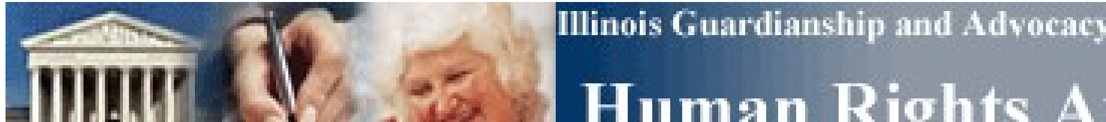

FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY – PEORIA REGION
REPORT OF FINDINGS

Case #24-090-9016
OSF St. Elizabeth Hospital - Ottawa

INTRODUCTION:

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations involving services at OSF St. Elizabeth Hospital - Ottawa. The allegations are as follows:

1 - Improper involuntary admission process.
2 - Inadequate treatment planning.
3 - Patient rights violation.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-100). The facility receives patients statewide, excluding Cook County. This hospital location serves several counties that surround the Lasalle County area. LaSalle is their primary county of service. The hospital provides behavioral health treatment, on an inpatient and outpatient level, to approximately 900 patients each year. The hospital averages about 70 voluntary admissions per month equating to approximately 840 per year. The hospital provides treatment to involuntarily admitted patients 1-2 per month, averaging 12 per year. In 2023, the hospital had 5 involuntary admissions that went to court. This hospital location does offer inpatient treatment and serves approximately 450 patients per year that are transfers to the hospital for treatment. The census for the inpatient unit is 22 beds. The average length of treatment for a voluntary admission is 3-7 days. On the day of the site interview, the hospital had 18 inpatient admissions.

Complaint Statement

The complaint alleges an individual was transferred to OSF St. Elizabeth – Ottawa from a sister facility and was subject to an involuntarily admission without explanation. The complaint also alleges that a patient was not allowed to have a family meeting to discuss treatment plan goals for discharge from inpatient behavioral health care. Allegedly, a patient rights violation occurred when communication with a patient's person of choice

(family, pastor, and partner) was restricted by hospital staff without cause. A patient's diet required gluten free meals due to their medical diagnosis of Lupus and Hashimoto's Disease but their diet was reportedly not accommodated during the admission.

Interview with staff (05.08.2024)

The HRA facilitated a visit with several members of the OSF St. Elizabeth – Ottawa leadership team. The HRA had a signed and witnessed consent to release information for the service recipient. A patient's care experience begins in the emergency department (ED). The ED Provider would assess the patient for medical concerns before entering an order for a mental health evaluation. The Psychiatrist would be part of this process and would make the determination if a patient should be admitted for behavioral health treatment. The admission decision is based on a patient's crisis level. If a patient transfers to this facility from another sister hospital location, they would be required to be medically cleared at that location before being admitted. When a transfer is being facilitated, the sister hospital notifies the receiving hospital of the patient assessment and referral needs. There is a liaison between the two hospitals that helps facilitate this during business hours. A Psychiatrist would review the referral to ensure this location can provide the necessary treatment. The reason for the inpatient admission for this individual was due to "mania" based on the sister hospital's psychiatrist.

The recipient was transferred from an OSF sister facility to this hospital location for inpatient behavioral health care. She was medically cleared at the other hospital location and transferred from their "med surge" unit. She arrived via transport and would have been provided with involuntary paperwork consisting of the petition and first certificate from the sending hospital if they started the involuntary admission. OSF St. Elizabeth – Ottawa would scan any documents that arrived with the recipient into the electronic medical record. When she arrived to OSF St. Elizabeth Hospital she was a direct admission to the unit and was assessed to be appropriate for a voluntary admission for treatment on January 30. The recipient's patient rights were read and acknowledged by her signature. The hospital is able to review treatment at another location through the electronic medical record.

OSF St. Elizabeth provided inpatient behavioral health care treatment for this recipient from January 30, 2024 - February 2, 2024. The History & Physical form was briefly reviewed during the site visit and the recipient's admitting diagnosis was bipolar/mood disorder. There were no medical concerns noted. The recipient was examined by Internal Medicine during her admission. A Registered Nurse (RN) reviewed hospital documentation with the recipient. The recipient signed the documentation and was provided copies. If a recipient has questions about their admission or treatment plan, they can communicate with any admission partner involved with the care. The hospital will also provide advocacy resources. The recipient was given a workbook with unit rules. This explains what belongings a person can keep, phone calls/phone access, and a release of information for family/friend would be coordinated by staff. During the first 24 hours of admission is when a patient would have the most contact with the treatment team. The nurse's station is always available to patients for questions or concerns. A workbook

would be provided. A safety plan would be created with the consultation of the psychotherapist. No signatures are needed on the patient workbook. The recipient had access to records through MyChart on their phone or when they discharge.

Within the first 24 hours of admission, a Biopsychosocial, which is an assessment, would be completed by staff to gather information on a patient. This would be completed with a recipient to develop the treatment plan. The recipient's treatment plan was developed on 1/31/24. Family is not typically involved with this process unless requested. A family meeting is another part of the treatment process that could be facilitated by the interdisciplinary team. This recipient did have a release of information signed for two family members: brother and mother. Interdisciplinary or team meetings are not held on the unit. They are held on the employee side of the floor. The recipient did not leave the unit to attend. Patients are not allowed to leave the unit. The meeting details would then be discussed afterwards with the recipient in relation to the service plan. A copy of the service/treatment plan would not be printed off and/or provided. If there were disagreements with the plan, it would be noted in the chart record. A psychotherapist would review the service plan with the recipient and did in this case. The treatment plan is electronically signed. There is a paper that unit staff use to sign and acknowledge reviewing with a patient. A case manager and nursing would also be involved. Family could attend the meeting that is creating the treatment plan. The recipient's mother and brother may have been involved. If the recipient no longer wished these individuals to be part of her treatment planning, then she could refuse to permit the hospital to communicate with them.

The family is involved with the recipient during the admission. During the Discharge Planning, staff had issues contacting the mother. Family members picked the recipient up from the hospital at discharge.

The recipient was a voluntary admission. The unit has signs up that explains a patient's rights during treatment. The recipient did not require any rights restrictions during the admission. The recipient had access to phones, with the exception of when they are shut off during group hours. A patient has access to calling advocacy, police, lawyers, and mental health advocates at any time.

All treatment provided on the unit are coordinated based on orders from the psychiatrist. The unit does not want to restrict rights. If a rights restriction was required, the patient would receive a copy of the rights forms. The hospital employs chaplains who visit during and outside of visiting hours. However, if a patient requested to visit with their own pastor or another denomination that would not be restricted. The treatment team had no knowledge of a clergy visit or other religious denomination visit being requested by the recipient and then restricted by staff.

Those involved in the site visit were unaware of the recipient having a visit restricted with other family. The team did have awareness of the recipient being involved in a bad breakup. The mother and daughter were arguing about the relationship. The facility does not know if the partner was contacted by the recipient. She had her own cell phone.

Nothing in the recipient's chart documents an issue with phone calls or rights restriction denying access to a phone.

The unit provides patients with three meals per day and snacks. The unit has a common area for eating meals together. Some patients do eat in their rooms. However, the unit tries to encourage everyone to eat together. The menu is posted on the unit. If a patient has an allergy that is not noted in the chart record, a patient will need to notify the nurse or any other mission partners. A request for a dietician to consult could also be made by staff or the patient. Recently, the process for meals has changed. Kitchen mission partners are now reviewing with patients what is available every meal and taking an order. Previously, the kitchen has always taken the order based off the menu. The direct review with patients is new and changed for patient experience. The process for documenting allergies is straight forward. If a patient reports an allergy, then there is a "banner" that highlights this in the chart record.

The recipient did have a diagnosis of Lupus. The recipient completed a survey and indicated they had "robust care services". During her treatment, laboratory work was facilitated due to poor oral intake. This was part of the treatment received at the sister facility and not an issue at this hospital location. The recipient did have an order for a general diet on admission as of 1/30/24. She did have a gluten free diet while admitted. The recipient would have ordered her own food.

COMPLAINT #1 - Improper involuntary admission process.

FINDINGS

The HRA reviewed the chart record. This recipient was a transfer to this hospital from a sister facility after being admitted on 1/25/24 for medical treatment. On 1/27/24, the sending hospital began the emergency/involuntary admission process with the recipient after being medically cleared at their facility. The HRA observes the Involuntary Petition and two certificates being completed by this hospital. On 1/30/24 the recipient was transferred to OSF St. Elizabeth – Peru, arriving in the evening around 7:30pm. On 1/31/24, the recipient was assessed by a psychiatrist to have capacity to voluntarily admit for behavioral health treatment.

The HRA reviewed the "BH Admission Note" entered by an RN documented on 1/30/24 at 7:09pm "Patient was dressed in scrubs per hospital policy. Patient was wanded for contraband, none was found. RN read patient rights. Patient signed all legal documents; copies were given; patient verbalizes an understanding of all legal paperwork prior to signing. Patient signed all consents; patient verbalizes understanding of all consents prior to signing. Patient was escorted to 3rd floor, safety was maintained. Patient was provided with an admission workbook. Patient transferred to behavioral unit safely. All questions and concerns addressed."

On 1/31/24 at 10:51am the attending Psychiatrist entered a note certifying the following statement about the recipient's decisional capacity, "In my professional judgement this, the person: has capacity to consent to voluntary admission."

The HRA reviewed the Application for Voluntary Admission. It documents the recipient's admission for behavioral health care with a diagnosis of "mania". This document is signed by the recipient and nursing staff on 1/30/24 at 7:09pm. The HRA reviewed a document titled "Rights of Individuals Receiving Mental Health Services and Developmental Disabilities Services" and it was signed by the recipient and signed by an RN. When the recipient and staff signed the form, they attested to a copy being provided to the recipient.

The HRA reviewed the hospital policy "Admission or Transfer to the Behavioral Health Inpatient Unit" which was last reviewed October 2023. The purpose of the policy is defined as "Facilitate the admission or transfer of patients to the inpatient behavioral health unit." And "A patient's diagnosis must meet criteria from the DSM-5 and must meet the Behavioral Health admission criteria. The patient must be medically stable prior to transfer. Patient must be pre-certified and/or pre-screened as appropriate." The section titled "Process" explains " 1. There must be a physician's order indicating the patient is to be admitted to the behavioral health unit. 2. Adult patients (18 and over): Any physician on staff at SEMC may admit an adult to the inpatient behavioral health unit after consulting with an accepting SEMC psychiatrist. If the patient resides on any SEMC unit other than the behavioral health unit, within 24 hours of admission the admitting physician will order a psychiatric consult. The admitting physician is expected to abide by the direction of the psychiatrist regarding the patient's psychiatric needs. 3. Patient's complete medical records will accompany him/her to the behavioral health unit. … Voluntary Admission - If the patient agrees to admission, a behavioral health staff member will have the patient sign the legal documents required for admission (IL462-2001 & IL462-2202M). … 5. If the patient lacks decisional capacity, the patient's Guardian or Power of Attorney is aware of, and participates in, the decision- making process regarding admission to the Inpatient Behavioral Health unit *prior to* admission/transfer. The Power of Attorney may sign the patient into the behavioral health unit. A verbal consent may be obtained and documented on the voluntary admission papers (IL462-2202M). 6. If the patient does not have a Power of Attorney or the Power of Attorney is unable to be contacted and the patient lacks decisional capacity to sign him/herself in, a petition (IL462-2005) and a certificate (IL462-2006) must be completed prior to transferring the patient. The certificate must be completed by the attending physician prior to the transfer. 7. The transferring nurse provides report to the accepting nurse. 8. A behavioral health services staff member will accompany the patient after the patient has signed in and had their rights read."

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."

COMPLAINT #1 CONCLUSION:

The HRA finds the allegation that OSF St. Elizabeth – Ottawa facilitated an improper involuntary admission process for the recipient **unsubstantiated**. The recipient was transferred and admitted to the facility on 1/30/24 for a behavioral health admission due to "mania". The sister hospital that sent the recipient to this location for admission began the involuntary admission process. However, upon arrival to OSF St. Elizabeth – Ottawa, the recipient agreed to a voluntary admission. On 1/31/24, the attending psychiatrist entered a note documenting the recipient had decisional capacity based on their professional judgement. The HRA reviewed the voluntary application signed by the recipient on the date of admission. There is a psychiatric note entered in the record documenting the recipient had decisional capacity to understand the process and voluntarily admit per 405 ILCS 5/3-400.

The HRA makes the following **suggestions**:

- The HRA suggests that when an individual has an involuntary admission for behavioral health care at another location and is then transferred to this hospital location for a behavioral health admission, someone on the interdisciplinary team should provide the patient with the Involuntary Admission Petition and Certificate to ensure the legal documentation was received.

- Although, this recipient did not have a POA for Healthcare in place, when the HRA was reviewing OSF St. Elizabeth's policy titled "Admission or Transfer to the Behavioral Health Inpatient Unit" the HRA noted that number 5. Of the policy should be clarified to ensure the hospital is verifying a Power of Attorney for Healthcare and documenting its validity in the patient record and if there are any limits to the broad authority granted by a Durable Power of Attorney for Healthcare. Due to the restrictiveness of an admission for behavioral health care the hospital should request an "Agent's Certification and Acceptance of Authority" per 755 ILCS 45/2-8 that states "b. Upon request, the named agent in a power of attorney shall furnish an Agent's Certification and Acceptance of

Authority to the reliant in substantially the following form:" to ensure the POA agent has the authority and agreed to act as the legal decisionmaker.

COMPLAINT #2 - Inadequate treatment planning.

FINDINGS

The HRA reviewed an "IDR Behavioral Health Treatment Plan" created on 1/30/24 with the diagnosis of "Bipolar and related disorder, unspecified anxiety disorder, unspecified," and the presenting problem was documented as "Mania". The treatment team was providing care to rule out "Psychosis induced by medical condition" The recipient had a long-term goal of "Do photography". The recipient had short term goals of "100% medication compliance" with the Objective of "RN and pharmacy to offer, and patient to participate in, medication education group 4 days out of 7 days to increase compliance and knowledge. RN to administer medication as prescribed by the physician daily and increased knowledge related to prescribed medication." And, the patient is to "Improve functioning" with the Objective of "Reduce psychosis and mania". The HRA reviewed a document titled "Behavioral Health Interdisciplinary Treatment Plan" and "See EPIC for tx (treatment) plan goals" is handwritten in the box titled "Initial, Ongoing, Discharge". In a section titled "Staff in Attendance", the HRA observed the initials of a Psychiatrist, and signatures of a Registered Nurse (RN) and Licensed Clinical Social Worker (LCSW). The HRA also observed the signature of the service recipient which indicates that the recipient participated in this meeting.

On 1/30/24, the first day of admission, the record also reflects an LCSW inquiring about a Power of Attorney and documented that "Pt is unsure if she has a POA but believes if she has one it would be her mother." This same assessment mentions what steps should occur for discharge and the LCSW documents "Pt will be linked with aftercare services prior to discharge. Therapist will staff this patient, as appropriate, with psychiatrist and treatment team to determine further recommendations. Patient should follow up with existing PCP or Psychiatrist once discharged or arrange an initial appointment with a psychiatric professional to help address any psychosocial needs."

Further along, the HRA then reviewed the following statement, as part of the treatment plan signature page "The patient/legal representative signature below indicates that a copy of this treatment plan has been reviewed and explained to patient/legal representative. A copy of the treatment plan has been offered/received/refused". This section of the document does not explain to the HRA if the recipient received it. The line that would be used for the patient/recipient or representative to sign is blank.

The HRA reviewed the Rights of Individuals Receiving Mental Health and Developmental Disabilities Services signed by the recipient on 1/30/24. According to the document, when signing the rights form, the person is acknowledging that the rights have been explained and they received a copy. The HRA observes on this rights form that it communicates to the recipient they are entitled to "adequate and humane care and services in the least restrictive environment and to an individual services plan."

On 1/31/24 the HRA reviewed a case management note written by an LCSW that documents “Pt is open to her mother (Name and Phone Number) and brother (Name and Phone Number) being involved in her care. Consent already on file.” There is nothing in this note that indicates the facility communicated with either family member about discharge planning although the record reflects that family picked the recipient up at discharge on 2/2/24.

The HRA reviewed the hospital’s After Visit Summary, dated 2/2/24, that explains to the recipient what treatment they received during their admission. There is a section on this document that lists “allergies” and gluten is not listed as an allergy. The recipient was scheduled for three aftercare/follow-up visits: primary care physician, adult behavioral health outpatient program, and a psychiatrist appointment.

The HRA reviewed a Case Management Discharge Readiness Note completed by an MSW staff on 2/2/24. Under the section of this form titled “Discharge Plan Notification/ Verification” the HRA reviewed the following, “Final home discharge arrangements: home with other outpatient services Mode of transportation at discharge: Family car Additional Information regarding DC Plan: patient to discharge home today with family who will transport home. Outpatient follow up appointments listed on AVS.” The notes also read “6. Family/ Caregiver's readiness, willingness and ability to support patient with anticipated community discharge plan: Unable to contact family/caregiver.”

The HRA reviewed the OSF Patient Behavioral Health Workbook. The HRA reviewed the Section of the handbook titled “Rules and Conduct for Inpatient Programs” and notes “Process. The rules of conduct include: 1. We encourage you to attend and take part in all program activities.” The HRA also reviewed a handbook page titled “Unit Information”. There is a question of “What should I expect while I’m here?” and the handbook answer is “OSF Healthcare St. Elizabeth Medical Center’s Behavioral Health Unit offers a number of services. We will help you manage your symptoms and stress while creating a therapeutic environment for you to thrive. Your treatment plan will be created by you and your treatment team. We try to find out what works best for you. This is a group focused treatment program. Group work will be strongly encouraged throughout your treatment. You may also have individual therapy sessions, medication management, and case management services. It is important that you understand and take part in your treatment plan.” The handbook communicates different group approaches. The HRA notes that the group called “Rise and Shine” is the first group of the day and provides patients with an opportunity to discuss roles of their healthcare team, issues experienced in the treatment milieu and “talk about their treatment goals for the day.” The Handbook also offers a worksheet for patients to complete titled “Individualized Treatment Goals. The top 5 things you want to work on while here:” The patient would then complete the worksheet on their own. This worksheet also explains to a patient “You will meet with each health care team during your first 24 hours. Each one will ask you to set treatment goals for yourself. They will help you set goals you can measure and achieve. … The goals will reflect what you feel is important to your treatment.” Another section of the workbook explains a “Family/Social Support Session” and explains to a patient “You may want to involve your family or social support in your treatment. If you do, we will have a support

session with them. During this, we will talk about safety. We will develop a safety plan. We will talk about what led to your hospitalization. We will discuss discharge plans. We highly encourage this session. It gives you a safe space to talk about stressors or concerns you may have with your support." There is then a list of questions to be answered by the patient to prepare for the support session.

The HRA reviewed hospital policy titled "Psychosocial and Treatment Plan" last reviewed and in effect since December 2023. The purpose of this policy is explained as "To assure that patients admitted to the inpatient unit receive a psychosocial assessment in order to develop a treatment plan within 72 hours." The Policy section also explains that "All patients should receive a psychiatric social assessment as soon as it is possible and not to exceed 72 hours." On page 2 of 3 it states "6. The assessment will be documented in Epic in the bio-psychosocial assessment interdisciplinary note. 1. The initial Interdisciplinary Treatment Plan is reviewed with the patient; a Treatment Plan Review will be completed at the next scheduled Treatment Team meeting. All members of the treatment team shall sign that they participated and agree to the plan, including the patient. Treatment plans should be updated every 7 days. 2. The Interdisciplinary Treatment Plan consists of the following information: Admission Date, Patient Strengths, Admitting Diagnosis/Dual Diagnosis, Family Involvement, Discharge Plans, Prioritized Problem List, Short/Long Term Goals, Participant Signatures. 7. Patient should be given a copy of their treatment plan."

The HRA reviewed OSF "Discharge Planning" policy, which was last approved in April 2024 and applies to All OSF Hospitals - Clinical. This hospital policy defines "Discharge Planning" as "a multidisciplinary process that determines the care a patient will need following a hospitalization including services, supplies, and equipment, in alignment with the patient's goals and treatment preferences to enhance continuity of care and support the patient's optimal health outcome." The Purpose of the policy is "To outline a discharge planning process that focuses on patients' goals and treatment preferences through sharing information and promoting active participation in planning for post-discharge care and prepares patients and/or patients' legal decision maker(s) and caregiver(s) for hospital discharge." The policy defines "**Legal Decision Maker:** Agent appointed in a Power of Attorney for Health Care, parent(s) of minor patients or minors,". The policy defines "**Caregiver:** A person in the community who assists the patient with activities of daily living, either voluntarily or paid." The Policy section explains "1. Only a licensed provider can authorize the hospital discharge order in accordance with state practice laws and hospital policies. 2. Patients identified by screening at an early stage of hospitalization as being at risk to suffer adverse health consequences upon discharge in the absence of adequate discharge planning or upon request by the provider, registered nurse (RN), patient or patient's legal decision maker(s) or caregiver(s) will have a discharge evaluation performed. 3. RN, social worker, or other appropriately qualified personnel performs or supervises others to perform the discharge evaluation, establishes a recommended discharge plan and discharge plan revisions. 4. Discharge plans are created in collaboration with the interdisciplinary team, patient and/or patient's legal decision maker(s) and caregiver(s) to meet the patient's needs as determined by the patient's medical condition, goals and

treatment preferences, and options available. … the Process to identify a patient ready for discharge is An RN screens bedded patients at an early stage of hospitalization to determine potential need for discharge planning. If discharge needs are identified, the RN places an order or otherwise notifies the Case Manager or other appropriately qualified personnel designated to perform the discharge evaluation. 1. Any member of the interdisciplinary team, the licensed provider, the patient or the patient's legal decision maker(s) or caregiver(s) can request a discharge plan on a bedded hospital patient during a hospital stay. If a person wishing to request a discharge plan cannot enter an order, an RN or licensed provider facilitates the request for discharge planning to the appropriate personnel on their behalf. 2. Case Management or qualified personnel assigned to perform the discharge planning function will automatically evaluate and follow bedded patients identified by OSF standards as high risk for discharge planning."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) Care and services; psychotropic medication; religion** states "(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 Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment 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 [405 ILCS 5/2-200] shall be noted in the recipient's treatment plan."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107) Refusal of services; informing of risks** states "(a) An adult recipient of services … must be informed of the recipient's right to refuse medication … . The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication … . If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-200) Admonishment of Rights** requires "(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 notice shall include, if applicable, the recipient's right to request a transfer to a different Department facility under Section

3-908 [405 ILCS 5/3-908]. Every facility shall also post conspicuously in public areas a summary of the rights which are relevant to the services delivered by that facility as well as contact information for the Guardianship and Advocacy Commission and the agency designated by the Governor under Section 1 of the Protection and Advocacy for Persons with Developmental Disabilities Act [405 ILCS 40/1]. **(b)** A recipient who is 12 years of age or older and the parent or guardian of a minor or person under guardianship at any time may designate, and upon commencement of services shall be informed of the right to designate, a person or agency to receive notice under Section 2-201 [405 ILCS 5/2-201] or to direct that no information about the recipient be disclosed to any person or agency."

COMPLAINT #2 CONCLUSION

The HRA finds the allegation that OSF St. Elizabeth Healthcare – Ottawa provided inadequate treatment planning evidenced by denying the recipient's request for a family meeting to discuss discharge plans **unsubstantiated**. The recipient was making decisions as their own person during the admission. The hospital record does not document a Power of Attorney, guardian, or direct request from the recipient to communicate with a particular member of their family about their discharge plan. There was one case management note in the record that states "the patient is open to… ." having family involved. However, nothing in the record indicates the recipient requested someone other than herself to be involved with her Discharge Plan or even treatment plan surrounding discharge as required by **(405 ILCS 5/2-102)** that states *"The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan."* This same note indicates consents to release information were on file, although they were not found in the chart record that was reviewed by the HRA. The treatment plan was completed within 72 hours of admission, per hospital policy, and was signed by three members of the interdisciplinary team and the recipient. When the recipient discharged from OSF St. Elizabeth – Ottawa, they left in "family car." The Behavioral Health Unit Workbook does communicate to the recipient that *"they may want to"* involve family or a social support for treatment and if the recipient wanted that then a "support" session could be facilitated. However, the record does not reflect that a support session was requested or facilitated.

The HRA makes the following suggestions:

- The hospital should clearly document what "family or social supports" are identified by a patient and ensure they are consistently communicated with and if they are unable to be reached; members of the interdisciplinary team should consistently document their efforts to contact the identified supports.

- During the site visit the team indicated that copies of a patient's treatment plan are not printed out and provided to the person. This is contrary to the hospital's own Psychosocial and Treatment Plan policy that states "7. Patient should be given a copy of their treatment plan." The HRA would also like to highlight that 740 ILCS 110/4 of the Mental Health and Developmental Disabilities Confidentiality

Act mandates "(a) The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof: …(2) the recipient if he is 12 years of age or older;"

COMPLAINT #3 – Patient rights violation.

FINDINGS

The HRA reviewed the recipient's chart record. The record references historical patient information from 2017 when a "youth pastor" had concerns with the recipient after attending a camp. The HRA reviewed a document titled "Behavioral and Mental Health Flowsheet" and there are two questions under the section of "Social Connections" and a member of the Interdisciplinary Team asks the recipient "How often do you attend church or religious services?" and the corresponding answer is "1-4 times per year." There is a second question "Do you belong to any clubs or organizations such as church groups …?" The corresponding answer is "No".

The HRA does not find any Rights Restrictions forms, provider orders or any nurse notes documenting the recipient was refused communication with family, pastor or partner during their three-day admission at OSF St. Elizabeth – Peru.

The HRA reviewed the recipient's History and Physical completed on 1/30/24 and based off information from the sister facility. The recipient did not have a medical diagnosis of Lupus or Hashimoto Disease, it is listed as "questionable Hashimoto thyroiditis". The HRA reviewed a document titled "Patient Education" and there is a section titled "Point: Orientation to Care" and mentions that the healthcare team will explain "how to order meals and what time meals are ordered". The nurse completing this orientation with the recipient documented in the "Learning Progress Summary" the patient's "Acceptance, Explanation, Teach-Back, Verbalizes Understanding" during the evening of 1/30/2024. This information was documented as having been reviewed with the recipient by a Registered Nurse (RN) as evidenced by the nurse's initials.

The HRA reviewed the "Admission Behavioral Health" note entered on 1/30/24. The recipient had a goal with a start date of 1/30/24 listed on her interdisciplinary note to "Optimized Nutrition Intake: Manic or Hypomanic Signs/Symptoms" with the following "Description: Perform a nutrition assessment; include a nutrition-focused physical exam. Evaluate need for frequent meals, snacks and nutrient-dense finger foods; consider vitamin and mineral supplementation. Monitor food and beverage selections; assess intake, eating patterns and behaviors. Weigh patient and monitor trends. Encourage healthy food choices, such as fruits, vegetables, whole grains, low-fat dairy products and lean meats, when stable. Consider cultural and religious preferences when providing food and beverage choices." A "Nutrition Risk Screen" is also noted in the chart having been completed on 1/30/24 at 11:22pm and the RN charted "no indicators." The recipient's Nutrition Intake was charted sixteen times, by different staff and at different times of the day, during her three-day admission as either eating "no apparent abnormalities with appetite", "100%" of meals or "adequate".

On 1/30/24 at 9:31pm the medical record documents an RN communicating a "gluten free" diet. On this same day an RN documents that the recipient's "Orientation to Care Setting, Routine" occurred. Part of this orientation explained to the recipient "how to order meals". The "Learning Progress Section" of this form is documented as "Acceptance, Explanation, Teach-Back, Verbalizes Understanding" being understood and received by the recipient. This is initialed by the staff. On 1/31/24 the Psychiatrist entered an order for a gluten free diet.

On 1/31/24, a Licensed Clinical Social Worker (LCSW) developed a Behavioral Health Bio/Psycho/Social Assessment on 1/31/24 with the recipient. This assessment tool documents, under the section "Presenting Problem" a conversation with the recipient's mother that mentions Lupus. It reads, "The patient is supposed to be following up with rheumatologist for her history of lupus, however, the patient's mother states that it has probably been at least a year since the patient has followed up with that specialist." Further along the recipient explains under the section titled "Current and past symptoms of anxiety" the patient reports she is "Currently 5-6 (which she reports is baseline) with sx (symptoms) of nervousness, fidgeting, worry and anxiety attacks which she describes as feeling like an 'allergic reaction' with numbness and tingling and feelings of difficulty breathing." This same assessment lists current Medical and Past Medical History Positives and the HRA observes "allergic to dogs, seasonal allergies."

The Discharge Summary completed on 2/2/24 documents the recipient reporting "She wanted to eat gluten free food again."

The HRA was provided with a document titled "Skills Admission" and is not hospital policy but guidance to follow from the American Nurses Association that explains how a Nurse should assess a patient. The HRA takes particular note of the section titled "Assessment" and number nineteen on the list explains an RN should assess "History of allergies (medications, food, and environment), including the type of substance and a description of the reaction that patient has experienced. Provide an allergy armband listing allergies to foods, drugs, latex, or other substances, per organization's practice."

The HRA reviewed OSF Hospital Policy "Visitation by Clergy of Area Churches" last approved in March 2022. This purpose of this policy is "To provide guidelines for pastoral visits from the patient's place of worship." And the Policy explains "Clergy (e.g. priests, rabbis, ministers, spiritual leaders and other authorized church representatives) from the patient's place of worship may visit their own members." The Process for this is "1. Clergy are encouraged, when possible to visit during regular visiting hours. It is suggested that there be no regular visits between 8am to 10am since this is a particularly busy time for patient clinical care. … 3. Visiting Clergy/Spiritual Leader: 1. May only receive a list of/visit members from their specific place of worship."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) Care and Services; Religious Objection** states "(b)A recipient of services who is an adherent or a member of any well-recognized religious denomination, the principles and tenets of

which teach reliance upon services by spiritual means through prayer alone for healing by a duly accredited practitioner thereof, shall have the right to choose such services. The parent or guardian of a recipient of services who is a minor, or a guardian of a recipient of services who is not a minor, shall have the right to choose services by spiritual means through prayer for the recipient of services."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-103) Communication** mandates "Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation."

CONCLUSION – COMPLAINT #3

The HRA finds the complaint that a patient's rights were violated during the three-day behavioral health admission is **unsubstantiated**. The complaint alleges the recipient had restrictions implemented by the hospital team and was not allowed to communicate with family, pastor, and boyfriend. Per 405 ILCS 5/2-103 the hospital is mandated to ensure "*that telephones are reasonably accessible*," and "*b) Reasonable times and places for the use of telephones and for visits may be established in writing by the facility director.*" The right to uncensored communication was communicated to the recipient when the rights of individual form was signed on 1/30/24. The recipient was also provided with the Unit Handbook that explains phone use while on the unit. The same rights of individual form also notify the service recipient that restrictions could be implemented upon a physician's order if there were concerns. The chart record does not document any concerns or rights restrictions being implemented during the three-day admission.

The HRA also has no findings about the allegation that the hospital did not provide special diet to a recipient with an autoimmune disorder of "Lupus" and "Hashimoto Disease" that results in an allergy to gluten. Staff at the site explained that a recipient would order their own meals. The record reflects this process was communicated with the recipient during their orientation to the unit on 1/30/24. The recipient's History and Physical did note "questionable Hashimoto thyroiditis". Lupus is not diagnosed in the medical record provided. It is mentioned by the mother. The chart also noted that a 1/30/24 interdisciplinary note to "Optimized Nutrition Intake: (Manic or Hypomanic Signs/Symptoms)" and the recipient's nutrition intake was assessed 16 times during the admission and did not note a gluten allergy. The record did note the Psychiatrist entered an order on 1/31/24 for the recipient to have a gluten free diet. The HRA did not review what the recipient ate for their meals during the three-day admission.

The HRA makes the following suggestions:

- OSF St. Elizabeth – Ottawa should update their Behavioral Health Workbook provided to patients to include clear group times that a patient would not have access to a phone.

- OSF St. Elizabeth- Ottawa should update their Behavioral Health Workbook to explain the unit's process for ordering meals and how a patient would notify their interdisciplinary team of a dietary needs such as gluten free or other allergies.

- OSF St. Elizabeth – Ottawa should review how the behavioral health unit ensures that the nutritional needs of a behavioral health patient are met. The chart record provided did not document what meals the recipient was eating only noting that they had been eaten.

- OSF St. Elizabeth- Ottawa should review and update their Visitation by Clergy of Area Churches policy to include information to the employee on how a patient could make a request for a pastoral care visit from a non-Catholic denomination even if they do not regularly attend a church. This same policy should also be updated to reflect language found in section 405 ILCS 5/2-102 of the Code and how a patient may choose treatment based on their religious belief system.

RESPONSE

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