FOR IMMEDIATE RELEASE

The Pavilion
Report of Findings
Case # 23-060-9008

The East Central Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission voted to pursue an investigation of The Pavilion in Champaign, Illinois receiving the following complaints of possible rights violations:

1. **Inadequate discharge including failing to notify consumer of patient rights and falsifying documentation**
2. **Inadequate treatment including restricting patients' rights**
3. **Inadequate communication**
4. **Inadequate access to records**
5. **Lack of access to property**
6. **Inadequate grievance procedure**

If the allegations are substantiated, they would violate protections under The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102, 405 ILCS 5/3-401, 405 ILCS 5/2-103, 405 ILCS 5/2-104, 405 ILCS 5/3-403, 405 ILCS 5/2-201, and 405 ILCS 5/4-210), The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4), and The Code of Federal Regulations (42 CFR 482.13).

Complaint Summary: The complaint alleges the facility filed a petition for involuntary admission after the individual requested discharge and the physician and staff did not notify the individual of her rights and falsified the documentation saying they informed the individual of her rights. Additionally, the complaint alleges the witnesses to the petition were not present but signed as a witness anyway. Allegedly, the individual was on 1:1 observation for her entire stay at the facility and the individual, who is female, had a male supervising her while using the restroom and showering. Allegedly, the individual was not allowed to make private phone calls. Additionally, the complaint alleges the individual was not allowed access to her phone or wallet and had to obtain a court order to have access to her phone. The complaint alleges the individual requested to see her records twice but was denied and told she had to wait until after discharge. Additionally, the complaint alleges the individual wanted to allow her attorney and primary care physician access to her records, but the facility refused. Furthermore, the complaint alleges the individual attempted to file two grievances, but the facility did not respond to her grievances.

Investigation:

The HRA proceeded with the investigation after having received proper consent. To pursue the matter, the HRA visited the facility virtually and the program representatives were interviewed. Relevant practices, policies and sections of the consumer's record were reviewed.

Interviews:

On March 3rd, 2023, the HRA met virtually with staff of The Pavilion. Staff stated the Pavilion offers many different types of programs including an adult inpatient psychiatric unit, medication detoxification, substance abuse, a pediatric psychiatric unit, and a behavioral health school. Staff stated the adult psychiatric unit consists of two units, one has a 30-bed unit, and one has a 12-bed unit. The units are staffed by 7 workers per shift, working 8-hour shifts. Staff stated the patient to staff ratio is approximately 4 to 1. Staff stated patients in the adult inpatient psychiatric unit attend group programming daily. Additionally, patients meet with the psychiatrist daily to review treatment.

The Pavilion has approximately 260-270 employees. Upon hire, employees attend one week of classroom training. During that week, staff are trained on subjects such as therapeutic crisis intervention, risk management, patient rights, and abuse and neglect. Additionally, staff have access to an online health stream platform for additional training courses. Annually, staff attend a fair where they participate in interactive training. Also, staff stated the nursing director provides monthly meetings review updates about any incidents that occurred.

Staff stated the individual was sent to a hospital emergency room after calling her therapist and stating she wanted to drive her car off a bridge to commit suicide. Staff stated the individual's vehicle ran out of gas in her attempt to drive off a bridge. Staff stated the individual was then transported to the Pavilion after agreeing to be admitted voluntarily. Staff stated the individual was explained the voluntary admission process and her rights at admission. The individual signed all the forms which stated the individual was explained her rights and she was provided a copy of her rights. A day after her voluntary admission, the individual submitted a written request for discharge. Staff stated four days later, the involuntary admission process was started. Staff stated the individual was not suitable for discharge because of statements that she made about committing suicide once discharged. Additionally, the individual was not engaging in treatment or attending group sessions. Staff stated they wanted the individual transferred to another facility which provided a higher level of care. Staff stated the individual was notified that the staff was meeting with her for the purpose of obtaining involuntary admission. Staff again went over the rights with the individual. Staff stated the form that is completed is provided by the state and there is not a place for the individual to sign however, the clinician signs stating they have reviewed the rights with the individual. Staff stated the witness section is for the registered nurse to sign indicating the nurse has observed the behavior of the individual not that the nurse witnessed the clinician explain the rights to the individual.

Staff stated the individual continued to express desires to commit suicide while at the Pavilion. The individual was placed on 1:1 observation due to the individual's continued insistence on committing suicide. Staff stated the individual remained on 1:1 observation the entire time she was at the Pavilion which was approximately 28 days. Staff stated it is not their goal to keep a patient on 1:1 observation for that long but in this case, it was needed. Staff stated they would

discuss the individual's restriction daily during their morning meetings. Additionally, the physician met with the individual daily. Staff stated the physician wanted the individual to have better insight to the severity of her condition. Furthermore, the physician wanted the individual to find a reason to live. Staff stated some of the conditions of the 1:1 observation changed during the 28 days. Staff stated the treatment team felt the individual was minimizing her suicide attempt and risk for suicide. Staff stated the individual was aware of the restrictions and why they were needed. Furthermore, the physician discussed the restriction with the individual daily during their meetings. Staff stated when a patient is on suicide watch, and has 1:1 observation, the patient is observed in the bathroom and shower. Staff stated they ensure a member of the opposite sex is not observing patients in the bathroom or shower. Staff stated they reviewed the 1:1 observation logs for the individual and the staff signatures indicating they observed the individual in the bathroom or shower were all female. Staff stated they do not have a formal Human Rights Committee; however, they do have a team of staff members and administration that meet daily to discuss all restrictions.

Staff stated they have phones on the wall near the nurse's station. Staff stated the phones are far enough away that staff cannot overhear the patient's conversation, but the patient can still be within visual observation requirements. Staff stated patients are allowed to use the phones whenever they choose but it is discouraged during group session times. Staff stated the individual used the phone several times during her time at the Pavilion. Staff stated the individual was allowed access to her personal cell phone on several occasions to obtain phone numbers. However, staff stated patients are not allowed to use their personal cell phones due to safety and security concerns. Staff stated they can also look up phone numbers or information for patients if asked. Staff stated they did receive a court order for the individual to have a virtual visit with her children. Staff stated this was a rescheduled visitation with her children that was previously missed due to weather. Staff stated the individual was allowed to use her phone for the virtual visit with her children and this is documented in a progress note. Additionally, staff stated the individual was allowed to meet privately with her attorney. Staff stated patient's personal belongings are stored in a locked room, only accessed by staff. Staff stated are not allowed to keep their wallets on them but can access the wallet if needed. Staff stated there is nothing documented stating the individual requested to obtain information from her wallet.

Staff stated patients are allowed to view their records or obtain copies. However, the request needs to be in writing. Staff stated if there is clinical justification, a request can be denied. If a request was denied, the physician would notify the individual in writing of why the individual's request was denied. However, staff stated that a denial rarely occurs. Staff stated the individual submitted a request for physical copies of her records. However, staff stated it is unclear if the individual was provided a copy of her records or not. Staff stated typically when a patient request records, the request is sent to medical records to fulfill the request. Staff stated they normally only have request for records after discharge. Three days after admission, the individual signed a request for two attorneys working on her child custody case to obtain her discharge summary and instructions. Staff stated at that time, that information was not available since the individual was not discharged for another 23 days. It is unknown if the records were sent after the individual was discharged. Staff stated the individual did not request any records be shared with her primary care physician.

Staff stated the individual never filed a grievance. Staff stated patients are allowed to file a grievance by calling the patient advocate. The patient advocate will then respond to the patient within 24 hours to discuss the grievance. The patient advocate then has 7 days to complete the investigation or request an extension in writing. The patient bill of rights lists how patients can file a grievance. Staff stated there are also flyers posted on the walls informing patients how to file a grievance. Staff stated patients can submit a grievance in writing but that is not listed in the patient bill of rights or the posters throughout the facility. Staff stated if a patient has complaints and expressed those to a staff member, that staff member would try and address the complaints. If the complaints cannot be addressed by the staff member, then the staff member would contact the patient advocate. Staff stated the individual expressed several complaints with the physician and those complaints were addressed with the patient. However, no formal grievance was filed by the individual.

Policy Review:

The "Patient Observation" policy states "One to One patient observation: The 1:1 observation procedure may be implemented if one or more of the following conditions exists: Safety concerns related to the high-risk nature of the patient's actual or potential behaviors. Safety concerns related to a specific vulnerability of the patient and specific risk in the milieu. Intensive Behavioral Management (Youth Services only) and If there is a written physician's order, which must: Specify criteria and Be rewritten daily. The attending physician will monitor patient status and criteria for increased staff supervision on an on-going basis to assure the appropriate level of supervision is maintained for patient safety. If at any time the Charge Nurse determines a patient may need increased staff supervision to prevent harm to self/others, the RN will take action to provide the additional supervision, contact the Director of Nursing/designee to inform of patient condition, and contact the attending physician/designee for appropriate orders. For 1:1 supervision, at the beginning of each shift, the assigned RN will contact the physician to review the patient's current status and criteria for maintaining 1:1 supervision. The physician will provide orders for continuing or discontinuing 1:1 supervision, based on the patient's current status and in consultation with the treatment team. The order will include clinical criteria for the level of supervision ordered, including justification for decreasing the level of supervision, if ordered. Every twenty-four (24) hours while on 1:1 supervision, the physician/designee will conduct and document a face-to-face assessment of a patient's risk to self/others, to include justification for current level of staff supervision. The status of all patients assigned to 1:1 supervision will be reviewed in the morning Flash meeting. This status check will allow for ongoing clinical and administrative issues related to 1:1 supervision to be addressed. A specific staff member will be assigned to be in constant visual contact with the patient while on 1:1 observation. This staff member will have no other duties and will intervene immediately, when necessary to protect the patient or others. Assigned staff will inform the patient of the need for and process involved in 1:1 monitoring. Staff will document in the patient's medical record a minimum of every four hours."

The HRA reviewed the "Suicide and Self-Harm Prevention and Response" policy which states "During the course of the assessment process, assessment staff who identify a patient as a suicide risk will follow the protocol outlined below: An identified suicide risk who needs to use the restroom will need to be escorted by staff to the designated ligature resistant restroom. Those who

are not identified as a suicide risk may use the front near the front desk. A key will be provided by the front desk to use those restrooms. Family members/visitors will obtain a key from the front desk to use those bathrooms. Unit staff will receive initial communication about the patient's risk of suicide and self-harm on hand-off communications from the person conducting the initial assessment. Staff will communicate risks to other staff daily via the shift report and the patient observation hand-off procedure as outlined in separate policy… Staff will ensure that patient treatment plans address identified risks for suicide and self-harm. Staff will immediately intervene when a patient's behavior puts them at risk for suicide or self-harm. Staff will immediately notify supervisory staff of any suspicious or other behavior of concern. Supervisory staff will notify all other appropriate treatment team members, as well as include notifications within the shift report. During observation monitoring, if a patient is in an area where staff cannot visualize them (e.g., bathroom or shower), staff will inform the patient that if they cannot come out to be visualized that staff must enter the area in order to visualize them. All attempts will be made to secure additional staff quickly prior to such observation and the observer shall be of the same gender."

The "Assessment and Management of Suicide Risk" policy states "The Treatment Team is to begin formulation of the Discharge Safety Plan upon admission. Patients and family members, or others as identified as support systems by the patient, should be invited and allowed to participate in the formulation of the plan. Elements of the plan should include, but are not limited to: List of names of those involved in the Discharge Safety Plan, Potential Triggers/Specific Contingency Plans, An overview of protective factors – including coping strategies and strategies for distraction and support, Names and numbers of key contacts (outpatient providers, next level of care providers, crisis hotlines, community and peer support groups), Instructions regarding lethal weapons / firearms that the patient may have access to upon discharge. If the patient has access to weapons or firearms and is unwilling or unable to provide for a safe plan, the facility may contact legal authorities in order to maintain and protect patient safety, Safe storage and management of all medications, and Warnings to abstain from the use of alcohol or other illicit substances. The contents of the Discharge Safety Plan are to be clearly communicated to the patient, family members, next level of care, and any others that the patient identifies prior to or upon discharge. The MD is to review, approve and sign off on the Discharge Safety Plan indicating review and approval of the plan."

The HRA completed a review of the "Patient Request to Access PHI (Public Health Information)" policy which states "As described in the Notice of Privacy Practice, an individual may request in writing access to their PHI in the medical and/or billing records. The individual's request for access to the will be process as follows: Written Request: Request for access to PHI will be in writing. The request for access to the individual's PHI will identify the particular PHI for which access is sought. The request for access to the individual's PHI will identify the manner in which the individual is requesting access to the PHI (i.e. a paper copy, an in-person review, or an electronic copy of the medical/billing records). Facilities will designate a person or office that will be responsible for receiving and processing access request. Typically, this would be assigned to the director of Health Information Management/Medical Records Department. The information on the responsible individual's and/or department will be retained by the Facility for six years. A facility will respond to an individual's request for access to the PHI within thirty days after receipt of the request for the PHI if it's maintained on site. A facility may extend its time to respond to a request for access for one additional 30-day period if a Facility notifies the individual requesting the PHI

before the initial term period expires of the reasons for the delay and the date by which a facility will complete its action on the request…A facility may deny access to PHI in the following situations, and the individual must be provided a right to have a denial reviewed: A licensed health care profession has determined, in the exercise of professional judgement, that the access requested is reasonably likely to endanger the life or physical safety of the patient or another person, The PHI makes reference to another person…In providing access to PHI under this policy, the facility will: provide the individual with access to the PHI through inspection, copying or both. Arrange a convenient time and place for the individual to inspect or obtain a copy of the PHI…".

The HRA reviewed a copy of the Pavilion's "Appropriate use of Involuntary Commitment" policy. The policy states "Involuntary Commitment- is a legal intervention by which persons designated by the state of Illinois may order a person with symptoms of a serious mental disorder, and meeting other specified criteria, be confined in a psychiatric hospital for some period of time as defined by the State. Involuntary Admissions-Patients presenting for admission who are on an involuntary commitment or other state designated process initiated by a person outside of the hospital. Involuntary admission refers to admission of a patient against his/her will. An involuntary admission may be needed when, due to mental illness, a person is reasonably expected to be a danger to themselves or others, or unable to care for themselves due to mental illness. The exact legal requirements for an involuntary are contained in the Illinois Mental Health Code and change/are updated from time to time. The Pavilion Hospital will comply with current Mental Health code in admitting patients on an involuntary basis. Voluntary to Involuntary Commitment- is a change in legal status where a patient who was admitted voluntarily during the course of treatment a determination is made that a patient meets involuntary commitment criteria. (405 ILCS 5/3-401). Persons designated by the state of Illinois to initiate involuntary commitment: Petition – Any persons 18 years or older. (405 ILCS 5/3-601), Certificate 1 – Physician, qualified examiner, psychiatrist, or clinical psychologist. (405 ILCS 5/3-602), and Certificate 2 – Psychiatrist (not same as Certificate 1), physician, clinical psychologist, or qualified examiner. (405 ILCS 5/3-610). The process for involuntary commitment is outlined in the Illinois Mental Health and Developmental Disabilities Code Article VI – Emergency Admission by Certification (405 ILCS 5/Ch. III Article VI). The Director of Admissions/Intake coordinates the involuntary admission process at The Pavilion Foundation Hospital. Petition and Certificate is presented at time of admission. Within 24 hours, the patient is examined by a second certifier. The second certificate is completed, and all documents are forwarded to the Champaign County Clerk for processing. A court hearing is presided over by a Champaign County judge who reviews the evidence, documentation, and hears witness testimony. If the patient is not found subject to involuntary admission, the court shall dismiss the petition and order the patient discharged. If the patient is found subject to involuntary admission, the court shall enter an order so specifying. (405 ILCS 5/3-809)."

The HRA received a copy of The Pavilion's policy titled "Patient Bill of Rights" which states "…You have the right to receive proper care and mental health services in the least restrictive environment appropriate to your needs. You have the right to request medical care. A physician is not staffed on the premises 24 hours a day, but a physician is on-call and may be reached 24 hours a day by hospital staff…You have the right to be informed of your clinical condition, unless your physician for appropriate reasons, chooses not to inform you, and so indicates in your medical record. You have the right to actively participate in the development of your

treatment plan, which will be implemented by the clinical staff and reviewed periodically. You have the right to receive information necessary to give informed consent prior to the start of any treatment or services to be provided, and prior to being involved in activities that include the use of tape recorders, one-way observation mirrors, photography, or any special audio-visual techniques. You (or your guardian on your behalf) have the right to refuse treatment and/or medication to the extent permitted by law and to be informed of the consequences of refusing treatment…You have the right to be informed by the prescribing physician of the benefits and/or risks of the drugs being prescribed in term you are able to understand. In the event that you are unable to understand, your family or guardian shall be informed…".

The HRA reviewed the "Patient Discharge Management" policy which states "Discharge Procedure - Complete Discharge Process Checklist. Individualized Crisis/Safety Plan. The Individualized Crisis/Safety Plan is developed by the patient and case manager to assist in recognizing relapse warning signs and identifying ways to maintain safety. The plan also serves as a tool if a crisis ensues. The case manager and patient develop the individualized crisis/safety plan during hospitalization. The nurse or case manager reviews it again with the patient and family at discharge. The patient and parent/guardian/significant other is to sign and be given a copy of the individualized crisis/safety plan. If the family/support is not available at discharge, the nurse or case manager may review by phone and document on the crisis plan accordingly… Discharge and Continuing Care Plan. The case manager/discharge planner will develop the Discharge and Continuing Care Plan for each patient to determine that patient discharge needs are being appropriately met. The case manager will document the previous treatment providers/referral sources, aftercare provider and aftercare appointments. The nurse will complete medications prescribed at discharge section and any applicable referrals. The nurse will review all sections of the Discharge and Continuing Care Plan with the patient and family at discharge. The nurse needs to sign the Discharge Care Plan which indicates the review was done with the patient/family. The patient and parent/guardian/significant other is to sign the Discharge and Continuing Care Plan. The patient and parent/guardian/significant other is to sign and be given a copy of the individualized crisis/safety plan. If the family/support is not available at discharge, the nurse or case manager may review by phone and document on the crisis plan accordingly.…Notification: patient, family or other appropriate resource, and Case Manager will document in a progress note the response of the patient's family (for all levels of care) when notifying them about identification and removal of weapons, lethal medications, and/or other means of self-harm from the home… Write discharge note in staff progress notes - include time and date of discharge, prescriptions sent, and with whom the patient left…".

The HRA reviewed the "Interdisciplinary Patient-Centered Care Planning" policy which states "It is the policy of Pavilion Behavioral Hospital to provide therapeutic services based upon a patient-centered, individualized treatment plan. The treatment team, led by the attending psychiatrist, works with the patient and family/representative to collaboratively identify the patient's assessed needs to be addressed during treatment and develop appropriate goals and interventions.…The nurse completing the Nursing Assessment or designee shall develop the Initial Treatment Plan within eight hours of admission. The nurse will utilize the problems and specific behavioral manifestations identified in the initial assessment and nursing assessment to develop clinically appropriate and individualized goals and interventions which will be included in the initial treatment plan.…The social services staff member assigned to the patient will be responsible for

meeting with the patient and family/representative, if appropriate prior to the MTP meeting to obtain their goals for treatment and any input they may have related to treatment interventions. Within 72 hours of admission, the multidisciplinary team shall meet to develop the treatment plan. Whenever possible, the patient and family/responsible party will be included in the treatment team meeting.…The patient/family and/or representative is to sign the treatment plan to indicate their agreement with and participation in development of the plan. A designated staff member is responsible for discussing the treatment plan with the patient and family/representative if they are not present at the treatment plan meeting…".

The HRA reviewed The Pavilion's policy titled "Admissions Process" which states under the assessment process "…Upon arrival in the lobby, persons in the building requesting services are given written material (Acknowledgment of Understanding of Initial Assessment) to assist them to understand the assessment process. They will also receive a copy of the HIPAA privacy statement…Unless eminent safety concerns preclude doing so, the following documents will be reviewed with the patient and their informed consent/signature obtained: Application for Admission, Consent for Admission, Patient Rights, Acknowledgement of receipt of HIPAA notice, Advance Directives, Insurance Documents…". Furthermore, the policy states under Patient Rights that "Patients being admitted on a voluntary basis are to be given a copy of the 'Rights for Voluntary Admittee' at admission. Their signature on the Application for Voluntary Admission documents their consent to be admitted on a voluntary basis. Consent is to be obtained by the RN on the unit if assessment department staff are not present at the time of admission…A voluntary patient who requests his/her release by writing a five (5) day notice may be converted to an involuntary status if the attending physician, within five (5) calendar days from the receipt of the request for your patients and five (5) court days from the receipt of request from adult patients, files or causes to be filed an affidavit with the court. The patient's request for release serves as a request for a probable cause hearing. Failure of the attending physician to cause an affidavit to be filed with the court within five (5) calendar days of your patients and five (5) court days for adult patients results in the release of the patient. Notify the attending physician whenever a patient requests their release by writing a five (5) day notice. A patient may be held for the entire five (5) day notice to make a determination…".

The HRA reviewed the policy titled "Allowed Patient Possession and Possession Checklist" which states "All patient belongings brought onto the unit at the time of admission must be examined and evaluated by staff for safety and appropriateness, as described below…The assessment department will secure patient belongings, place them in a tub, close the lid, and put a sticky with the patient's name on top. That bin will then be delivered to the unit upon admission. Staff will take the patient bin and place all patient belongings behind the counter in the nurses' Station until these items have been examined and evaluated. Staff will inform the patient and family that any items brought onto the unit following admission must also be checked in and that the patient and/or family are obligated to tell staff of any personal belongings that are subsequently sent home. Complete the possession checklist. Staff will inform patients that staff may inspect personal belongings at the time of discharge to reconcile the Procession Checklist with items being taken home, although it is each patients' responsibility to keep track of personal belongings while hospitalized…Staff will document all items that remain in the facility on the possession checklist. After patient belongings have been examined, determined to be appropriate for patient possession on the unit, and entered on the Possession Checklist, patient

property not locked up will be given directly to the patient to whom it belongs or placed in that patient's room."

A review of the Pavilion's "Patient Precautions" policy states "Utilizing the Comprehensive Assessment, all patients are assessed by an Intake Specialist for unsafe behaviors and situations. Precautions may be initiated by a nursing or physician order. Any team member may request precautions through the charge nurse, who will communicate with the physician. Orders are recorded on the physician order form. Precautions are recorded on the cardex and the report sheet. All responsible staff is notified of precautions. Precautions are documented on the observation flow record. Once a precaution order is in place, it can only be discontinued by a physician order. Precautions may be addressed in the Master Treatment Plan. Applicable goals and interventions, including education, will be addressed with assessment and reassessment to identify risk factors that may prompt initiation of or changes in precautions. The Master Treatment Plan will also include a response and notification plan as applicable….".

The HRA reviewed "Patient Advocacy and Grievance Resolution" policy which states "a patient grievance is a formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient's representative, regarding the patient's care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital's compliance with CMS Hospital Conditions of Participation, or a Medicare beneficiary billing complaint related to rights and limitation provided by 42 CFR 489…If a patient care complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution, then the complaint is a grievance for the purposes of these requirements. A complaint is considered resolved when the patient is satisfied with the actions taken on their behalf…. A written complaint is always considered a grievance. This includes written complaints from an inpatient, an outpatient, a released/discharged patient, or a patient's representative regarding the patient care provided, abuse or neglect, or a patient's representative regarding the patient care provided, abuse or neglect, or the hospital's compliance with CoPs… Patients and their family members are informed of their rights and responsibilities upon admission, and the process by which they can voice any concerns related to their rights and/or treatment. This information includes the procedure by which a grievance can be submitted, the name and method to access the patient advocate, the time frame for review of the grievance, the provision of a written response to the complaint and the timeframe for that response. The patient advocacy phone number is posted throughout the facility and admission packets contain information related to the grievance procedure. On each unit in the hospital, the phone number of how to reach the patient advocate is posted. The phone number and address of the Illinois Guardianship and Advocacy Commission and Illinois Department of Public Health is posted…".

A review of the "Communication and Visitation Guidelines" states "A recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, ad uncensored communication with persons of his or her choice by mail, telephone and visitation…Unimpeded, private and uncensored communication by mail, telephone, and visitation may be reasonable restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to recipients upon admission. When communications are restricted, the facility

shall advise the recipient that he has the right to require the facilities to notify the affected parities of the restriction, and to notify such effective party when restrictions are no longer in effect…Cell phones are restricted at the Pavilion. All numbers needed from the patient's cell phone can be obtained upon admission. Until discharge, the cell phone will be locked up for safe keeping and returned to patients upon discharge."

Record Review:

The individual signed the "Application for voluntary admission" on [admission day]. The individual signed certifying that she was informed of her rights, provided a copy of her rights, and understood her rights. Additionally, the individual signed a consent for treatment. It was documented that the individual had capacity to consent.

On her admission day, the individual signed "patient bill of rights" that states "…You have the right to request discharge by submitting your request in writing to any staff member...you then have the right to be discharged within 5 business days, unless your physician believes it is not in our best interest to be discharged and files a petition with the court for your continued hospitalization on an involuntary basis…You have the right to review your treatment record, upon written request. You have the right to confidential treatment of your personal and medical records. Information from these sources will not be released without prior consent, unless required by law. You have the right to privacy in your care and in the fulfillment of your personal needs. You have the right to communicate with other people in private, without obstruction or censorship by the staff at the facility. This right includes mail, telephone calls and visits. Any limitations to these rights are outlined in your medical record and/or explained in the client handbook. You have the right to consent to receive the visitors you designate…You are entitled to receive, possess, and use personal property unless it is determined that certain items are harmful to you or others. When you are discharged, all lawful property must be returned to you…If your rights are restricted, the facility must notify you and it will be documented in your record. Documentation will include a plan with measurable objectives for restoring your rights that is signed by you or your parents or guardian. You, along with your parents or guardian, will receive a copy of the plan…You and/or your guardian have the right to voice opinions, recommendations, and grievances in relation to polices and services offered by the facility, without fear of restraint, interference, coercion, discrimination or reprisal. The Chief Executive Officer's decision shall be the final administration decision. You have the right to contact the public payer in the case of grievance and be informed of the public payer's process for reviewing grievances. We want to assure that your rights are upheld. If you have a complaint or grievance, please call the Pavilion Patient Advocacy Line at 217-373-1744 and the patient advocate will assist you…".

The individual filled out a written request for discharge a day after her admission to the Pavilion. The Pavilion filed a petition for involuntary admission 4 days after the discharge request. Two certificates were filed a day after the petition.

A review of the "Petition for involuntary/judicial admission" states "The patient has not made adequate progress in treatment. Patient was admitted following suicidal ideation with intent to act upon a plan to end her life by driving her car off an overpass and into a river. Patient ran out of gas, and was taken to the hospital for treatment. The patient has stated on multiple occasions

since admission that she will end her life if she is released from care. Patient is not attending group programming and has shown limited insight into severity of her symptoms." Furthermore, the case manager signed the form indicating "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. I have explained the rights of admittee to the respondent and have provided him or her a copy of it. I have also provided him or her a copy of rights of individuals receiving mental health and developmental services and explained those rights to him or her."

The HRA reviewed the inpatient certificate which states "43 y/o female with history of depression admitted to the Pavilion for worsening symptoms of depression and suicidal thoughts with the plan of driving off a bridge into a river. She has been having problems with her mood since her son committed suicide 6 years ago. On [admission date], [Individual] had an argument with her roommate. The police were called. [Individual's] mother also came to her house, with the plan of taking her granddaughter with her. Allegedly, [Individual's] mother told the police that [Individual] had mental health problems. [Individual] got in her car with the intention of committing suicide. She contemplated different plans, including standing in front of a semi-truck, crashing her car against a wall or driving off a bridge into a river. She choose the latter. On her way to commit suicide, she ran out of gas. She called her counselor who asked her to call the police. The police transported her to the ED where she was evaluated by the crisis team. She finally was referred to the Pavilion for inpatient psychiatric treatment. I evaluated [Individual] the next day. She started our meeting stating, 'I am ready to die'. She stated that she has been under a lot of stress. She is currently in a custody battle with the father of her children. She admitted that she is tired of fighting. 'I want to die', 'I am ready to die', 'you cannot keep me here long enough, I will kill myself after leaving the hospital'. She reported that she has been feeling calm since she took the decision of killing herself. She admits to a history of sadness, depression, feelings of hopelessness and suicide attempts. She has received outpatient treatment, partial hospitalization, and inpatient hospitalization. [Individual] required long term inpatient psychiatric treatment at [another hospital], to receive the appropriate level of mental health treatment and to prevent her from harming herself." This certificate was signed by the physician. A second certificate was filled out by the director of clinical services. The certificate states "Patient discussed with the writer reasons for admission which included suicidal ideation with plan to drive off a bridge. Pt stated the reason she did not attempt this plan was that she ran out of gas and called police, who hospitalized the patient. The patient stated that she told ER staff that she was still planning on dying by suicide. The patient stated that she informed our staff and doctor upon admission that she planned on dying by suicide upon release. The patient has multiple stressors, such as child custody case that is ongoing, severe grief due to child dying by suicide 5-6 years ago, and loss of job. Patient has limited family support at this time, identifying her father as her sole source of support. It is reported by the patient that she has been engaged in partial hospitalization previously, as well as inpatient hospitalization in the past. The patient is recommended for long-term treatment at [another hospital] at this time."

A review of the patient's discharge summary states "…the patient was placed on one-to-one observation due to intermittent suicidal ideation. Patient stated while she was admitted she would not engage in any suicidality and self-harm behaviors because she planned to complete suicide when she was discharged. She was clear that she wanted to die by assisted suicide by a doctor. Patient was put on finger food, had room stripped, and was then in paper gowns for safety on [3

days after admission]. The patient was compliant with medication. She attended group therapy. Her mood was depressed and restricted. She denied suicidal ideation, self-harm urges, 1:1 monitoring continued…the patient acknowledged the severity of the suicidal statement she made on admission. The patient was concerned about court hearing regarding her custody of her children that was put in place on this day…The patient reported she felt upset after learning that the petition report was filed for involuntary hospitalization. The patient acknowledged that she had made statements requesting assisted suicide; however, she felt that she had been making progress. She wanted to be discharged from the hospital. Patient was reminded that during her initial psychiatric evaluation, she stated that no matter how long hospital stay would be, she would kill herself after being discharged…The patient went to court on [discharge date]. The filing for the commitment was dismissed. As such, the patient was able to leave immediately. Administration contacted the adult unit charge nurse at 2pm and informed them that the patient was granted to be discharged and nursing staff returned the patient's belongings to her."

Three days after admission, the individual signed "Authorization for release of protected health information" for two different attorneys. The authorization allowed the Pavilion to provide the attorneys "phone calls, discharge instructions, continuing care plan and discharge summary". Additionally, within 2 weeks of admission, the individual signed stating "I am requesting disclosure of my protected health information for the following purpose: continuing care, academic, disability determination legal investigation, child custody, billing/insurance, and personal use". The individual requested all records including "flow records, written notes, one-on-one progress notes".

The HRA reviewed a court order which states "…On [holiday] [Individual] shall be permitted the use of her cellular phone to call her family for not less than 20 minutes. All other restrictions on [Individual] deemed medically necessary shall remain at the discretion of the Pavilion staff."

The HRA reviewed a psychiatric evaluation of the individual conducted the day after admission. The evaluation states "…She stated that she wanted to find a doctor who would help her die through assisted suicide. The patient admits having dissociative events. She reports that she has been in treatment for a longtime. She states that she was attending a PHP (partial hospitalization program) and was about to be discharged from that program tomorrow…She admits having episodes of anger. She also reports feelings of hopeless, mood swings, but denied periods of increased energy, decreased need for sleep or racing thoughts. Admits problems with insomnia. Report recurrent crying spells. Admits feeling anxious all the time and reports excessive worrying. Denies auditory hallucinations or paranoid delusions. Admits suicidal thoughts. The patient reported several suicidal intentions and plans…Treatment Plan- Suicidality: the patient was admitted to inpatient unit on suicide and self-harm precautions. The patient will be placed on one-to-one observation. Admission labs were obtained from the emergency room. The patient will receive individual case management and participate in group activities. Depression: The patient reports good response to duloxetine. We will continue duloxetine 120 mg p.o daily. Substance use issues: The patient will continue naltrexone 50mg p.o. q.a.m. We plan to contact the patient's family to obtain collateral information. We also would consider filing a petition to court to request an inpatient treatment."

The HRA reviewed the individual's initial nursing treatment plan dated the day of admission. The treatment plan states the short-term goals are "[Individual] will participate in MD orders or recommendation. [Individual] will report worsening symptoms or changes of condition. [Individual] will take medications as ordered. [Individual] will report no symptoms of asthma including SOB, wheezing, coughing, chest tightness, feeling of anxiety or panic. [Individual] will verbalize preventative measures to maintain freedom from attack." Under "problems" the plan states "Special needs- None, Substance Abuse-None, Suicidal, Self-Harming". However, under Suicidal and Self-harming there is nothing selected or filled out for "specific intervention focus" which indicates what staff will do. Furthermore, "1:1 observation level" was not selected. However, under "treatment modality" for suicidal it states "1:1 with staff". The individual signed the initial nursing treatment plan. Two days after admission the "master treatment plan goal sheet" states "Suicidality-[Individual] will create a crisis safety plan to help identify supports in times of crisis and identify at least three coping skills for symptoms of depression." The treatment plan goal sheet which is dated 9 days after admission states "[Individual] placed on 1:1 observation due to ongoing SI (suicidal ideation). Staff will process current stressors with [Individual] and complete assigned 1:1 staff checklist." The master treatment plan was not signed by the individual.

The HRA reviewed the individual's treatment plan update dated 9 days after admission that states "[day after admission] 1:1 started d/t increased thoughts of suicide". Furthermore, the update states "This treatment plan has been presented and reviewed with me in a language that I understand. I had the opportunity to ask questions". However, there is no signature for the individual. Two other treatment plan updates were reviewed, and both were not signed by the individual. Additionally, there is nothing documented to indicate what needs to occur for the 1:1 observation to be removed.

A review the Pavilion's "One to One Staff Checklist" states "One-to-one staff requirements: Constant visual contact with the patient maintained (this includes using the bathroom, showering, etc.)- Never turn back on patient or take eyes off patient. No other duties performed while on one-to-one observation. Immediate intervention, when necessary to protect the patient or others. No object provided to patient (unless approved by the treatment team). No charting, book reading, or any other activity by staff. Arm's length maintained (if on arm's length one-to-one). This includes during bathroom use and showering. No items given to patient-no pens, papers, pencils, books, etc. No staff items in possession except personal clothing, identification badge, and support code button-no cell phone, cordless phone, pens, keys, paper, etc. Room remained stripped of any items except pillow (no case) and comforter. Room remained well-lit for visual purposes, including nighttime hours. Patient in paper gown or suicide gown (no undergarments) unless otherwise approved by the treatment team. Patient receiving finger foods only. Nurse in charge please maintain the following: Patient room is located next to the nurse's station or other deemed safe. Staff assigned to one-to-one is relieved by another staff member every 2-3 hours. Any visits must be supervised following all above criteria. Any allowed visitors must be searched. Patient not allowed in the dayroom unless approved by the treatment team. If allowed in dayroom for group, the following must be maintained. Patient must sit in a plastic, cushion-less chair. Patient must sit next to staff assigned as the one-to-one. Patient must exit group prior to any other patient leaving the dayroom."

The HRA reviewed "progress notes" for the individual's 1:1 observation. Three days after admission the note stated the individual "talked on the phone" from 1645-1730 hours and from 1835-1900 hours and again at 2235 hours. The next day the individual made several more phone calls. Two days later the individual received a call. The following day the individual spent almost 2 hours on the phone. The individual continued to make calls every few days. There is nothing noted that the individual requested access to her cell phone or wallet. Every time it was documented the individual used the bathroom or showered the staff member making the observation was a female. The note 11 days after admission states "Pt woke up from nap, then had a snack, took meds and called home. Pt has not attempted self-harm or suicide since admission-very confused as to why pt has been/continues to be assigned supervision. Pt went to bed and is now reading. Pt was denied seeing me today. She requested seeing her medical documents to see if any 1:1 staff had any concerns about her behaviors. Pt is also confused at continued 1:1 supervision, as well as not being released from facility since pt has had no incidents of self-harm or concealment of contraband or aggression towards others. Lack of intervention from doctors or administration is both perplexing and frustrating to pt and technicians as pt has demonstrated full compliance with treatment plan and has significant reduction of risk behaviors. Pt not risk to self or others safety...".
Fifteen days after admission the progress note indicated the individual had visitation with a family member and later that same day with her attorney. The next day the note states "Pt has been polite and cooperative. Pt had a 2-hour meeting with attorney and therapist. Due to the doctor/patient and attorney/client confidentiality, 1:1 could not be present in the room but maintained visual contact on the patient. During the meeting with therapist, pt had a few crying spells. After the meeting, patient returned to the unit and ate dinner. Pt made phone calls to family members. Patient attended unit activity/closing group with minimal to moderate participation. Soon, patient went to her room and laid down. No issues." The note dated 26 days after admission states "[Physician] approved patient to go to cafeteria. Admin still denied…[Physician] removed patient from arm's length precautions."

Psychiatrist Notes Review:

A review of the psychiatrist notes states "The patient reports she is very upset after learning that petitions report was filed for involuntary hospitalization. The patient acknowledged that she had made statements requesting assisted suicide; however, she felt that she has been making progress and that she wants to get out of the hospital. The patient was reminded that during her initial psych evaluation, she stated that no matter how long hospital stay would be, she would kill herself after being discharged…". On another date the psychiatrist note states "Patient wanted to do the interview with her one-on-one sitter because she felt like she had been misrepresented in her prior encounters. She feels like she does not need one-on-one sitter. She feels like she had a very bad day on admission and said some dumb things, but she did not really mean it. She admitted originally, that she was going to find a way to kill herself no matter how long she was admitted in the hospital. She believes that she made that statement when she was excited and feeling particularly and no longer feels that way. She feels like she has overall been pretty stable. She has not been having any mood swings or racing thoughts. She has been tolerating her medication without side effects."

Another note states "…Reportedly, she is under legal proceedings for involuntary commitment. She feels like that comment was just a mistake, that she said when she was feeling very upset. She does not feel like ending her life any longer. She is having difficulty getting in touch with her public defender to defend herself against the involuntary commitment order. She requested access to her phone to coordinate her legal case. This physician told her that we would check with hospital policy about that."

A few days later the notes states "The patient reports she is very uncomfortable with the regulations of the unit. The patient is requesting to be stepped down from her one-on-one observation. She stated she is feeling tired since she started taking Trileptal. She reports that she is very unhappy being in the hospital. She is uncomfortable with the restrictions that have been imposed on her such as not being able to use markers and her yoga mat and going to the cafeteria or meeting with her lawyer without a sitter. She has not noticed any improvement in her mood since she started taking Trileptal.

A few days later the notes states "…Reports that she is a typically positive person and so she is going to make the best of this current situation. Patient verbalized remorse about making statements on admission…Discussed this with patient, reviewed reasons for hospitalization and concerns of staff regarding her safety for discharge and why current involuntary petition is being pursued in court. Patient verbalized understanding, but reports stated that her reactions were blown out of proportion. Given her previous statements to other physicians, credibility of the statement is questionable. It is difficult to ascertain whether these statements are legitimate or simply efforts to manipulate…"

Conclusions

Complaint 1. Inadequate discharge including failing to notify consumer of patient rights and falsifying documentation

The Mental Health and Developmental Disabilities Code (405 Ill. Comp. Stat. Ann. 5/3-401) states "(a) The application for admission is a voluntary recipient may be executed by: 1. The person seeking admission, if 18 or older; or 2. Any interested person, 18 or older, at the request of the person seeking admission; or 3. A minor, 16 or older, as provided in Section 3-502. (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 holiday, 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 Ill. Comp. Stat. Ann. 5/3-403) states "A voluntary recipient shall be allowed to be discharged from the facility at the earliest appropriate time, not to exceed 5 days, excluding Saturdays, Sundays and holidays, after he gives any treatment staff person written notice of his desire to be discharged unless he either

withdraws the notice in writing or unless within the 5-day period a petition and 2 certificates conforming to the requirements of paragraph (b) of Section 3-601 and Section 3-602 are filed with the court."

The Mental Health and Developmental Disabilities Code (405 Ill. Comp. Stat. Ann. 5/4-210) states "Whenever a petition has been executed pursuant to Sections 4-401 or 4-501 [405 ILCS 5/4-401 or 405 ILCS 5/4-501], and prior to the examination for the purpose of certification, the person conducting this examination shall inform the person being examined in a simple comprehensible manner: that he is entitled to consult with a relative, friend, or attorney before the examination and that an attorney will be appointed for him if he desires; that he will be evaluated to determine if he meets the standard for judicial or emergency admission; that he does not have to talk to the examiner; and that any statement made by him may be disclosed at a court hearing on the issue of whether he meets the standard for judicial admission. If the respondent is not so informed, the examiner shall not be permitted to testify at any subsequent court hearing concerning the respondent's admission."

Originally the individual was a voluntary admission into the Pavilion. The individual signed the voluntary paperwork certifying that she was explained her rights and given a copy of her rights. This form includes information about the patient's right to request discharge and how the hospital may pursue involuntary commitment if the patient is deemed a threat to themselves or others. A day after admission, the individual submitted a written request for discharge. However, a few days later, the Pavilion filed a petition and two certificates for involuntary admission. On the involuntary petition, staff certified that the individual was explained what was occurring and her rights. The complaint alleged the person who signed as a witness to the individual being explained her rights was not present and signed the form later. Staff stated the witness is certifying that they observed the behaviors of the individual not that they witnessed the physician explain the individual her rights. There is no documentation to support the complaint. Therefore, the East Central Human Rights Authority concludes that the recipient's rights were not violated, and the complaint is **unsubstantiated.**

Complaint 2. Inadequate treatment including restricting patients' rights

The Mental Health and Developmental Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-102) states: "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 Mental Health and Developmental Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-201) states " (a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's

services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice; (3) the facility director; (4) the Guardianship and Advocacy Commission, or the agency designated under "An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named", approved September 20, 1985,1 if either is so designated; and (5) the recipient's substitute decision maker, if any."

The Mental Health and Developmental Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-202) states "The Secretary of Human Services and the facility director of each service provider shall adopt in writing such policies and procedures as are necessary to implement this Chapter. Such policies and procedures may amplify or expand, but shall not restrict or limit, the rights guaranteed to recipients by this Chapter."

Upon the individual's admission to the Pavilion, she was placed on 1 on 1 observation due individual's suicidal statements. The individual's initial nursing treatment plan listed she was suicidal however 1:1 observation was not selected. The individual signed the initial nursing treatment plan. The treatment plan update a few days later does states that the individual was placed on 1:1 observation a day after admission. However, the individual's signature was not on any other treatment plans or updates. This does not align with the Pavilion's treatment plan policy that states "The patient/family and/or representative is to sign the treatment plan to indicate their agreement with and participation in development of the plan." The individual remained on 1:1 observation her entire stay at the Pavilion which was 28 days. Staff stated they typically do not have a patient on 1:1 observation for that long of a time, but the individual lacked insight and minimized her condition and staff felt the individual needed to remain on 1:1 observation. Eleven days after admission the 1:1 observation progress note states the individual wanted to see her records in order to see if staff had any concerns about her behaviors. Additionally, the staff member who was observing the individual also expressed concerns about the individual remaining on 1:1 observation since the individual had not attempted self-harm since arrival and did not display any concerning behaviors to warrant 1:1 observation. The HRA reviewed the Pavilion's one on one observation policy, however there is nothing about restricting patients' rights in the policy. Staff stated the Pavilion does not have a Human Rights Committee however the grievance committee reviews restrictions daily. The Patient Bill of Rights does cover in minimal detail about restricting patients' rights. However, staff stated they do not have a policy specific to restricting patients' rights which does not align with The Code (405 Ill. Comp. Stat. Ann. 5/2-202). The policy should include detailed requirements found in The Code (405 Ill. Comp. Stat. Ann. 5/2-201) about promptly notifying the individual, guardian and IGAC of any rights restrictions. Therefore, the East Central Human Rights Authority concludes that the recipient's rights were violated, and the complaint is **substantiated.**

The HRA makes the following recommendations:

1. **The Pavilion follow The Mental Health and Developmental Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-202) by developing a restriction of rights policy. Provide**

the HRA with a copy of the policy.

2. **The Pavilion train staff on the restriction of rights policy and provide the HRA with evidence of the training.**
3. **The Pavilion follow The Mental Health and Developmental Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-201) by "…promptly giving notice of the restriction" to all individuals, guardians and IGAC who have rights restrictions.**
4. **The Pavilion follow the Patient Bill of Rights that states "If your rights are restricted, the facility must notify you and it will be documented in your record. Documentation will include a plan with measurable objectives for restoring your rights that is signed by you or your parents or guardian."**
5. **The Pavilion follow The Mental Health and Developmental Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-102) by ensuring treatment plans "…be formulated and periodically reviewed with the participation of the recipient…"**
6. **The Pavilion follow their Interdisciplinary Patient-Centered Care Planning policy by ensuring the "patient/family and/or representative sign the treatment plan to indicate their agreement with and participation in development of the plan."**
7. **Re-train staff on The Code (405 Ill. Comp. Stat. Ann. 5/2-201 and 5/2-102), the Interdisciplinary Patient-Centered Care Planning policy, and the Patient Bill of Rights. Please provide the HRA with evidence of the training.**
8. **The Pavilion ensure the initial nursing treatment plan is accurate and includes all information on the patient including any interventions or treatment needed for patients.**

The HRA **strongly suggests** the Pavilion create a Human Rights Committee to monitor and review the means used by the Pavilion to promote the rights of individuals served. With the creation of a Human Rights Committee the HRA **strongly suggests** the Pavilion create a Human Rights Committee policy and train staff on the policy.

Complaint 3. Inadequate Communication

The Mental Health and Developmental Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-103) states "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. (a) The facility director shall ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible, and that space for visits is available. Writing materials, postage and telephone usage funds shall be provided in reasonable amounts to recipients who reside in Department facilities and who are unable to procure such items. (b) Reasonable times and places for the use of telephones and for visits may be established in writing by the facility director. (c) Unimpeded, private and uncensored communication by mail, telephone, and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission. When communications are restricted, the facility shall advise the recipient that he has the right to require the facility to notify the affected parties of the restriction, and to notify such affected party when the restrictions are no longer in effect."

Staff stated patients are allowed private communication via mail, visitation, and phone. Staff stated the individual made several phone calls during her admission at the Pavilion. The 1:1 observation progress notes document that the individual was on the phone multiple times a day. Furthermore, the progress note documents the individual was allowed private visitation with her attorney and family. The individual obtained a court order to use her personal cell phone for a zoom visitation with her children which the facility followed. Therefore, the East Central Human Rights Authority concludes that the recipient's rights were not violated, and the complaint is **unsubstantiated.**

Complaint 4. Inadequate access to records

The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4) states "(a) The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof: (1) the parent or guardian of a recipient who is under 12 years of age; (2) the recipient if he is 12 years of age or older; (3) the parent or guardian of a recipient who is at least 12 but under 18 years, if the recipient is informed and does not object or if the therapist does not find that there are compelling reasons for denying the access. The parent or guardian who is denied access by either the recipient or the therapist may petition a court for access to the record. Nothing in this paragraph is intended to prohibit the parent or guardian of a recipient who is at least 12 but under 18 years from requesting and receiving the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed, including medication, if any… (b) Assistance in interpreting the record may be provided without charge and shall be provided if the person inspecting the record is under 18 years of age. However, access may in no way be denied or limited if the person inspecting the record refuses the assistance."

Staff stated patients are allowed to request access to review their records or to receive copies of their records. Additionally, staff stated patients are allowed to submit requests for their records to be shared with others. The Patient Bill of Rights indicates that patients have the right to inspect or review their records upon written request. The "Patient Request to Access PHI (Public Health Information)" policy states "…an individual may request in writing access to their PHI…". However, this does not align with The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4) which states "upon request" and does not require the request be in writing or that the patient must wait 30 days to receive documentation. The Act does not state that patients should need to wait for records or that they must provide a written request. Staff stated the individual submitted a written request for physical copies of her records. However, staff did not find any documentation showing the individual was provided a copy of her records as requested. Furthermore, the individual submitted a written request for two attorneys to receive discharge records. Staff stated when the individual submitted the request, discharge records were not available. However, it is unclear if the discharge records were sent to the attorneys once available. Therefore, the East Central Human Rights Authority concludes that the recipient's rights were violated, and the complaint is **substantiated.**

The HRA makes the following recommendations:

1. **The Pavilion ensure they follow The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4) by not requiring record requests to be in writing.**
2. **The Pavilion update the Patient Bill of Rights and Patient Request to Access PHI policies to remove "written request" and replaced with "upon request" per The Confidentiality Act (740 ILCS 110/4. Please provide the HRA with a copy of the updated polices.**
3. **The HRA has concerns that the "Request to Access PHI" policy states "A facility will respond to an individual's request for access to the PHI within thirty days after receipt of the request for the PHI if it's maintained on site." Update the policy to reflect compliance with the Act.**
4. **The Pavilion train staff on the updated Patient Bill of Rights and Patient Request to Access PHI policy. Please provide evidence of the training to the HRA.**
5. **Re-Train staff on The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4). Provide the HRA with evidence of the training**
6. **The Pavilion ensure all of the individual's request for records are fulfilled as stated in her written request for records.**

Complaint 5. Lack of access to property

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-104) 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."

The complaint alleges the individual was not allowed access to her wallet to obtain a credit card to make a payment. Staff stated the individual never requested access to her wallet. However, staff stated if a patient needs to obtain payment information, the patient would be allowed access to the wallet. Furthermore, the complaint states the individual was not allowed access to her phone to obtain phone numbers. The individual had a court order allowing her access to her cell phone for 20 minutes to call her children. Staff stated the individual was allowed her phone per the court order. Staff stated cell phones are not allowed due to safety and security concerns. Staff stated that if a patient needs their phone to obtain a phone number, they are allowed access to their phone to obtain the phone number. However, the Pavilion's policy states "All numbers needed from the patient's cell phone can be obtained upon admission. Until discharge, the cell phone will be locked up for safe keeping and returned to patients upon discharge." The Code (405 ILCS 5/2-104) allows for facilities to restrict cell phone use due to safety concerns. Therefore, the East Central Human Rights Authority concludes that the recipient's rights were not violated, and the complaint is **Unsubstantiated.**

The HRA **strongly suggest** the Pavilion follow their "Communication and Visitation Guidelines" policy.

Complaint 6. Inadequate grievance procedure

The Code of Federal Regulations (42 CFR 482.13) states "2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum: (i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital. (ii) The grievance process must specify time frames for review of the grievance and the provision of a response. (iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion."

Staff stated the individual did not file any grievances while at the Pavilion. However, the records indicate that the individual was not happy about being on 1:1 supervision and expressed that to several staff members. Staff stated if a patient makes a verbal complaint to staff, then that staff member will attempt to resolve the complaint. The facility policy also defines a grievance as a verbal or written complaint. If staff is not able to resolve the complaint, then the staff member will contact the Patient Advocate to file a grievance on the patient's behalf. However, no staff member contacted the Patient Advocate about the individual's complaints. Staff stated patients are allowed to contact the Patient Advocate to file a grievance. The Patient Advocate will then reply to the patient within 24 hours and complete the investigation within 7 days. Staff stated the Patient Bill of Rights explains how patients can file a grievance. Patients are provided the Patient Advocates phone number in the Patient Bill of Rights. Additionally, staff stated the information on how to file a grievance is listed on posters throughout the facility. Staff stated patients can submit a grievance in writing. However, the right to submit a grievance in writing is not listed in the Patient Bill of Rights or on the posters. This does not align with The Code of Federal Regulations (42 Code of Federal regulations 482.13) which states "The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital." Additionally, it appears to the HRA that the patient made a verbal complaint but there was no action taken on the complaint. Therefore, the East Central Human Rights Authority concludes that the recipient's rights were violated, and the complaint is **substantiated.**

The HRA makes the following recommendations:

1. **The Pavilion follow The Code of Federal Regulations (42 Code of Federal regulations 482.13) by establishing a form that clearly explains the procedure for patients to submit a written or verbal grievance.**
2. **The Pavilion update the Patient Bill of Rights and posters posted throughout the facility to include directions for submitting a grievance in writing.**

3. **The Pavilion retrain staff on The Code of Federal Regulations (42 Code of Federal regulations 482.13) and the updated Patient Bill or Rights. Please provide the HRA with evidence of the training.**
4. **The Pavilion ensure all complaints expressed by recipients are either resolved by staff or contact the Patient Advocate to file a grievance on the behalf of the recipient, per facility policy and procedure.**

RESPONSE

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