Admission Timeline:

The recipient was transferred to Carle Methodist from another area hospital for a behavioral health admission on Friday, 8/4/23. The recipient was a direct admission to Carle Methodist’s 6W. Based on site interview information, the recipient was medically cleared at the sending hospital prior to admission for behavioral health care at Carle Methodist.

Day 1 of treatment began as an involuntary admission on a Friday evening; the first hospital completed the “Petition for Involuntary Admission” along with one certificate with a date of 8/4/23 and a time of 4:45pm. The recipient then transferred to Carle Methodist and was directly admitted to the behavioral health unit. Upon admission a Registered Nurse with Carle Methodist completed pages 4 and 5 of this legal paperwork.

These two pages are part of the involuntary petition documentation and when signed indicates the staff did the following “I certify that I provided respondent a copy of this form. (Pages 1-5)”. The Carle Methodist RN attests to the following statement when signing this form “Within 12 hours of admission to the facility under this status and/or completion of a new petition. I gave the respondent a copy of this petition (IL465-2005). I have explained the rights of the admittee to the respondent and have provided him/her with a copy of it. I have also provided him/her with a copy of Rights of Individuals Receiving Mental Health and Developmental Services (IL462-2001) and explained those rights to him/her (405 ILCS 5/3-609).”

On day 2 of the admission, a “Mental Status Exam” was completed by a Resident Psychiatrist and signed by the Attending Psychiatrist and documents the following “Sensorium: alert Orientation: Oriented to person, place, time, and situation. General Appearance: Well-groomed. Gait/Behavior/Motor: ambulating in wheelchair due to inability to stand and walk secondary to pain and lack of sensation ... Attitude: Normal and appropriate. Mood: Euthymic Affect: Full. Speech: Spontaneous, regular rate and rhythm and Excessive. Thought Process: Tangential. Thought Content: No thoughts of harm to self or others and Paranoia. Perception: Normal. Memory: Normal memory for immediate, recent, and remote. Concentration: Intact Fund of Knowledge: Intact. Insight: Poor. Judgment: Poor.”

On day 2 of the admission, this same Resident Psychiatrist documented a phone call with the recipient’s husband. In this conversation the Resident Psychiatrist documented the reported fall on 7/22/23, other issues with Lyme Disease and being prescribed a placebo medication to treat. The recipient stopped taking her medications on or around this same day. The husband also explained that he felt the recipient’s pain was causing her to have difficulty ambulating and cooperating. The husband also reported that a remote is needed for a bladder stimulator device that is called an Interstem device. “He would bring the remote to the unit.” It is also noted, “No less physically restrictive setting is reasonably available to provide safety and needed care. Unless otherwise noted, patient understands burdens and benefits of recommended and current care, including common and serious medication risks, has had any questions and concerns addressed, and consents to the plan as outlined above.”

In the morning of day 4, a Monday, the second Inpatient Certificate was completed by Carle Methodist Psychiatrist and is signed by the Examiner attesting to the following statement “*I personally informed the above-named individual of the purpose of this examination and that he or she did not have to speak to me, and that any statements made might be related in court as to the individual's clinical condition or need for services.*”

On day 4 at 3:23pm the Mental Health Professional documents “E-filed for involuntary court enforced hospitalization” On day 4 a Psychosocial Assessment completed by the Mental Health Counselor (MHC) documented speaking with the recipient about involuntary commitment versus voluntary admission and the patient stated she would not sign any papers or take medication until labs were performed then she would do whatever the treatment team wanted. Staff documented telling the recipient that if she was staying

involuntarily then she will be “served with court papers”. Patient acknowledged this as documented saying, “That’s fine. I will elope from the unit.” The Mental Health Counselor (MHC) communicated this to nursing staff.

On Day 6 at 7:13pm a “UICOMP Psychiatry Residency Teaching Service History and Physical Exam” addendum was completed by a Resident Psychiatrist for the recipient. The addendum documents that the recipient was admitted to 6W with “manic-like behavior” with a history of “bipolar disorder, borderline personality disorder, dissociative identity disorder, depression”, from 8/4/23-8/24/23. The Assessment completed by the Resident Psychiatrist documented “46 y.o. female patient admitted for concern for manic-like behavior. Patient reports past psychiatric history of bipolar disorder, borderline personality disorder, dissociative identity disorder, depression. Patient's biggest concern is chronic pain that she understands is from her diagnosis of chronic Lyme disease. Patient has difficulty ambulating, therefore sitting in wheelchair and requiring assistance. Patient presents with mania, likely primary diagnosis of bipolar 1 disorder. Patient's primary symptoms are mania, paranoia, delusional content (mainly somatic delusions). There is concern of psychotic features with manic episode versus primary psychosis. At this time, plan to treat bipolar 1 disorder with Seroquel. Continue to reassess to see if there is improvement in psychotic features and determine if an additional medication may be of benefit.” There is a section titled “Problem List” and lists “Principal Problem: Bipolar I disorder, current or most recent episode manic, severe with mixed features and psychotic features (HCC) Concern for Unspecified Psychosis Concern for Delusional Disorder R/o Brief Psychotic Disorder R/o adjustment disorder” The following medications were ordered “**Increase Seroquel 200 mg nightly** Resume PTA Synthroid 75 mcg Continue to hold PTA Zoloft 100 mg due to concern for mania.”

On day 6, the treatment team met to review the recipient’s plan of care documenting the following: “Due to the patient's current medication nonadherence with no improvement, the treatment team recommends court enforced medications for up to 90 days. The patient has not been consistently compliant with medications while in the hospital. Due to the patient's lack of insight into her mental illness and medication noncompliance it has resulted in a dangerous environment inside and potentially outside of the hospital. She is unable to care for herself and remain safe outside of a supervised setting. The patient's family and treatment team feel that it would be beneficial for the patient to be ordered for court enforced medications for up to 90 days. Should the court find the patient is not appropriate for court enforced medications, the treatment team believes the patient will have little to no improvement and likely further deterioration. If the patient is not court ordered for enforced treatment, she will be discharged without a safe discharge plan. Both her mother and husband do not agree that the patient is safe or appropriate for discharge without the aid of medications.” On day 6, a petition for court enforced medication was completed by the Attending Psychiatrist. The Dispositional Report is also written and attached to the petition by an MSW and addresses the recipient’s inability to make a reasoned decision about the treatment. On day 6 the MHP (Mental Health Professional) documented electronic filing of legal documentation for court enforced medications. The recipient’s husband was also updated on the hospital’s intent to file for enforced medications. There is also a treatment team note entered that

documents the husband and mother agreeing that the recipient needed medications to be safe to discharge. The record provided does not reflect if this report was provided to the recipient. On Wednesday day 6, the Medical Director along with the MHP prepared a Dispositional Report to present in mental health court for court enforced medications. On day 6 of the admission, the MHP documents "Provided pt with order for hearing for involuntary commitment. Explained that she will also be given another order for hearing for involuntary treatment once received from the court. This writer explained the difference between the two hearings as well as the process. ... An order for a hearing was electronically filed."

On Day 8 a Resident Psychiatrist met with the recipient and documented the following progress note "Patient slept 3 hours overnight. Staff notes continue to endorse patient exhibiting manic and psychotic thinking. Patient continues to endorse 'naturally cleansing and de-escalating staff'. Patient did not have episode of incontinence overnight. Patient evaluated bedside. Patient was consistently manic and continues to exhibit signs of psychosis during the interview however was more reasonable and redirectable during the time of the interview. ... Patient has been compliant with lithium which she reports 'it is natural'. Patient has also been compliant with Seroquel. Patient is happy with the current medication regimen and a continuance for court will be filed today. ... Patient also reports that she 'will sign in voluntary.'"

On day 8, the Voluntary Application was signed by the recipient and witnessed by an LPC (Licensed Professional Counselor) and a nurse. The LPC also signed on behalf of the Facility Director. This application documents the individual being assessed to have capacity stating, "the above person has been examined and is considered clinically suitable for voluntary admission, that the individual has the capacity to consent to voluntary admission." This application also explains the Rights of Voluntary Admittee as "You have the right to request discharge from the facility. Your request must be in writing. After you give your request, the facility must discharge you at the earliest appropriate time. This time may never exceed 5 days, excluding Saturdays, Sundays, and holidays, unless it is expected that you are likely to inflict serious physical harm on yourself or others in the near future. If the facility director believes you are likely to harm yourself or others, he/she must file a petition and 2 certificates with the court within the same 5-day period. You will then have a hearing in court and the court will determine if you must remain at the facility. You will have the right to withdraw your request to be discharged if you should decide to remain at the facility. Thirty days after your admission, if you have not been discharged, the facility director will determine if you need further hospitalization. If the facility director determines you should remain, he/she or designee will consult with you. If you do not agree to stay, your request will be considered a request for discharge (as above). Every 60 days thereafter, the facility director will review your record and consult with you. As a general rule, you do not lose any of the legal rights, benefits, or privileges simply because you have been admitted to a mental health facility (see your copy of the Rights of Individuals)." On 8/11/23 a Behavioral Health Counselor (BHC) documented "Pt signed voluntary. Placed in hard chart. Change in status eFiled."

On 8/14/23 the MHP with a master's degree in social work (MSW) documented on a progress note entitled "Patient Response" as follows: "Provided pt with her continuance regarding her court hearing for treatment. Explained at length the difference between her two court cases. Educated the pt that now due to her voluntary status she would no longer be taken to court for involuntary commitment. Pt very childlike in her speech throughout the conversation with this writer. At one point the pt referred to herself at 'the baby'. Pt talking about events last week when this writer and other staff members assisted the pt in changing into a diaper." Also, the progress notes documents speaking with the recipient about her court paperwork and providing her with the records.

MEDICATIONS and INFORMED CONSENT:

Beginning day 1 of the admission, the "Patient Education" record documented nursing communicating with the recipient about medication need and side effects. There is a section titled "First Dose Education" and explains "Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report." There is a "Learning Progress Summary" that is used for nursing to document a patient response to understanding their medications. Beginning Day 1, the recipient was prescribed lithium and on day 8 and 17 it is documented as "Needs Reinforcement and verbalized understanding". On day 1, the recipient was also prescribed "hydroxyzine and Quetiapine" and refused the medication on day 6. The medication education for Olanzapine was listed as "refused teaching" by the recipient on day 6. On day 16, the medication education chart documents the recipient "needs reinforcement" on day 16 for Clonazepam and verbalized understanding of this medication by day 21. By day 21 the document indicates the recipient verbalized understanding of the medication treatment need and side effects for the Lithium medication. This same record also documents the recipient verbalized understanding of the following medications on day 21: "Lorazepam, Hydroxyzine, Quetiapine, Prochlorperazine, and Clonazepam". The recipient's signature is observed on this chart record along with the signature of a registered nurse on day 9 and 19. Medications were also reviewed with the recipient by Psychiatrists as evidenced on the residency teaching notes on day 6 which read "Patient was extremely manic and increasingly exhibiting signs of psychosis during times of the interview. ... Patient unable to understand taking medications are required for her condition. Patient was offered lithium for which she agreed to take the medication because 'it is natural'... ." The chart record provided consistently shows members of the Interdisciplinary team communicating with the recipient about her medication needs. She refused to take Zyprexa and was not forced to take this medication.

On day 2 of the admission, an RN documented the recipient stating, " 'I will admit I was manic, I stopped taking all of my medications on July 21 when I went to [Rural Hospital] and the doctor told me to stop taking all of my medications so I could sleep' ". Another triggering event for the recipient's mania was noted as her visiting with a Primary Care Physician (PCP) in late June/early July who had been treating her with a placebo medication to treat a medical diagnosis of Chronic Lyme Disease. When the recipient discovered that she was receiving a placebo she did not respond well. She then fell on 7/22/23. She was taking her prescribed Zoloft and Seroquel every other day after that.

On day 6, The HRA also reviewed a note written by the MSW – MHP, documenting the following: “Provided the pt with medication education paperwork and discussed being taken to court for medications. This had also been discussed with the pt at length this morning. Pt was encouraged to take her medications as opposed to being court enforced. Pt remains adamant that she does not need medications. She explained that she is currently detoxing from all of her old medications. Pt often needs redirected to the conversation as she will begin talking about other topics. E-filed for court enforced medications. Her husband requested to speak with (Attending Psychiatrist) which was shared with the doctors this morning. Either (Attending Psychiatrist) or (Resident Psychiatrist) will be reaching out to speak with him today. This writer informed him that we would be moving forward with court enforced medications. He requested to speak with Peoria State's Attorney prior to her hearing on Friday. This writer provided his information per his request.”

On day 6, the MHP documented that the “Pt reported that she was upset due to her wedding ring being lost. Attempted to redirect the conversation back to her upcoming court hearings. Pt explained that she would not be taking the medications as she is allergic to almost all of them. Pt then began talking about her lack of care at the facility about being left in her bed in her urine. Pt perseverating on yesterday morning being left in bed after urinating. This writer explained to the pt that I was present and assisted in cleaning and changing her with multiple other staff members. Pt reported that she had been left for hours before assisted. Provided pt with second order for hearing for involuntary treatment. A copy was placed in her hard chart. Pt is upset as she does not need to be on a psychiatric floor. Pt believes she needs to be on medical being treated for a TBI [traumatic brain injury].”

On day 7, a Progress Note was entered by a Resident Psychiatrist that documents speaking with the recipient's husband about the recipient's medical treatment “including meds” and “answering husband's questions and concerns about treatment,” along with “Clarifying process for court ordered medication process.” The Resident MD also documented communicating with the husband about the bladder stimulation device. On this same day a “Psychiatry Resident Teaching Note” documented the Resident MD speaking with the recipient about her court petition for forced medications would be filed “this week” and documented that the “Patient was agreeable to this.” This same teaching note also documented the recipient being compliant with ordered Lithium. She was refusing to take Seroquel and Zyprexa. On day 7 of the admission, the MHP documented a phone call with the husband communicating about the court hearing. The husband is documented as hoping the recipient would take her medications, so they are not court ordered. On day 7, the recipient asks for her “bladder stimulator”.

The HRA reviewed the Carle Healthcare Education Documentation titled “Medications Explanation and Written Information on Side Effects Given” chart that documents the recipient was informed of the side effects of the following behavioral health medications on 8/4/24-8/7/24: “Seroquel, Zyprexa, and PRN Atarax” with the nurse charting “PUU [Patient Unable to Understand].” On day 5 of the admission, the nurse discussed the

Zyprexa side effects with the recipient and documented the recipient reporting that it “makes me sick”. On day 6, “Lithium and Zyprexa” were again discussed with the recipient and a patient signature is not found on the document but the comment “Pt. unable” is noted. Beginning on day 7, this form documents the recipient signed and verbalized that she understood her Seroquel medication. For days 9-14, Seroquel, Zoloft and Lithium medication side effects were discussed with her, and the nurse documented “Verbally educated and understood”. On day 15, she had Klonopin added twice a day. On day 18, the recipient acknowledged understanding the purpose and side effects of the medication Hydroxyzine being ordered to treat Anxiety. On day 19, the recipient signed the form indicating she was educated and understood the reason the Klonopin medication was ordered.

On day 8, a progress note documents the recipient saying she "will sign in voluntary". On day 8, an RN documented in the recipient's chart record “Pt signed voluntary. Placed in hard chart. Change in status eFiled.”

The recipient's chart does not provide any evidence of the recipient receiving emergency medications, forced medications or even as needed medications for her behavioral health symptoms. The record provided does not show any rights restrictions being provided to the recipient due to receiving behavioral health medications without her informed consent. The hospital provider had developed a treatment plan to present the recipient's mental health case in court on a petition for court enforced medications. The case for court enforced medications was continued and eventually dismissed.

FIRE ALARM

On day 5 of the admission, at 11:03pm an LPN (Licensed Practical Nurse) documented “Patient states, ‘That staff in the hall, I de-escalated her. She was scared of the noise (referring to the fire alarm). You (writer) witnessed it you saw the de-escalation. I did that.’ Patient stated the staff member was sitting on patient's toilet and patient calmed the staff member down from the fire alarm.”

On day 12 of the admission, a Resident Psychiatrist documented the service recipient was ambulating the halls most of the night upset about “four fire alarms” going off the night before. This is why she didn't sleep well. The service recipient also reported “Regarding sleep, patient is amenable to increasing Seroquel. Patient also indicates ‘there were four fire alarms last night’. Endorses ‘a member of our staff locked herself in my bathroom and was screaming the whole time I had to de-escalate her’. No staff notes available to corroborate this detail.” The service recipient was also reminded that nursing must complete a “postvoid bladder scan” while waiting for a urology consult to occur. The note documents the service recipient understood and was agreeable. Further along, the service recipient reported that an unknown staff member had called her a “fucking whore”. The recipient continued to have issues with bedwetting. The Resident Note indicates the treatment team was still treating the recipient for “Bipolar I, currently manic with psychotic features” and ruling out a secondary diagnosis of “mania due to a medical issue”. It is documented again the recipient reporting “ ‘15 times laying in my own filth’.

This has been referenced to the night shift. Unable to corroborate this information per staff notes.”

BRACELET

Part of the complaint alleges the recipient was wearing “the wrong bracelet”. The HRA did not review any documented complaints about the recipient wearing the “wrong bracelet” noted in the chart record provided for review. On day 7, there is one referenced incident in the chart record that the recipient mentions taking off a bracelet. There are no other details specific to the type of bracelet. The recipient was a direct admission to the behavioral health unit from the ED of another hospital. On day 2 of the admission at 12:14am, the chart record Flowsheet documents an “Arm Band - On” for identification purposes through discharge on day 21. An arm band from another hospital is not mentioned in the record or a “wrong” arm band being used to identify the recipient.

POLICY

The HRA reviewed Carle Healthcare policy titled “Admission and Discharge Criteria”. This policy outlines the “Clinical criteria used by the ordering psychiatrist to assist in determining appropriate inpatient admission and discharge. Clinical factors will be considered in determining the type of admission.” The section of the policy titled “General Information” explains the types of admission and references the Mental Health and Developmental Disabilities Code. A Voluntary Admission is defined in the policy as “1. Any person 16 or older may be admitted to a mental health facility as a voluntary recipient for treatment of a mental illness upon the filing of an application with the facility director of the facility if the facility director deems such person clinically suitable for admission as a voluntary recipient. C. Involuntary – An involuntary admission is defined in Article VII of the Mental Health Code. The admission is facilitated by a Petition, (2) Certificates, and a court hearing to determine the appropriateness of the admission.” Section IV. of this policy describes “Clinical Criteria for Admission to and Discharge from an Inpatient Unit” as “B. Admission Criteria 1. Significant risk for self-harm; or, 2. Significant risk of harm to others due to mental illness; or, 3. Significantly impaired ability to care for self, to manage behavior, or to reasonably cope with symptoms, due to mental illness and that cannot be clinically managed in a more appropriate setting. 4. Patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately in an inpatient hospital setting and a primary psychiatric diagnosis.”

The HRA reviewed the “Carle Health Methodist Hospital Community Behavioral Health Program” patient handbook and noted the following is communicated to a behavioral health patient under the section “Wrist I.D. Bracelet” and states “Nursing personnel will place an identification bracelet on your wrist when you arrive. It identifies you by name, identification number, your physician’s name, and your date of birth. The bracelet must remain on your wrist during your entire hospital visit, as a means of ensuring your personal treatment and accurate medication administration. If it becomes damaged, please let the staff know so it can be replaced.” This handbook does not provide guidance to a

patient on how they are to respond, and protocol for staff to respond, to an emergency situation on the behavioral health unit, such as a fire alarm.

The **Mental Health and Developmental Disabilities Code 405 ILCS 5/2-107 Administration of psychotropic medication and electroconvulsive therapy upon application to court** mandates “(a-5) Notwithstanding the provisions of Section 2-107 of this Code [[405 ILCS 5/2-107](#)], psychotropic medication and electroconvulsive therapy may be administered to an adult recipient of services on an inpatient or outpatient basis without the informed consent of the recipient under the following standards: (1) Any person 18 years of age or older, including any guardian, may petition the circuit court for an order authorizing the administration of psychotropic medication... to a recipient of services. ... The petitioner shall deliver a copy of the petition and notice of the time and place of the hearing, to the respondent, his or her attorney, any known agent or attorney-in-fact, if any, and the guardian, if any, no later than 3 days prior to the date of the hearing. (E) That the recipient lacks the capacity to make a reasoned decision about the treatment.”

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/3-400) Voluntary Admission to Mental Health Facility** states: “(a) Any person 16 or older, including a person adjudicated a person with a disability, may be admitted to a mental health facility as a voluntary recipient for treatment of a mental illness upon the filing of an application with the facility director of the facility if the facility director determines and documents in the recipient’s medical record that the person (1) is clinically suitable for admission as a voluntary recipient and (2) has the capacity to consent to voluntary admission. (b) For purposes of consenting to voluntary admission, a person has the capacity to consent to voluntary admission if, in the professional judgment of the facility director or his or her designee, the person is able to understand that: (1) He or she is being admitted to a mental health facility. (2) He or she may request discharge at any time. The request must be in writing, and discharge is not automatic. (3) Within 5 business days after receipt of the written request for discharge, the facility must either discharge the person or initiate commitment proceedings. (c) No mental health facility shall require the completion of a petition or certificate as a condition of accepting the admission of a recipient who is being transported to that facility from any other inpatient or outpatient healthcare facility if the recipient has completed an application for voluntary admission to the receiving facility pursuant to this Section.”

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/3-401) Application; Right to Discharge** states: “(b) The written application form shall contain in large, bold-face type a statement in simple nontechnical terms that the voluntary recipient may be discharged from the facility at the earliest appropriate time, not to exceed 5 days, excluding Saturdays, Sundays and holidays, after giving a written notice of his desire to be discharged, unless within that time, a petition and 2 certificates are filed with the court asserting that the recipient is subject to involuntary admission. Upon admission the right to be discharged shall be communicated orally to the recipient and a copy of the application form shall be given to the recipient and to any parent, guardian, relative, attorney, or friend who accompanied the recipient to the facility.”

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) Care and services; psychotropic medication; religion** mandates “(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. ... In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided.”

The **Mental Health and Developmental Disabilities Code 405 ILCS 5/2-200** admonishment of rights mandates “(a) Upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient, as well as the recipient’s guardian or substitute decision maker, and every recipient who is 12 years of age or older and the parent or guardian of a minor or person under guardianship shall be informed orally and in writing of the rights guaranteed by this Chapter which are relevant to the nature of the recipient’s services program.”

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) Care and services; psychotropic medication; religion** requires that “(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. ... In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan. (a-5) If the services include the administration of ... psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment...”

The **Mental Health and Developmental Disabilities Code 405 ILCS 5/3-609 [Disclosure of information to respondent]** mandates, “Within 12 hours after his admission, the respondent shall be given a copy of the petition and a statement as provided in Section 3-206 [\[405 ILCS 5/3-206\]](#). Not later than 24 hours, excluding Saturdays, Sundays, and holidays, after admission, a copy of the petition and statement shall be given or sent to the respondent’s attorney and guardian, if any. The respondent shall be asked if he desires such documents sent to any other persons, and at least 2 such persons designated by the respondent shall receive such documents. The respondent shall be allowed to complete no less than 2 telephone calls at the time of his admission to such persons as he chooses.”

COMPLAINT #1 and #2 CONCLUSION:

The allegation of inadequate treatment and patient rights violation is found **unsubstantiated**. The HRA reviewed the chart record provided by Carle Methodist. This recipient’s care began at another hospital, and she was transferred to Carle Methodist for

inpatient care. The involuntary petition process and one certificate was completed by the first hospital. When the recipient arrived at Carle she was provided with another copy of the petition and the rights form per 405 ILCS 5/3-609 that mandates a recipient is provided with “Disclosure of Information, within 12 hours after his admission, the respondent shall be given a copy of the petition and a statement ...”. Nothing in the chart record reviewed by the HRA indicates the recipient was disagreeing with inpatient admission at any point in the process. The treatment team admitted the recipient due to the mental health diagnosis of “Bipolar I with mania”. The recipient had not been taking home medications to treat her behavioral health diagnoses prior to admission. The recipient was scheduled for a mental health hearing where she had legal counsel appointed by day 8 of the admission. This court hearing was continued due to the voluntary admission application being completed.

Specific to complaint #2 alleging a patient rights violation, the HRA finds this complaint **unsubstantiated**. The HRA reviewed the chart and found no evidence of staff administering emergency or PRN psychotropic medications to the recipient during her inpatient treatment. The record reflects the opposite; the hospital’s treatment team continually discussed her medications and the importance of taking them as ordered. There was a hearing planned for court enforced medications that was continued to a later date. The Dispositional Report that was written by a qualified professional documented “(E) That the recipient lacks the capacity to make a reasoned decision about the treatment,” in alignment with 405 ILCS 5/2-107. The interdisciplinary team consistently communicated with the recipient about the legal process as evidenced in the chart record on day 8 of the admission which was 3 days prior to the scheduled court hearing and in alignment with 405 ILCS 5/2-107. Eventually, the plan for court enforced medications was dismissed due to the recipient taking agreed upon medications to treat her acute behavioral health needs.

The HRA suggests:

- Per (405 ILCS 5/3-401) **Application; Right to Discharge**, a patient who is a voluntary admission should always be reminded by the treatment team that they have a right to sign a 5-Day discharge form at any point in time in the inpatient treatment process.
- The facility should review their Carle Health Community Behavioral Health Program Patient Handbook and update sections to better explain involuntary vs. voluntary admission process to a recipient of behavioral health services.
- The facility should review their Carle Health Community Behavioral Health Program Patient Handbook and create a section that explains what a patient’s responsibility is during an emergency response to unexpected activation of the fire alarm as this can be triggering to those receiving treatment due to the sound of the alarm and anxiety a fire drill could create.

COMPLAINTS #3- Inhumane care and #4 – Failure to provide timely medical care.

On day 2, the Medical Director/Psychiatrist requested a consult from an Internal Specialist Medical Doctor (MD), on the service recipient to “evaluate medical problems”. The service recipient reported an incident of bladder incontinence and that she has a

bladder stimulator. The MD reviewed another provider's Urology Notes and documented the recipient had a "sacral nerve stimulator" and had been replacing the batteries regularly. No acute issues were noted by this physician with regards to the sacral nerve stimulator. The use of a remote to control the medical device is not mentioned.

INCONTINENCE/MEDICAL:

The patient was given her remote on day 7. There were still incidents of incontinence documented on days 8 and 9.

On day 1 a medical doctor placed the recipient on seizure precautions and ordered "F. Patient must be assisted at all times with ambulation, toileting, and any other activity. Use a gait belt." The recipient also had orders placed for a "bladder scan" frequently throughout the medical record. On the first day of admission the husband contacted the unit to follow-up on information his wife had reported about being "overly rough and she had bruising on her left arm. She also said that her bladder device was broken and that she was more incontinent. That she had numbness between her chest and pelvis, which is where her lead wires from the stimulator go into her spinal column." He was asked to bring the bladder stimulator remote to the unit. On day 3, the husband brought the "bladder stimulator remote" to the unit. He provided information about how to use the remote to the RN. The RN documented that she updated the Resident Psychiatrist and "the remote/device was placed in med room."

On day 2, at 5:21am an RN documented on a nursing note "Pt had an episode of incontinence and staff assisted patient with changing. Pt states, 'I can't feel from here down' indicating that she is unable to feel from her chest down to her feet. Pt then states, 'I'm in so much pain. If I move and scream, I'm sorry. I hurt so bad.' Pt was whaling in pain as staff assisted her, pt was able to move her extremities and minimally maneuvered herself around in bed. Pt was able to push up off her feet and pull her pants up in bed. Pt stated to RN several times, 'I shouldn't be here. I need medical help.'" An hour earlier, the recipient is refusing to get out of bed to use the restroom and it was documented by another RN as "Patient refuses to sit up in bed, refuses to get up to use the restroom with assistant. Patient is currently lying in bed after urinating on herself and was witnessed rolling over in bed on multiple occasions, then tells this nurse she is unable to move. Patient states this is a classic bait and switch that she needs medical not mental help." This same nurse further documented the recipient's arrival on the unit as "Patient is a direct admit from [First Hospital] for mania and psychosis. Patient arrived by EMT in a w/c d/t [in a wheelchair due to] back pain, patient states she is unable to walk and needs assistance, report from [First Hospital] states patient was up and walking around. Patient disheveled appearance makes eye contact, calm, cooperative, tangential speech and flight of ideas, A&O (alert and oriented) x4. Saline lock and IV cannula in right antecubital, patient unable to state why she had an IV." She did have a medical diagnosis of "incontinence" and staff assisted her with toileting needs. On 8/6/23 there is a nursing note charted that the recipient had a sitter and "do not leave unattended while toileting."

On Saturday, Day 2, the HRA reviewed Nursing Notes and documentation entered by the attending psychiatrist that document "History of urine retention/incontinence s/p [status

post] sacral nerve stimulator. Patient s/p her hysterectomy she had a bladder stimulator placed. Follows with OSF urology in the outpatient setting. Will defer management to them as there are no acute issues for now.” This same day a Behavioral Health Unit Intake Note documented the service recipient reporting pain: “Patient complains of excruciating pain from her lower back that wraps around her abdomen and goes down legs and feet. Rates the pain a 10 out of 10 unable to describe how the pain feels. States when at [First Hospital] the staff tried helping her up and when she stood it felt like tearing. Patient states she only takes marijuana gummies for pain. ... On assessment this morning, patient is in a good mood, cheerful, and feeling well. She is currently in a wheelchair and says it is difficult for her to ambulate due to pain and because she is not able to feel anything besides pain from chest and down. Patient reports pain when she is trying to move her legs passively but is seen at times being able to do so with no issues. Patient has had a significant pain medication regimen including Valium, Ativan, medical marijuana. Patient was actually on fentanyl patches which were then titrated down to Dilaudid patches and then transitioned to medical marijuana. Patient also reports concerns of urinary incontinence. She has a bladder stimulator in place and is unsure if that had gotten affected when she was transferred from [First Hospital] to Methodist. She also had reported concerns about her intestines coming out of her anus. She does have a history of hemorrhoids but says that it is bigger than that. Patient was evaluated by nursing staff while patient was urinating in the toilet bowl and there was no concern for any intestinal or rectum prolapse. Patient does not report any pain in the rectum area while sitting in the wheelchair.”

On day 5, at 11:03pm, an LPN documented that the “...Patient has shower after being cleaned up by two staff after incontinence accident and patient said that she did not feel clean enough, so shower was option presented to patient. Staff cleaned urinated bed pads and sheets. ... Patient has bruising on left shoulder down to elbow and on lower left leg close to ankle. Patient also has bruising on right elbow to forearm that is scattered. Patient refused evening medication and said that it made her have behavior problems and that it would make her husband upset if patient was given this medication because of past medical reactions to the medication. Patient refused education attempts several times. Patient refused to get up to visiting room when husband came to visit this shift. ... Patient took 800 mg of Ibuprofen for back pain 10/10 at 2042. ... Reassessment of pain at 2130 is 0/10. Patient said pain was gone and patient felt good. ...”

On day 6, a Psychiatry Residency Teaching Note documented that the “Patient did not sleep overnight. ... Patient had episode of urinary incontinence overnight and was showered and cleaned up by staff as a result. Patient evaluated bedside. Another note written this same day documents “ complains of urinary incontinence and staff had assisted her to the bathroom.” The Resident MD also documented communicating with the husband about the bladder stimulation device. On this same day a “Psychiatry Resident Teaching Note” documented the Resident MD speaking with the recipient. On day 7 the record also reflected the MHP documenting “the recipient asks for her ‘bladder stimulator’”. On day 8, at 6:23am a Behavioral Health Technician was assisting the recipient and documented the following interactions: “Patient again claimed to writer that she was ‘left in her filth last night.’ Writer informed patient that was not true, as she had a

shower before bed and did not urinate in the bed at all last night. Writer told patient that she urinated on the toilet this morning as well. Patient said, 'oh, well I don't remember that. I guess I'm still trying to put it all together.'"

It appears to the HRA, based on the chart record, the incontinence issues lessened once the bladder stimulator remote was provided to the recipient although it did not resolve the issue. On day 7, at 2:46pm the Psychiatrist documented that it was permissible for the recipient to have her bladder stimulator remote. On (day 7) an LPN documented that the "Pt would utilize their bladder stimulator. Stimulator remote placed in med room." This same day the MHP - MSW staff documented the following conversation with the recipient's husband and plan of care: "Spoke with the pt's husband again on the phone this afternoon who requested that the pt be allowed to use her bladder stimulator. Addressed it with the treatment team. Pt will be allowed to use the device moving forward."

On day 10, the psychiatrist documented that the "Patient continues to fixate on 'being left in my urine 12 times per night'. Is unable to be confirmed per staff notes."

On day 11, a "Psychiatry Residency Teaching Progress Note" documents "Patient also continues to endorse 'Urinating more...flipped bladder stimulator'." The Resident Psychiatrist documented "Postvoid residuals have been normal while on the unit. Treatment team will try to contact outpatient urologist for further examination recommendations." On day 11, the medical doctor entered an order for the service recipient to have a consultation with urology due to urinary incontinence. The consultation was ordered due to the service recipient having a "bladder pacemaker" also known as an "InterStim device" and having had "recent trauma". The consult was ordered to rule out the device not working or the "lead" being "misplaced".

According to the records reviewed by the HRA, the recipient had two image testing completed during her admission. She had a CT of the lumbar spine without contrast on day 17 which was compared to a Lumbosacral spine radiograph she received on day 14 and previous CT scans that were taken prior to admission. Also, on day 13, there was an x-ray to evaluate the orientation of the bladder stimulator device.

The HRA reviewed a Psychiatry Resident Treatment Note on Day 14, when the service recipient was being evaluated for "Manic Behavior;" the resident documented that the "Patient also endorses being '16 times in my own filth that is unprofessional'. This is unable to be corroborated by any staff notes or documentation." She also voiced concerns with her Seroquel dosage which was discussed with the treatment provider and a plan to possibly switch to a different medication was tentatively made at the time of consult. The service recipient also voiced confusion with why she was at the hospital. At this time, she had been involuntarily admitted for inpatient behavioral health care for 14 days.

POLICY

The HRA reviewed the Carle Methodist Policy on “Admission and Discharge” criteria that is applicable to the behavioral health unit. This policy explains what medical needs would exclude a recipient for a behavioral health admission. The policy explains that a patient could be excluded from a behavioral health admission if they have “3. An unstable medical condition (Refer to guidelines for medical clearance parameters of psychiatric patients that require inpatient hospitalization. Consult psychiatry on case-by-case basis); or, 4. A medical condition that is likely to imminently worsen such that proper medical care would be better managed on a medical unit; or ... 7. Uncomplicated major neurocognitive disorders without psychiatric symptomology e.g., traumatic brain injury, dementia with no acute mood/behavioral disturbances.”

The HRA reviewed the Carle Methodist Policy on “Pain Management and Controlled Substance” which explains “It is the policy of the Carle Methodist Physician Group Clinics to: (a) acknowledge the patient has the right to pain management, and (b) ensure patients are able to effectively participate in the development and implementation of a plan of care to manage pain and monitor the use of controlled substances for other diagnosis. Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for acute and chronic pain. Providers should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with non-pharmacological therapy as appropriate.” This policy also guides the treatment to monitor “Acute and Chronic Pain Assessment” and “are to be conducted by designated personnel and based on a numeric scale of 0-10 ...”

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) Care and services; psychotropic medication; religion** mandates “(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan.”

The **Medical Patient Rights Act (410 ILCS 50/3) Patients’ Rights** mandates “The following rights are hereby established: (a) The right of each patient to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordinating his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law.”

COMPLAINT #3 and #4 – CONCLUSION:

The HRA finds the allegations of inhumane care and failure to provide timely medical care to treat the medical needs to be **unsubstantiated**. The chart record reviewed shows the treatment team continually assessing the recipient for her medical and pain management needs. During the initial stages of the admission, the treatment team was trying to determine if her complaints of physical pain were reality based or somatic due to her manic behavior diagnosis. The recipient had not been taking her home medications for several days prior to her admission. The treatment team provided medical treatment to the recipient as evidenced by medications for pain management being ordered and

administered and a pain assessment completed each shift during the 21-day inpatient admission in alignment with their hospital policy on “Pain Management and Controlled Substances”. The chart record did indicate the recipient had a bladder stimulator device implanted to assist her with bladder control. This device required a remote to be used when the recipient used the restroom to urinate. On day 1 of the admission the remote to the bladder stimulator was not with the recipient. The hospital worked with the husband to bring the remote to the unit on day 3 of the admission. The recipient had an order for staff to assist the recipient when toileting per the record. The record does not indicate there was a refusal by the treatment team to use the remote or keep it on her person. The record indicates that on day 7 the Attending Psychiatrist ordered that it was allowable for the recipient to have the remote. The recipient continued to have incontinence needs after being given the remote to the bladder stimulator.

During the 21-day admission the Attending or Resident Psychiatrist entered orders for the recipient to be seen by specialty providers: Internal Medicine, Urology and Orthopedics. The recipient also had special testing completed to further explore the underlying cause of incontinence and lower back pain. This is evidenced by an x-ray of the Lumbar Spine being completed along with a follow-up CT scan of the lower back area.

The HRA concludes that per the Mental Health Code the hospital treatment team was providing adequate and humane behavioral health care as mandated by 405 ILCS 5/2-102. The HRA would conclude that the recipient’s interdisciplinary team continually assessed the recipient’s care needs for medical care per the **Medical Patient Rights Act (410 ILCS 50/3)**. Both behavioral health and medical symptoms improved during her 21-day admission.

The HRA makes the following suggestions:

- Staff on 6W behavioral health unit should consistently document activities of daily living interventions they provide to mental health patients with incontinence issues. The recipient did have several instances of incontinence during her admission, yet not every documented instance clearly noted how staff assisted the recipient.
- All members of the Interdisciplinary Treatment team on the 6W behavioral health unit should be trained on the causes of incontinence and what types of treatment interventions can be used to treat this medical diagnosis.
- All members of the Interdisciplinary Treatment team should be trained on a bladder stimulator device.

COMPLAINT #5 – Failure to complete inventory of personal items

The HRA reviewed one form titled “Notice of Restricted Rights of Individual” that was completed by the admitting RN on day 1 of the admission. This form documents a rights restriction being ordered for the recipient to retain their “personal property” and then explained under “other” as “no shoes and must wear scrubs,” and the reason for the precautions was documented as “involuntary admission, moderate suicide risk, elopement risk, and impulsiveness”.

On the third day of admission the HRA reviewed a "Psychiatry Residency Teaching Service Progress Note" that documented that the recipient was disorganized, delusional, and paranoid and stating she, "... does not know if her husband is real, she does not know how she has a wedding ring on her finger." This note does not confirm that the provider observed a wedding ring on the recipient's finger or any rings for that matter. On day 7 an LPN documented on Other Clinical Notes that the "Patient would report having, 'Lost my wedding ring.' Pt was informed that no wedding band or rings were documented on their inventory sheet. Pt's belongings were searched, no ring was found. Pt would report, 'Having it here, because I remember taking it off with my bracelet.' Pt was provided with the pt advocate number which they would indicate they already have. Pt was encouraged to contact their husband to see if they are aware of where the pt's ring is. Charge Nurse made aware." This same morning, a Behavioral Health Counselor also helped the recipient look for the missing ring documenting "looked through patient's room and through her belongings in the nurses' stations for her wedding ring. Writer did not locate the patient's ring. Patient claims it is 'missing or stolen.'" It was mentioned one other time on day 22, on a Flowsheet Note stating that the patient "Can't find her wedding ring."

On day 7 the MSW-MHP documented a conversation with the recipient's husband specific to the wedding ring: "Addressed multiple questions as well that were left via voicemail to this writer. He confirmed that he is unable to find her ring at home. This writer personally went through her belongings and was unable to locate her ring."

The HRA reviewed 8 Personal Inventory Tracker forms completed on admission days: 2, 3, 8, 9, 11, 13, 16, and 20. The recipient acknowledged the inventory documents at discharge as the HRA reviewed her signature associated with the date. She did not sign each inventory document at the time of completion. The HRA did review two Carle Healthcare nursing staff signing as witnesses to the inventory. Out of the 8 "Personal Inventory Tracker" forms reviewed, none of them document any jewelry, specifically, a wedding ring or bracelet as mentioned on day 7 of the admission. The HRA did note in the recipient chart that unit staff consistently documented that she wore prescription glasses. The HRA notes the prescription glasses are not documented on the inventory form. The only "glasses" documented are "sunglasses" on day 3 at 1:30am. Glasses at bedside is documented in a nursing note on day 19 and consistently throughout the medical records indicating she wears prescription glasses. The HRA also notes that the bladder stimulator remote is not mentioned on either of these inventory forms.

The HRA reviewed Carle Healthcare Policy titled "Q-15 Personal Belongings of Patients/Safekeeping of Valuables". The Policy explains "Carle Health does not assume responsibility for patient belongings that are not required for patient use, unless placed in a Valuables Envelope and kept in the designated secure area." One Purpose of the policy is "A. Provide guidelines for the safekeeping of patient valuables during hospitalization." The HRA reviewed the section titled "General Information" which explains "A. The patient should be encouraged to send home any unnecessary belongings. If a patient cannot or does not wish to send valuables home, Carle Health will provide safekeeping of

items as described.” The procedural expectation found in the policy requires “At the time of the admission, the nurse should review all patient belongings brought into the hospital setting and encourage the patient to send home any money over \$10.00 ... or jewelry with a relative or friend. If the patient does not have any relatives or friends to take the items home or does not wish to send valuables with friends or relatives, items will be reviewed with the nurse to determine security measures for each item. B. Inpatient Units Process for valuables sent to hospital safe 1. If a patient is unable or declines to send valuables home with a relative or friend, these items can be secured in the hospital safe until their time of discharge at the patient’s request. ... B. Inpatient Units Process for valuables sent to hospital safe 1. If a patient is unable or declines to send valuables home with a relative or friend, these items can be secured in the hospital safe until their time of discharge at the patient’s request. 2. Valuables Deposit: valuables sent to the safe are inventoried on the valuables inventory form by the care provider and sealed in the valuable’s envelope (on which the patient’s name is printed).”

The HRA reviewed the “Carle Health Methodist Hospital Community Behavioral Health Program” provided to the HRA as evidence of a unit handbook given to patients during their admission. There is a section titled “Clothing and Personal Belongings” that explains “We suggest keeping a limited amount of clothing (3 outfits) and other personal items at the hospital. ... Staff will label all other personal items. Carle Health cannot be responsible for lost, misplaced or stolen items.” There is a section titled “Valuables” that explains to the patient “The hospital will not assume responsibility for any money or valuable items lost or stolen. For that reason, we ask you to deposit all valuables in the locked area on the unit or send home with relatives. The receipt for your valuables will be kept in your chart. Any money over \$10 will be put in the hospital safe.” This same handbook has a section titled “Patient Rights and Responsibilities” which explains “While you are a patient of Carle Health Methodist, we will do our best to protect and promote your personal rights in accordance with all relevant state and federal laws, and Joint Commission Accreditation of Healthcare Organization standards. For additional information about your rights, you may also contact our Patient Advocate at”

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-104) Personal Property; storage; return**) states “Every recipient who resides in a mental health or developmental disabilities facility shall be permitted to receive, possess, and use personal property and shall be provided with a reasonable amount of storage space therefor, except in the circumstances and under the conditions provided in this Section. (a) Possession and use of certain classes of property may be restricted by the facility director when necessary to protect the recipient or others from harm, provided that notice of such restriction shall be given to all recipients upon admission. (b) The professional responsible for overseeing the implementation of a recipient’s services plan may, with the approval of the facility director, restrict the right to property when necessary to protect such recipient or others from harm. (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.

COMPLAINT #5 – CONCLUSION:

The HRA found no evidence in the chart record provided that indicates a wedding ring was listed on the recipient's personal inventory. On day 3 of the admission, the Resident Psychiatrist documented the recipient "does not know if her husband is real, she does not know how she has a wedding ring on her finger," unfortunately this note does not provide concrete evidence that the recipient was wearing a wedding ring at the time. Nothing in the record indicates to the HRA what personal items in possession of the recipient upon admission were restricted by unit staff. There is a Notice of Restricted Rights of Individual form found in the recipient's record for day 1 of the admission but it restricted "personal property" then checked "other" and documents "no shoes and must wear scrubs;" and this was due to suicidal risk. The HRA noted in the chart record the recipient communicating with staff about a missing ring. Staff assisted the recipient in looking for the ring, but it was not located. The recipient had 8 "6W Belongings Tracker" forms completed during the 21-day admission. No jewelry is documented on the form.

During the site visit, it was reported that individuals receiving behavioral health care would be allowed to keep jewelry unless certain precautions were ordered. Carle Methodist's policy dictates "Carle Health does not assume responsibility for patient belongings that are not required for patient use, unless placed in a Valuables Envelope and kept in the designated secure area." Carle communicates their unit policy on personal belongings in the patient handbook as "The hospital will not assume responsibility for any money or valuable items lost or stolen. For that reason, we ask you to deposit all valuables in the locked area on the unit or send home with relatives." Section **(405 ILCS 5/2-104)** of the Code mandates "(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** (emphasis added) shall be returned to him." Nothing in the record documented the hospital using a "Valuables Envelope" for any of the recipient's personal belongings. If a "Valuables Envelope" was used staff would be required to place the envelope in a designated secure area. Once this intervention occurred, then the hospital would be responsible for lost or stolen items per **(405 ILCS 5/2-104)**.

The HRA found no evidence of car keys being in the recipient's possession upon admission and keys were not documented on any of the eight of the "6W Belongings Tracker" forms nor does any of the chart record provided document the recipient being in possession of car keys.

The HRA **strongly suggests** the following:

- Carle Methodist Hospital should require a personal inventory list to be completed prior to admission to their units for those patients transferred to their hospital for inpatient behavioral health care.
- Carle Methodist Hospital should train their staff on how to complete the Personal Inventory Tracker form and to document essential items in possession of a patient. In this case the recipient wore upper dentures, prescription glasses and also used a remote for a bladder stimulator medical device. These items were never inventoried as personal property for the recipient during the 21 days stay.

- The HRA does question why jewelry would have been left in the possession of the recipient based on the rights restriction notice documenting “moderate suicide risk” and strongly suggests the interdisciplinary team discuss small items such as jewelry being left on a person with “moderate suicide risk” and “impulsiveness”.

RESPONSE

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