



FOR IMMEDIATE RELEASE

**East Central Regional Human Rights Authority
Sarah Bush Lincoln Health Center
Report of Findings
Case # 23-060-9020**

The East Central Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission voted to pursue an investigation of Sarah Bush Lincoln Health Center after receiving the following complaints of possible rights violations:

Complaints:

1. Inadequate guardian notification including not obtaining consent for treatment

If the allegations are substantiated, they would violate protections under The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102 and 107), The Medical Patient Rights Act (410 ILCS 50/3), The Health Care Surrogate Act (755 ILCS 40/20), and The Illinois Probate Act (755 ILCS 5/11a-23).

Complaint Summary: The complaint alleges the facility did not notify the guardian prior to performing mammograms on two individuals. Allegedly, the facility did not obtain consent from the guardian. The complaint alleges the facility notified the guardian and asked for consent after the mammograms were performed.

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 consumers' records were reviewed.

Interviews:

On August 7th, 2023, the HRA met virtually with Sarah Bush Health Center staff members. Staff provided general information on Sarah Bush Lincoln Medical Center mobile mammography clinic. Staff advised that the mobile clinic was started around 2000. The mobile clinic goes around to various locations providing mammograms to the community. The mobile clinic is scheduled months in advance and flyers are posted. Staff advised anybody wishing to receive a mammogram screening via the mobile clinic are instructed on how to contact central scheduling for an appointment. However, walk-in appointments are also available. Staff advised that the internet is not available on the bus, so any walk-in patients need to be called into central scheduling to be added. Staff stated central scheduling obtains basic personal information on the patient and insurance information.

Staff stated they host the mobile clinic annually at a [nursing home] where the two individuals reside. Sarah Bush staff and the nursing home staff work together to agree on a day and time for

the mobile clinic to come to the nursing home. Staff stated this year the mobile clinic was scheduled at the nursing home on 4/3/23. Approximately 3 months prior, Sarah Bush sent flyers to the nursing home to post throughout the facility. The flyers include information on how to contact central scheduling to schedule an appointment with the mobile clinic. Staff stated the nursing home typically calls central scheduling prior to the mobile clinic staffs' arrival to schedule residents for mammogram screenings. However, this time the nursing home did not make that contact in advance. Staff advised that on the day of the clinic, there were no residents of the nursing home scheduled for the mobile clinic. However, there were 2 non-residents scheduled for mammograms that day. Staff advised upon the mobile clinic's arrival at the nursing home, nursing home staff provided face sheets for 9 residents to receive screenings. Staff explained that they contacted central scheduling and got the 9 residents added to the mobile clinic's schedule. Staff advised 3 of the 9 residents refused to have the mammogram screenings. Staff stated the staff at the nursing home provided a face sheet on each resident however, guardianship information was not included. Staff advised they asked the nursing home staff if any of the residents had a legal guardian, but the nursing home staff stated no. Staff stated they had each resident sign a consent form for the mammogram screenings.

Upon the mobile clinic's return to the hospital, staff began to formally register the individuals who received mammogram screenings that day. Staff advised this was not done on the mobile clinic because the mobile clinic does not have internet. Staff advised central scheduling just obtains basic patient information and insurance information. Staff advised individuals #1 and #2 did not have a legal guardian listed in Sarah Bush's records. However, staff recognized the name listed as the emergency contact for individual #1 and #2 as a State Guardian. Staff said they contacted the nursing home to obtain guardianship papers for individual #1 and #2 however the nursing home refused to provide the papers. Staff contacted the Office of State Guardian and spoke with the guardian and obtained consent for the mammogram screenings. Staff stated they asked the guardian for the guardianship paperwork but have yet to receive the papers.

Policy Review:

The HRA reviewed Sarah Bush "Condition of Care and Service Form" policy. The policy states "Patient consent is a process of communication between the patient and their health care provided that often leads to an agreement or permission for care, treatment, or services. Every patient has the right to get information and ask questions before procedures and treatment. If the patient is unable to make their own decision, medical care cannot begin unless the patient's legal representative gives consent by signing the Conditions of Care and Service Form... For patients receiving care from clinics operated by employed physicians, the clinic registration staff will obtain the patients (or legal representative's) signature on the Consent for Care and Service form before care and services are performed. In an emergency or critical situation in which the patient (or legal representative) is unable to sign the appropriate forms care and services should be performed, staff will make good faith effort to obtain the individual's necessary signatures. If the necessary signatures cannot be obtained, staff must document any effort to obtain the necessary signatures and the reason it was not obtained."

A review of the "Mammography Order Policy" that states "Patients may self-refer for screening mammography, but if further imaging is required a licensed medical provider must provide instruction and orders for care. Procedure: patients may self-refer for screening mammograms exams. Self-referred exams will be scheduled and ordered under the Chief of Radiology's name and the patient may provide a primary care physician's name to receive results. The primary care physician will receive the results in the Results FYI section of their Cerner task list, or it will be

faxed if it is from a physician that is not affiliated with SBL (Sarah Bush Lincoln). The mammography department will follow-up on all abnormal mammograms within 10 days to ensure that the patient is seeking follow-up care as recommended and will document follow-up and providers in the mammography reporting system. If a self-referred patient, has an abnormal screening mammogram, and does not have a primary physician, the patient will be given a list of physicians accepting patients for follow-up care from the mammography department. The SBL surgeons have agreed to accept patients for follow-up care if needed. If the patient does not provide the department with a primary care physician, the patient will be sent a lay person report as well as the final physician report that is documented in the medical record within 30 days after the exam. This will be documented in mammography reporting system. A radiologist may order additional Diagnostic radiographic images, but all other imaging such as Ultrasound, MRI and biopsies must be ordered by a referring provider. Referring providers may give permission, when ordering the diagnostic mammogram, for the radiologist to do additional imaging as needed.”

The HRA reviewed “Diagnostic Imaging-Scope of Service” policy. The policy indicates that mammography is available via “mobile service”. The policy states “...Self-referral is allowed for some screening exams, but the patient will receive strong recommendations to follow-up with a health care provider. Approved screening Exams include CT Cardiac scoring US vascular screening Mammography Screening. Inpatients: The physician, nurse, or clerical partner will enter into the health Center information system the appropriate tests or procedures ordered by the clinician. If the exam needs to be scheduled, they will call the Radiology desk to schedule the exam. Procedures are performed in order of receipt or based on the acuity of the patient. Outpatients: Most patients will be scheduled via the Central Scheduling department with the exception of general x-ray procedures, which can be performed on a walk-in basis as long as proper physician orders are obtained.”

Staff advised they do not have a guardianship notification and inclusion policy. The HRA requested a copy of the face sheet the nursing home provided to Sarah Bush. Staff advised they did not scan the face sheet into their records. However, staff advised they would be scanning all documents provided to the mobile clinic into the patients record from now on.

Record Review:

The HRA was provided written log of what occurred on 4/3/23 from Sarah Bush that states “[Staff] had 2 patients on the schedule when she left SBLHS that morning. [Nursing home staff] is whom scheduled the mobile unit with [Staff]. [Nursing home staff] came out around 0915 asking when they could start bringing patients out. 9 additional patients were added to the schedule while the bus was on site at [Nursing Home]. [Staff] called Central Scheduling to have these pts. put on the schedule. [Central Scheduling staff] scheduled them for her. When patients are added on the daily schedule as a walk on and [Staff] on the bus, she does not have any information in front of her and does not know what their guarantor status is or if they have active ins [insurance], whether a consent is needed, etc. (there is no internet on the bus). Patients came onto the bus and [Staff] did ask [Nursing Home] Staff if they had guardians.... the staff all stated no. 3 patients refused to have the exam when staff brought them to the mobile unit. When [staff] gets back to the facility, she takes the packets on the patients that were seen and gives them to the registration ladies in mammography and they register the patients. [Another staff] registered these 2 patients and noticed that they needed consent as they have a guardian. When registering [Individual #1] and [Individual #2], the patients are listed as their own guarantor, but have [guardian] listed in their emergency contact information which is how [Staff] knew that they had

a guardian and needed consent. [Staff] then called [Nursing Home] and spoke to [Nursing Home staff] to obtain the paperwork for consent and to have her send copies of the guardianship paperwork. [Nursing Home staff] refused to send the paperwork required stating she did not have it. [Staff] then called the State Office of Guardianship to obtain verbal consent and request guardianship papers. [Staff] asked to speak to [guardian] and was transferred to [another state guardian] ... [Another state guardian] was agitated to receive the call, stating that [Nursing Home] has the information and should have provided it, and that she would be following up with [Nursing Home]. [State Guardian] did give verbal consent for both patients and stated she would send the guardianship paperwork to the fax that [Staff] provided, however [Staff] has never received any paperwork.”

Individual #1

The HRA reviewed the medical consent form for individual #1. The consent form was signed by the individual on 4/3/2023 at 10:47 am. There was another consent form which indicated the guardian gave verbal consent on 4/3/2023 at 2:25pm. The guardian gave verbal consent after the mammogram was performed and the mobile clinic returned to the hospital.

The HRA reviewed a copy of the face sheet the nursing home had provided to the mobile clinic for individual #1. The face sheet did include the guardian’s name and contact information.

Individual #2

The HRA reviewed the medical consent form for individual #2. The consent form was signed by the individual on 4/3/2023 at 10:30 am. There was another consent form which indicated the guardian gave verbal consent on 4/3/2023 at 2:25pm. The guardian gave verbal consent after the mammogram was performed and the mobile clinic returned to the hospital.

Staff advised they did not have any other records regarding individuals #1 or #2 receiving or needing mammograms due to the individuals being added to the scheduled upon arrival at the Nursing Home. Furthermore, staff advised they did not keep a copy of the face sheet provided by the nursing home for the two individuals.

The HRA reviewed a copy of the face sheet the nursing home had provided to the mobile clinic for individual #2. The face sheet did include the guardian’s name and contact information.

Conclusions

Complaint 1. Inadequate guardian notification including not obtaining consent for treatment.

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107) states “An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. 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 or electroconvulsive therapy. 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 facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services.”

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) also requires that “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 Medical Patient Rights Act (410 ILCS 50/3) guarantees the right of each patient “...to be informed of the name of the physician responsible for coordinating his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law ...”.

The Health Care Surrogate Act (755 ILCS 40/20) states that “medical treatment decisions for a person without decisional capacity can be made by a surrogate decision maker in consultation with the attending physician. Section 25 of the Act identifies surrogate decision-makers in order of priority with the guardian of the person listed as having the highest priority. Section 25 further states that once a surrogate has been identified for a person who lacks decisional capacity that the surrogate can make medical decisions and shall have the same right as the patient to receive medical information.”

Finally, The Illinois Probate Act (755 ILCS 5/11a-23) states the following: “Reliance on authority of guardian, standby guardian, short-term guardian. (a) For the purpose of this Section, ‘guardian’, ‘standby guardian’, and ‘short-term guardian’ includes temporary, plenary, or limited guardians of all wards. (b) Every health care provider and other person (reliant) has the right to rely on any decision or direction made by the guardian, standby guardian, or short-term guardian that is not clearly contrary to the law, to the same extent and with the same effect as though the decision or direction had been made or given by the ward. Any person dealing with the guardian, standby guardian, or short-term guardian may presume in the absence of actual knowledge to the contrary that the acts of the guardian, standby guardian, or short-term guardian conform to the provisions of the law. A reliant shall not be protected if the reliant has actual knowledge that the guardian, standby guardian, or short-term guardian is not entitled to act or that any particular action or inaction is contrary to the provisions of the law.”

The complaint alleges patients received mammograms, but the guardian was notified after the mammogram screenings were performed and then the guardian gave consent. Staff stated the facility has a mobile clinic that offers mammogram screenings to the community. The mobile clinic was scheduled to be a local nursing home annually. Staff stated typically the nursing home will call central scheduling to schedule residents to receive the screenings but did not this time. On 4/3/23 the mobile clinic arrived at the nursing home without any nursing home residents on its schedule. However, nursing home staff provided a list of 9 residents to receive the screenings. Of the 9 residents, 3 refused to consent. Staff asked the nursing home staff if any of the residents had legal guardians, but the nursing home staff stated no. Staff had individuals #1 and #2 sign consent forms for the screenings. Staff stated the mobile clinic does not have internet and staff must rely on the nursing home staff and their residents to be up front and honest about guardianship. Upon the mobile clinics return to the hospital, it was discovered both individuals have a legal guardian. The guardian was contacted, and the guardian provided consent. Staff

advised that the nursing home staff provided a face sheet for each resident however no guardian information was provided. The HRA reviewed a copy of the face sheet for individuals #1 and #2 that the nursing home provided to the mobile clinic which listed the guardian's name and contact information. Therefore, the complaint is **substantiated**. The HRA makes the following recommendations:

1. Sarah Bush Hospital ensure to obtain complete and accurate information when registering walk-in appointments for the mobile clinic. In order to check the accuracy of information provided by other agencies, hospital records should be checked and verified for any guardianship information. The HRA requests evidence that the facility has taken steps to ensure accuracy of information provided.
2. Sarah Bush Hospital follow The Illinois Probate Act (755 ILCS 5/11a-23) by notifying the guardian and obtaining consent prior to conducting screenings or treatment on patients and The Medical Patient Rights Act (410 ILCS 50/3) by ensuring the guardian is notified of any proposed treatment or screenings prior to performing the treatment or screening. Provide the HRA with evidence that the facility is notifying and obtaining guardian consent for treatment.
3. Sarah Bush Hospital re-train staff on the importance of The Illinois Probate Act (755 ILCS 5/11a-23) and The Medical Patient Rights Act (410 ILCS 50/3). Please provide evidence of the training to the HRA.

The HRA **strongly suggests** that Sarah Bush Lincoln Medical Center develop a policy specifically regarding guardian notification and inclusion. The HRA **strongly suggests** that Sarah Bush Lincoln Medical obtain internet access for staff on the mobile clinic so any walk-on appointments can be properly registered prior to performing mammogram screenings.

procedures during admission and understand that they can call the patient hotline at any time to file a complaint. Those complaints are responded to within 24 hours and all complaints are reviewed by the Chief Executive Officer (CEO). After being discharged, there was a complaint filed with Pavilion on 8/26/19 that the patient's discharge was improper, pain was not treated adequately, the staff to patient ratio was inadequate, the room was unclean, and that the food was cold. Pavilion conducted an internal investigation and found the complaints to be uncorroborated but added that they did adjust the food tray pick up times to assure that food was arriving to while still hot. Pavilion staff added that similar complaints were investigated by the patient's insurance provider and were found to be unsubstantiated as well.

The Pavilion confirmed that the patient was transferred to their facility from another hospital, however it was not from a post operation stay. The patient presented to the Emergency Department (ED) at the patient's local hospital because he was aggressive and experiencing suicidal ideation. The patient was transferred from the ED to Pavilion on 8/11/19. At admission the patient was already prescribed psychotropic medication and an antibiotic for a Urinary Tract Infection (UTI). During the patient's stay at Pavilion, the main focus was adjusting psychotropic medications and watching for symptoms of the new medications to assure that the patient was no longer experiencing aggression and suicidal ideation and could be discharged safely. Staff stated that this kind of treatment is more appropriately done by behavioral health staff on an inpatient unit than in the hospital ED.

Staff stated that the patient's post-operative pain was addressed during the stay at Pavilion. The patient was provided pain management, moved to a hospital bed for positional comfort, and on one occasion the patient was transferred to the ED for pain management.

The Pavilion confirmed that the patient was scheduled to be discharged on 8/17/19 and the discharge was delayed until 8/19/19. The patient was visiting with his spouse on 8/15/19 and was angry and aggressive towards the spouse. Both the doctor and the spouse agreed that the patient's mood was not stable enough to return home on the planned date and therefore it was delayed.

The Pavilion has cleaning staff on the unit and the main areas are cleaned daily while the rooms are cleaned after a discharge and every other day when occupied by a patient. Staff stated that the patient did not point out any issues with the room's cleanliness during the patient's stay, however, after the complaint was filed on 8/26/19 the hospital created a cleaning checklist to document and to avoid any discrepancies. The HRA conducted an unscheduled tour of the patient's floor and found no concerns in the main area or in the room that was viewed.

Records Reviews:

The Pavilion provided the HRA with the following records:

Admission orders dated 8/11/19 state that the patient is being admitted for suicide precautions. A Voluntary Admission form dated 8/11/19 was signed by the patient. This form states that the patient had been examined and is considered clinically suitable for voluntary admission. A Standardized Intake Assessment dated 8/11/19 states that the patient had surgery 3 weeks ago and went to the ED for aggression and suicidal ideation. In the document, both the patient and

spouse state that this behavior is strange and unlike the patient and has been happening for 3 days. The document noted that the patient started taking a new psychotropic medication last week and believes that this may have led to the behaviors because the patient has no history of mental health hospitalizations or suicidal ideations. A history/physical was completed on 8/12/19 and notes the patient had recent surgery as well as lab results. This documentation notes that the patient had pain and a UTI.

The patient's treatment plan created 8/14/19 states that the patient's goal is to demonstrate resolution of suicidal ideation and create a discharge plan that allows for safe discharge. A goal was to avoid mood liability for 72 hours and focus on medication and therapies. The treatment plan states that the target date for completion was 8/18/19 (the HRA notes that the original date is scratched out and replaced with 8/19/19).

The patient completed a form titled State of Illinois Dept of Human Resources Request for Discharge dated 8/13/19. This form states that the patient will be discharged at the earliest appropriate time, not to exceed five days, excluding Saturdays, Sundays, and holidays unless the request is withdrawn in writing.

Nursing records indicate that the patient was offered a variety of pain control measures during the patient's stay including Tylenol, Ibuprofen, Flexeril, Lidocaine patch, and a medical bed. The patient was taken to the ED on 8/17/19 where he was assessed and given Halodol before returning to the Pavilion.

A Discharge summary stated admission was 8/11/19 and discharge was 8/19/19. This document indicates that during the patient's stay, the patient complained of pain and received increased Tylenol and ibuprofen, and was offered a fentanyl patch but declined. The patient requested to see a chiropractor. On 8/16/19 the patient complained of pain related to a recent surgery and was taken to the ED. At the ED, testing was completed with no significant findings and the patient was sent back to the Pavilion. Treatments were reviewed and the patient was discharged in "stable clinical condition".

A Pavilion grievance form dated 8/26/19 states that the patient contacted the hospital after the patient was discharged to file a grievance that the patient's pain was not managed properly, that staffing ratios were inadequate, food on the unit was cold, and that the patient's room was unclean during the stay. The patient also requested copies of the patient's medical records. The form indicates that the patient was contacted on 8/27/19 to follow up on the grievance and an investigation was opened. The Investigation found that the patient's discharge was delayed due to concerns raised during a visit with the patient's spouse, when the patient was aggressive towards the spouse. Regarding the pain, the patient was admitted with antibiotics for infection and continued the treatment while receiving inpatient treatment. The staff ratio on the unit was within ratio during the patient's stay, and the housekeeping staff cleaned the patient's room per policy. Additionally, changes were made to the tray pick up times to ensure that food stays warm. A staff member contacted the patient and explained how the patient could access medical records via fax or mail once the discharge summary has been dictated (within 30 days of discharge).

The HRA notes that there are no records for room cleaning or any documentation during the patient's stay that the patient complained about blood or fecal matter in the room.

Policy Reviews:

The Pavilion Clean Environment Procedures requires reviews of each area of the unit specifying areas and items that must be cleaned daily, weekly, and quarterly. The Routine and Standard Cleaning of Patient Rooms section of the procedure states that the desk, vanity, light fixtures, chairs, trash, and floors must be cleaned daily. Windowsills and baseboards must be washed weekly. Window screens, shades, and window must be cleaned quarterly" The cleaning of washrooms (public and private) specifies the following actions: cleaning and sanitizing toilet bowls and basins, cleaning and sanitizing all flush rings, drains, and overflow outlets, cleaning and sanitizing all chrome fittings, cleaning and sanitizing all toilet seats, cleaning and sanitizing all mirrored surfaces, emptying and cleaning all trash disposals, insert liners as required, washing exterior of all containers, removing spots, stains, splashes from walls adjacent to hand basins, refilling all dispensers to maximum, and wet mopping the floor. This section for the standard cleaning of washrooms does not specify when or how often the cleaning is to occur.

A Daily Housekeeping Log was provided. This form was created after the patient's grievance was investigated to document what areas are cleaned on what days. The bottom of this log states that "All patient rooms cleaned a minimum of three times per week".

Conclusions

Complaint 1: Inadequate admission

The Mental Health and Developmental Disabilities Code (405 Ill. Comp. Stat. Ann. 5/3-400) states "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."

The complaint indicated that, after admission to the facility, the patient was informed that the ideation may have been a result of medication and infection and that the patient should have been treated at the hospital instead of being transferred to an inpatient behavioral health unit at another hospital. Pavilion documentation states that the patient came from the ED where the patient presented with aggression and suicidal ideation. Intake documents note that the patient had started a new psychotropic medication, was experiencing post-operative pain, and was being treated for a UTI infection. The patient signed voluntary admission paperwork and the paperwork indicated that the patient had the capacity to consent to the admission to the inpatient behavioral health unit at Pavilion. Staff stated that the Pavilion was aware of the patient's condition when the patient arrived for inpatient treatment and the focus was on adjusting psychotropic medications and watching for symptoms of the new medications to reduce aggression and suicidal ideation so he could be discharged safely. Staff stated that this kind of

treatment is more appropriately done by behavioral health staff on an inpatient unit than in the hospital ED.

Based on the findings above the East Central Human Rights Authority concludes that the consumer's rights were not violated and, therefore, the complaint is unsubstantiated. No recommendations or suggestions are being made in relation to this complaint.

Complaint 2: Unsanitary living conditions.

Illinois Hospital Licensing Requirements (77 Ill. Admin. Code 250.1710) state "After the discharge of a patient, the bed, bedding, and room furnishings used by such patient shall be thoroughly cleaned ... 2) In order to guide personnel in providing a hygienic environment for patients and staff, specific housekeeping procedures shall be developed and available for all departments and services. They shall identify techniques and product used and shall include, but not be limited to the following: ... D) the maintenance of cleaning schedules;... d) The entire facility, including but not limited to the floors, walls, windows, doors, ceilings, fixtures, equipment, and furnishings, shall be maintained in good repair, clean and free of insects, rodents and trash." Illinois Hospital Requirements (77 Ill. Admin. Code 250.1720) state "f) Any potentially infectious medical waste such as blood, blood components, organs, semen, or other human tissue, and any other materials or paraphernalia exposed to, or contaminated by, blood, blood components, organs, semen, or other human tissue shall be completely incinerated, sterilized, or sealed in order to render the materials innocuous before disposal or removal from the premises." The Pavilion Clean Environment Procedures under The Routine and Standard Cleaning of Patient Rooms section states that the desk, vanity, light fixtures, chairs, trash, and floors must be cleaned daily.

The complaint alleges that during the patient's stay at the facility, the bathroom in the patient's room was covered in blood and fecal matter for over 24 hours before being cleaned. The Pavilion stated that the patient did not communicate issues with the room's cleanliness during the stay and Pavilion was unaware that there was an issue until a grievance was filed on 8/26/19. There is no documentation that the patient complained of an unclean room or that additional cleaning of the patient's room was required, however, at the time of the complaint no housekeeping documentation was being completed. The HRA observed the unit which had no sanitary concerns at that time. Pavilion Clean Environment Procedures state that some areas of the room should be cleaned daily, however, the grievance investigation and the staff interviewed note that patient rooms are cleaned every other day and at discharge.

Based on the findings above the East Central Human Rights Authority concludes that the consumer's rights were violated and, therefore, the complaint is substantiated.

The HRA acknowledges that between the patient's discharge and the HRA investigation the Pavilion identified an issue with lack of housekeeping documentation and created a form to ensure that room cleaning is monitored. Additionally, the HRA makes the following recommendations:

- I. The Pavilion review its Clean Environment Procedures and current housekeeping practices to assure that they align with each other as well as align with Illinois Hospital Licensing Requirements.

Complaint 3: Inadequate treatment

The Mental Health and Developmental Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-102) 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 Mental Health and 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. Upon receipt of the petition, the court shall order a hearing to be held within 5 days, excluding Saturdays, Sundays and holidays, and to be conducted pursuant to Article IX of this Chapter.¹ Hospitalization of the recipient may continue pending further order of the court."

Documentation states that the patient arrived at Pavilion after being seen at an Emergency Department. Admission paperwork states that the patient was 3 weeks post operation and had an active infection for which the patient was being treated with antibiotics. Records show that the patient made complaints about pain and was offered a variety of pain control measures including Tylenol, Ibuprofen, Flexeril, Lidocaine patch, and a medical bed. The patient was taken to the ED on 8/17/19 where the patient's pain was assessed, treatment was provided, and the patient was returned to Pavilion.

The patient signed a State of Illinois Dept of Human Resources Request for Discharge dated 8/13/19. This form states that the patient will be discharged at the earliest appropriate time, not to exceed five days, excluding Saturdays, Sundays, and holidays unless the request is withdrawn in writing. The patient was discharged on 8/19/19 (8/17/19 is a Saturday and 8/19/19 is a Sunday) which adheres to Mental Health and Disabilities Code (405 Ill. Comp. Stat. Ann. 5/3-403).

Based on the findings above the East Central Human Rights Authority concludes that the consumer's rights were not violated and, therefore, the complaint is unsubstantiated. No recommendations or suggestions are being made in relation to this complaint.

The HRA would like to thank the Pavilion staff for their cooperation with this investigation.

RESPONSE

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