FOR IMMEDIATE RELEASE

North Suburban Human Rights Authority
Report of Findings
Elgin Mental Health Center
HRA #08-100-9012

Case Summary: Provisions were not made so that mail could be distributed when the Case Manager was not available, a violation of the consumer's right to unimpeded communication. The HRA concluded that the consumer was given medication against his will; the medication was given in emergency situations, thus rights were not violated. Progress notes showed that the consumer reported behaviors associated with medication side effects and medical personnel were aware of his concern**s;** the consumer subsequently refused medications and the refusal was honored; rights were not violated. Each emergency intervention was not accompanied by a ROR Notice, the allegation that the consumer did not receive a ROR for each restriction ws substantiated. The HRA concluded that the consumer's emergency preference was used at least once; the allegation that he had no choice of an emergency interventions and that emergency medication was automatic was unsubstantiated. The HRA concluded that the consumer was denied visitation with a family member; however the visitation was denied because the consumer's behavior was such that would have been unsafe had he left the unit; rights were not violated. Center personnel were not aware that the consumer had a POA, thus it could not be honored. And, the document did not indicate when the POA became effective; rights were not violated. The consumer was denied off-unit programming (library) while he was on frequent observation; rights were not violated. The consumer was seen by Pastoral Services on one occasion and according to the one Chaplain, he interacted with the consumer every time that he was on the unit. The chart showed that the unit staff referred the consumer to Pastoral Services on three occasions - Pastoral Services had no record of these referrals. The requests were not located in the Pastoral Services department, it was concluded that rights were violated. The HRA found no evidence to substantiate the claim that legal records were given to a family member without proper consent authority. The HRA's public record on this case is recorded below; the provider's response immediately follows the report.

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Elgin Mental Health Center (EMHC), Forensic Treatment Program, Unit N. In October 2007, the HRA notified EMHC of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The following complaints were accepted for investigation:

1. The consumer was not receiving his mail in a timely manner.

2. The consumer was given medication against his will and he did not receive Restriction of Rights Notices. The medication caused temporary muscle rigidity and extreme confusion.
3. The consumer was denied visitation from a family member without cause.
4. The facility did not recognize the consumer's Power Of Attorney.
5. The consumer was restricted from going to church and the law library.
6. The consumer was advised that he had no choice of emergency interventions; he was told that he would automatically receive medication as the emergency intervention.
7. Legal records were given to a family member without proper consent authority.

The rights of consumers receiving services at EMHC are protected by the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102, 5/2-112, 5/2-103, 5/2-104), the Illinois Power of Attorney Act (755 ILCS 45) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 10/4).

To pursue this investigation, the HRA reviewed, with written authority, a portion of the clinical record (April thru September 2007) of the consumer whose rights were alleged to have been violated. An on-site visit was conducted in January 2008, at which time the allegations were discussed with the consumer's Psychiatrist and his Social Worker. Also contacted were the Director of Pastoral Services and the Director of Health Information. The consumer was also interviewed.

The HRA acknowledges the full cooperation of all hospital personnel contacted regarding these allegations.

Background

Consumers receiving services at EMHC's Forensic Treatment Program have been remanded by Illinois County Courts to the Illinois Department of Human Services under statutes finding them Unfit to Stand Trial (UST) and Not Guilty by Reason of Insanity (NGRI). Placement evaluations determine the most appropriate inpatient or outpatient setting for forensic treatment based on a number of factors including age, gender, mental health diagnosis, and security need. Unless a person is specifically ordered to receive services in an outpatient setting, court ordered referrals under state forensic statutes call for placement in a secure inpatient setting. The Forensic Treatment Program has 315 beds.

Allegation #1: The consumer was not receiving his mail in a timely manner.

Findings

The clinical record revealed data on a 30-year-old male who was admitted to the Forensic Treatment Program on August 9, 2006 as NGRI. On Tuesday, July 3, 2007, progress notes documented that the consumer was going on a hunger strike because he had not received his mail that day. At the site visit, the Case Worker stated that he distributes the mail to the consumers on his caseload. He stated that the mail is delivered daily and that on July 3rd it was delivered to the unit after he had left for the day. Since the following day was a state holiday, the consumer did not receive his mail until July 5th.

The Center's Patient Mail policy states (in part) that prior to handing mail to the patient receiving it, unit staff shall inform the patient that staff must check the mail for contraband and money in excess of the applicable program limits. If he or she agrees to allow the mail to be inspected for contraband or money, the patient shall open the mail in the presence of a staff member. If the patient refuses to open the mail in the presence of a staff member, it is held until the patient agrees to allow the mail to be inspected. If the mail is a package, the package must be opened in the presence of a Security Officer, or the patient's caseworker, or the Nurse Manager, or a staff member designated by the Nurse Manager. The policy states that all letters addressed by patients to the Governor; members of the General Assembly; Attorney General; judges; state's

attorneys; Guardianship and Advocacy Commission; Protection and Advocacy, Inc.; Officers of the Department of Human Services; or licensed attorneys at law must be mailed at once to the persons for whom they are addressed without examination by staff, except to ensure that the out-going mail meets the minimum U.S. Postal Services standards.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Code, Section 2-103, 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. The facility director shall ensure that correspondence can be conveniently received and mailed.

The consumer did not receive his July 3rd until July 5th; given that one day was a Federal holiday, it is concluded the allegation that mail was not received in a timely manner is unsubstantiated. However, provisions should be made so that mail can be distributed when the Case Manager is not available, a violation of the consumer's right to unimpeded communication.

Recommendation

It is recommended that provisions be made so that mail can be distributed when the Case Manager is not available. It is a suggested that the Patient Mail policy be amended to say that all incoming mail from the Governor; members of the General Assembly; Attorney General; judges; state's attorneys; Guardianship and Advocacy Commission; Protection and Advocacy, Inc.; Officers of the Department of Human Services; or licensed attorneys be given to the persons for whom they are addressed without examination.

Allegation #2: The consumer was given medication against his will and he did not receive Restriction of Rights Notices. The medication caused temporary muscle rigidity and extreme confusion.

Allegation #6: The consumer was advised that he had no choice of emergency interventions; he was told that he would automatically receive medication as the emergency intervention.

Findings

At the site visit, the Physician explained that medication was given to this consumer against his will, but it was given only in emergency situations. The Physician stated that he was prepared to take the consumer to court for court-ordered medication, but the consumer was transferred to a maximum security site before this came to fruition. The HRA was given a copy of the consumer's Petition for Involuntary Administration of Psychotropic Medication document that the Physician completed for the court-ordered medication. This document showed, and the clinical record confirmed, that the consumer had his right to refuse medication on the following days:

1) On July 24, 2007, the consumer was placed in seclusion per his emergency intervention preference to control "extreme agitation and belligerence" and he was deemed to be a danger to self and others; he was subsequently given emergency medication. The chart contained Restriction of Rights (ROR) Notices for each restriction.
2) On August 9th, the consumer received emergency medication on three separate occasions. At 9:35 a.m. he was noted to be severely manic, pacing the floor, agitated, hostile, belligerent, bumped into the shoulder of his physician and picked up a chair as if he was going to hit the physician; PRN medication was offered and refused - he received IM (intramuscular) medication. At about 10:30 p.m. he received IM medication due to hostility. At about midnight, the consumer was noted to be very manic; jumping in the dayroom, pacing, and pounding on the windows, opening other patients' rooms-medication was given. The chart contained one ROR for the emergency medications.
3) On August 10th (8:00 a.m.) he was described as very manic, agitated, hostile, and belligerent

and the consumer "lightly" hit his Physician on his chest with an open palm. The Physician noted that the consumer did agree to go to the interview room and initially agreed to resume his medication, however when the consent form was presented, the consumer replied that the physician was coercing the consumer into taking mediation. The consumer became agitated and medication was given. A ROR was not located in the chart.

4) On August 14th, the consumer was placed in restraints (11:00 a.m.) because he attacked a peer - he received emergency injections three times while in restraints. The first dose was shortly after the initiation of the restraints; the second administration occurred about two hours later. The 15 minute monitoring record documented that he was talking bizarrely and yelling; the third time was about five hours later - the 15 minute monitoring record documented he was pulling his arms and legs out of the restraints, he was spitting at staff and yelling and screaming. The chart contained RORs for each intervention.

The Notices documented that the consumer was given a copy and progress notes show that copies were given as the consumer would challenge what was written in the Notices. The Notices also showed that the consumer would, at times, designate an individual to be notified of the restriction; at other times he wished that no one be notified.

Regarding the allegation that the medication caused temporary muscle rigidity and extreme confusion, on July 28, 2007, the Physician documented that the consumer reported that the reason he is refusing Risperidone was because of the side effects, and reported "jerking of his arms." On August 1st, nursing notes documented that the consumer reported the medication made him have tremors (word illegible).

On August 7th, the consumer made the decision to discontinue all prescribed medication. The Physician then placed the consumer on frequent observation so that he could be monitored for seizures due to the abrupt discontinuation of Depakote. Two days later, the Case Worker documented that the consumer seemed confused, as he reported that his mother and father were dead (which to his knowledge they were not), and the consumer seemed confused about what certain documents were - specifically a release of information form.

Regarding the allegation that the consumer had no choice of emergency medications, it is documented that his emergency preference was seclusion; this was used on one occasion as his preference. During the other emergency situations, it was documented that the preference was not used due to the displayed behaviors. At the site visit, the Physician stated that it is not always possible to use the emergency preference.

The Center's Refusal Of Services/Psychotropic Medication policy states (in part) that an adult recipient of services or the recipient's guardian, if any, are to be given the opportunity to refuse generally accepted mental health services, including but not limited to medication. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others or are court ordered. The policy also states that a restriction of rights form shall be completed for each administration of emergency medication.

The Center policy that addresses Restriction of Rights states (in part) that whenever any rights of a patient that are specified in Section 2-103 of the Mental Health and Developmental Disabilities Code and listed on the Notice Regarding Restriction of Recipient Rights are restricted, a professional of the treatment unit shall be responsible for promptly giving notice of the restriction and the reason therefore to: the patient, and if the patient is under guardianship, his or her guardian; another person or agency. A staff member of the treatment unit shall be responsible for explaining the reason for the restriction and promptly recording the restriction and the reason for the

restriction in the patient's clinical record at the time it is initially given, the Hospital Administrator or designee shall be notified within 24 hours of the time of the restriction.

The Center policy that addresses emergency preference is the DHS (Department of Human Services) Program Directive - Use of Restraint and Seclusion policy, which states that the initial admission assessment process will engage the individual in identifying early interventions that may help minimize or prevent the need for restraint and/or seclusion. The assessment will be used to help formulate the treatment plan and will identify early indicators of escalating behaviors as well as techniques, methods, or tools that might help the individual manage his or her thoughts, feelings, and behavior. The individual and, when appropriate and consistent with confidentiality requirements, the family will assist in this process. Individuals will be queried regarding preferences for restraint, seclusion or medicine should it be necessary to employ emergency interventions.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Code (Code) Section 2-107, "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 HRA concludes that the consumer was given medication against his will; the medication was given in emergency situations, thus rights were not violated; the allegation is unsubstantiated. Progress notes showed that the consumer reported behaviors associated with medication side effects and medical personnel were aware of his concerns; the consumer subsequently refused medications and the refusal was honored. It is concluded that rights were not violated.

Pursuant to Section 2-201 of the Code, "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 therefore to the recipient [and to anyone so designated]." Since each emergency intervention was not accompanied by a ROR Notice, the allegation that the consumer did not receive a ROR for each restriction is substantiated.

Pursuant to Section 2-102 of the Code, "In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan." The HRA concludes that the consumer's emergency preference was used at least once; the allegation that he had no choice of an emergency interventions and that emergency medication would be automatic is unsubstantiated.

Recommendation

Hospital personnel must ensure that a ROR is completed for each emergency intervention.

Allegation #3: The consumer was denied visitation from a family member without cause.

Findings

According to chart documentation, on August 13th, the consumer asked a nurse "why did they send my father home yesterday"; the physician later documented that the consumer "got into my face very closely, touching his face with mine and asked why you did not let my father in for a visit". At the site visit, the physician recalled that the consumer's father was not allowed to visit because the consumer was too unstable to leave the unit. The chart documented that on August 12th, the consumer was on one-on-one line of sight supervision for the prevention of aggression and self-injuries behavior. The chart did not contain a ROR. Notice for this restriction.

The Center's Patient Visitation policy states that, "Visitors under age sixteen (16) shall be permitted to visit only with the prior approval of the Program Director or designee. The location shall be away from the mainstream of visitation or unit or program activities." The HRA reviewed the Patient/Family/Significant Other Information Booklet, which says that minors (under age 16) require special permission from the Program Director.

Conclusion

Pursuant to Section 2-103 of the Code, "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. 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."

The HRA concludes that the consumer was denied visitation with a family member; however the visitation was denied because the consumer's behavior was such that would have been unsafe had he left the unit; rights were not violated. However, as stated above, hospital personnel must ensure that a ROR Notice is completed for every rights restriction.

Suggestion

Because the Mental Health Code visitation mandates does not differentiate from an adult or minor visit, when a minor's visit is denied, documentation must clearly state the reasons for the denial and a Restriction Notice must be completed.

Allegation #4: The facility did not recognize the consumer's Power Of Attorney.

Findings

It was reported that the consumer's sister held medical Power of Attorney and that the consumer's Physician said that the consumer was fit to make his own decisions so the POA can be disregarded. The consumer's sister sent the HRA a copy of the POA document that was made on December 20, 2005. It is noted that the document does not show when the power of attorney becomes effective. Chart documentation showed that the sister spoke to the consumer's Physician about the consumer's medication regime, saying that the consumer did not need medication because he was not mentally ill. At no time during these conversations did she mention that she held POA. The consumer's admission Facesheet, completed August 2006, does not indicate that the consumer's sister held POA.

The first and only notation in the chart about the consumer's sister being the agent under the Power of Attorney is on August 11th, when the consumer refused to have a blood draw - saying that he would not do that until he talked to "my people, my lawyer, and my sister - who is my power of attorney."

It is noted that the Petition for Involuntary Administration of Psychotropic Medication documented that the consumer was legally competent and that the Physician had made a good faith attempt to determine whether the consumer had executed a Power of Attorney for Health Care; it was documented that there was no information to suggest that one existed.

At the site visit, the Case Worker stated that he did not know that the consumer had a POA until sometime after admission. He stated that the consumer had not revealed this information and that one day the documentation showed up in the chart.

The Center's Advance Directives procedures policy states that, "At the time of admission to EMHC, every patient or his or her representative is to be asked by admitting staff if he or she has an existing living will, durable power of attorney, or mental health treatment preference declaration." The Illinois Department of Human Services Program Directive on Advance Directives states that, "A durable power of attorney for health care designates one or more persons to make decisions (as specified in the document) in the event the individual becomes physically or mentally unable to do so. The provisions of the document will be incorporated in the medical treatment and decision-making process as soon as the individual becomes physically or mentally incapable of self-determination as it relates to the health care decision-making process. The physician will document in the clinical record the place, date, and time the durable power of attorney for health care goes into effect as well as the individual's clinical condition that becomes the cause of execution of the provisions specified in the durable power of attorney for health care."

Conclusion

Pursuant to the Illinois Power of Attorney Act (755 ILCS 45/2-1), "The General Assembly recognizes that each individual has the right to appoint an agent to deal with property or make personal and health care

decisions for the individual but that this right cannot be fully effective unless the principal may empower the agent to act throughout the principal's lifetime, including during periods of disability, and be sure that third parties will honor the agent's authority at all times." Section 2-4 states that, "The principal may specify in the agency the event or time when the agency will begin and terminate, the mode of revocation or amendment and the rights, powers, duties, limitations, immunities and other terms applicable to the agent and to all persons dealing with the agent, and the provisions of the agency will control notwithstanding this Act, except that every health care agency must comply with Section 4-5 of this Act." That Section prohibits administering healthcare providers from serving as agents.

According to Center personnel, they were not aware that the consumer had a POA, thus it could not be honored. And, the document did not indicate when the POA became effective. It is concluded that rights were not violated; the allegation is unsubstantiated.

Suggestion

When a legal document becomes part of the clinical record, staff members should note this in the progress notes.

Allegation #5: The consumer was restricted from going to church and the law library.

Findings

According to chart documentation, on June 4, 2007, the consumer was seen by the Chaplain. On July 3rd, the consumer was placed on frequent observations for unpredictable behavior; the observation was discontinued on July 5th, at which time the consumer was allowed to use his building pass. The consumer was again placed on frequent observations from July 24 through August 6, 2007. The chart documented that the consumer was referred to the Chaplain on at least three occasions; there is nothing in the chart indicating that the consumer needed to use the law library.

At the site visit, it was stated that the consumer did not have access to off-unit programming while on frequent observation. It was stated that a consumer must be clinically stable before off-unit programming is granted to maintain safety for the consumer and others. The treatment team assesses the consumer's clinical condition on an on-going basis to determine if the consumer is ready for off-unit programming. It was further offered that an assessment must be made each time a consumer leaves the unit to establish that the consumer is clinically stable.

The HRA contacted the Director of Pastoral Services and inquired about the procedure regarding a consumer who is unable to leave the unit due to being on a precaution. The reply was that the Pastoral Services staff go on the unit to administer services. It was stated that the Center currently has two "in house" chaplains who minister ecumenically; they are scheduled on all units at least once every other week either to hold a Spiritual Opportunities Group or to do general unit and/or special (by patient request) visits. All patients can request an individual visit by a chaplain simply by asking their case worker, or any unit staff (requests are made from Technicians, RNs and MDs, Activity Therapists and Psychologists as well); requests are made by calling or e-mailing the Director of Pastoral Services. When a request is received, the Director stated that she completes a "PCS (Pastoral/Chaplain Services) Request" slip and then leaves the slip for the chaplains. If there is any urgency communicated regarding the visit, the Director contacts one or both chaplains by phone to ask that they see the patient that day or the following - it was stated that the Director is almost always able to get a chaplain to a patient within two days. When there are any special circumstances, the Director gets back in touch with the referring staff member about when a chaplain will visit. When the chaplain completes the visit, he completes the rest of the referral slip, and it is kept in an envelope in the chaplains' office. The HRA then asked for any referral slips that were made on the consumer identified in this case - none were found. When no slips were found, the Director contacted both Chaplains and learned that one Chaplain did not remember the patient. When this Chaplain was reminded of the Unit, she/he immediately commented (according to the Director) that she/he gets no support from the staff on Unit N and that she/he would not be

surprised if staff did not follow through with a request. The other Chaplain immediately remembered the consumer in question and said that he interacted with him every time he was on the unit. The Director asked this Chaplain if the consumer had ever made any specific requests for any type of pastoral care services, and he said "no". It was stated that the Chaplains do not document in a consumer's clinical record.

The program's Off-Unit Supervision of Forensic Patients policy states that the program must have specific procedures in place when escorting patients without grounds pass privileges off the unit and within the fenced perimeter of the FTP complex. As a result, patients without unsupervised off-grounds pass privileges, when taken off the unit, must be under staff supervision at all times. The policy goes on to say that prior to leaving the unit, the patient must be screened to determine if his clinical condition is appropriate as it relates to being in the area.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Code, Section 2-100, "No recipient of services shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the receipt of such services." Section 5/2-102 states that "A recipient of services who is an adherent or a member of any well-recognized religious denomination, the principles and tenets of which teach reliance upon services by spiritual means through prayer alone for healing by a duly accredited practitioner thereof, shall have the right to choose such services."

The consumer was denied off-unit programming (library) while he was on frequent observations. The HRA does not find that the consumer's rights were violated. In the portion of the chart reviewed, the consumer was seen by Pastoral Services on one occasion. According to the one Chaplain, he interacted with the consumer every time that he was on the unit. The chart showed that the unit staff referred the consumer to Pastoral Services on three occasions - Pastoral Services had no record of these referrals. One Chaplain stated that he/she gets no support from staff members on this unit and would not be surprised if they did not follow through on requests. Since the requests were not located in the Pastoral Services department, it is concluded that rights were violated.

Recommendation

Staff members must ensure that the fundamental right to receive religious services is upheld - all requests for Pastoral services must be referred to that Department in a timely manner and follow-up must be made to make certain that the request has been made and received.

Suggestion

It is suggested that hospital administration follow-up with the Chaplain who claims to have problems with the staff members on the unit as it pertains to the pastoral referrals.

Allegation #7: Legal records were given to a family member without proper consent authority.

Findings

The chart contained an Authorization to Disclose/Obtain Information form that was signed by the consumer on August 9, 2006. The form allowed the Center to disclose to and obtain information from the consumer's sister and father; the consent was valid until August 9, 2007. On August 9th, the Case Worker documented that the consumer did not renew this consent. The chart also contained a form showing that on March 26, 2007, the consumer rescinded the consent that he had given to disclose/obtain information to his Mother. The Case Worker stated that he had no knowledge of the consumer's father requesting information about the consumer.

The Director of HIM (Health Information Management - new name for the Medical Record Department) was contacted and she stated that when someone calls for a record and states that the consumer is currently receiving services, HIM acknowledges nothing, but they will take the name and a telephone number of the caller. The caller is informed that nothing is released without an authorization. HIM personnel then contact the unit to locate the assigned Case Worker and relay the information to the caseworker to pass onto the consumer.

Conclusion

Pursuant to Section 5 of the Mental Health and Developmental Disabilities Confidentiality Act., "Except as provided in Sections 6 through 12.2 of this Act, records and communications may be disclosed to someone other than those persons listed in Section 4 of this Act only with the written consent of those persons who are entitled to inspect and copy a recipient's record pursuant to Section 4 of this Act." Section 4 lists the consumer if 12 years of age or older and legal guardians.

The consumer seemed very cognizant of whom he did and did not want to disclose his chart; HIM stated a chart would not be released without proper consent authority. The HRA found no evidence to substantiate the claim that legal records were given to a family member without proper consent authority.

RESPONSE

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

Rod R. Blagojevich, *Governor*

Carol L. Adams, Ph.D., *Secretary*

Division of Mental Health - Region 2

Elgin Mental Health Center ▪ Singer Mental Health Center

RECOVERY IS OUR VISION
Recovery is a Personal Journey of Hope, Healing, Growth, Choice, and Change

September 8, 2008

Mr. Dan Haligas, Chairperson
North Suburban Regional Human Rights Authority
9511 Harrison Street, W-300
Des Plaines, IL 60016-1565

Re: HRA #08-100-9012

Dear Mr. Haligas:

Thank you for your recent thorough investigation. Per your letter dated August 6, 2008, the HRA investigated seven allegations from a consumer. Below are responses to the allegations which were substantiated, or had recommendations or suggestions.

Consumer not receiving mail in a timely manner. Social Workers will be reminded to distribute mail as soon as it arrives on the unit and the facility policy will be modified to state mail from elected officials, Guardianship & Advocacy, Protection & Advocacy, licensed attorneys will be given to consumers without examination.

Consumer was given medication against his will and he did not receive a Restriction of Rights. Nurse Managers will meet with all nurses to review Restriction of Rights policy at unit meetings and reinforce with RN staff that they must be completed for every emergency intervention.

The consumer was denied visitation from a family member. Nurse Managers will meet with all nurses to review Restriction of Rights policy and reinforce with RN staff that they must be completed for every restriction of visitation.

The facility did not recognize the consumer's Power of Attorney. Nurse Managers and Discipline Chiefs will remind staff that all legal documents should become part of the clinical record and be noted in the progress notes. This will be noted in meeting minutes.

The consumer was restricted from going to church and the library. Nurse Managers and Discipline Chiefs will review policy for referrals to Pastoral Services and document in minutes.

I would request that this response be attached to the report and be included with any public release of your Report of Findings. Thank you again for your excellent work.

Sincerely,

Tajudeen Ibrahim, BA
Acting Hospital Administrator

TI/JP/pb