FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
TINLEY PARK MENTAL HEALTH CENTER— 09-040-9007
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary— The Authority made two corrective recommendations regarding one of the allegations, and the service provider accepted both of them. The public record on this case is recorded below; the provider did not request that its response be included as part of the public record.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA), the investigative division of the Illinois Guardianship & Advocacy Commission has completed its investigation into allegations concerning Tinley Park Mental Health Center, a state-operated facility. The complaint alleged the following: 1) a recipient's right to telephone communication was restricted, 2) the recipient was not provided with adequate medical care, 3) the facility did not respond to the recipient's grievances concerning abuse, and, 4) the facility is a smoke-free environment, but employees are allowed to smoke in view of recipients on the unit. If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.) and the Centers for Medicare/Medicaid Conditions of Participation for Hospitals (42 C.F.R. 482).

METHODOLOGY

To pursue the investigation, the Clinical Nurse Manager, the Quality Manager, the Recovery Specialist, a social worker and unit staff members were interviewed. The complaint involving the cigarettes was discussed with recipients on the unit. The recipient's records were reviewed with his consent. Relevant facility policies were also reviewed.

COMPLAINT STATEMENT

The complaint stated that the recipient called the police three times after he was physically abused by a peer. His right to telephone communication was restricted on that same day. The police never came to talk to the recipient who allegedly sustained an eye injury during the incident. It was reported that eye drops were not administered as ordered. The Magnetic Resonance Imaging (MRI) was rescheduled because the escort had to leave the outside medical facility before the test could be completed. The recipient was reportedly hit with a chair by another peer. He allegedly filed a grievance with the facility concerning both incidents, but he did not receive a response. The complaint further stated that the facility is a smoke-free environment, but employees are allowed to smoke in view of recipients on the unit.

FINDINGS
COMPLAINTs # 1-3: Rights Restriction, Medical Care and Grievances

According to the first admission record, the recipient was admitted to the facility on September 9th, 2008 because of depression and suicidal ideations. A social worker wrote on September 18th, at 1:00 p.m. that the recipient requested to call the police to report an incident. In response to the recipient's request, the social worker called several administrative staff members for guidance, and, according to the documentation, the recipient was interviewed by the police about five minutes later. A corresponding Unusual Incident Report reflected that the recipient told the police that another recipient had thrown a chair at him on the previous day. He further alleged that the chair had struck his left ankle. However, the peer involved in the incident claimed that he threw the chair after the recipient had left the room. The staff person who witnessed the occurrence did not confirm that the chair made contact with the recipient and said that both recipients had verbally threatened each other. The report documented that no injuries were observed. And, there was no written indication that the recipient filed a grievance with the facility regarding the incident. He was discharged on September 25th, 2008.

According to the second admission record, the recipient was readmitted to the facility for suicidal ideations two days later, and he had several altercations with peers including one that resulted in an eye injury. An "Injury Report" written on November 18th at 6:50 a.m. documented that the recipient had a minor scratch on his left cheek and a bruised right eye. Ten minutes later, a physician noted swelling of soft tissue, conjunctiva redness and tearing in the recipient's right eye. A cold compress and Ibuprofen 800 mg were ordered stat. By documentation, the recipient claimed that his injuries were peer related. He was reportedly hit with the remote control because he disagreed with his peer about what channel to watch on the television. The recipient was referred to the facility's Wellness Center because of a possible corneal abrasion on that same morning, and a Consultation Report indicated that he was referred to an outside Ophthalmology Clinic for further evaluation on that next day. Tobramycin (ophthalmic ointment) and an eye pad four times daily and Acetaminophen 650 mg every eight hours as needed were ordered. Ibuprofen 400 mg every six hours was later ordered because Acetaminophen was reportedly not effective. According to Medication Administration Records (MARs), an eye pad was offered twice and refused on the 18th.

Documentation on November 18th indicated that the recipient's rights to telephone communication were restricted because the police notified the facility that the recipient was calling them. According to a psychiatrist’s entry, the recipient acknowledged calling the police three times on the incident day, and he was appropriate for phone restriction following an evaluation. The record contained an order for the restriction. A form indicated that the recipient's telephone rights were restricted from November 18th at 5:00 p.m. to November 19th at 5:00 p.m. According to the notice, the recipient did not want anyone to be notified of the restriction, and he refused a copy of the form.

On November 19th, the recipient was escorted to the community eye clinic for further evaluation of trauma to his right eye. The complaint alleged that a Magnetic Resonance Imaging was ordered. However, a Computed Tomography (CT) Scan of the orbits was ordered because

an orbital fracture was suspected. Keflex 500 mg orally four times daily for seven days, Prednisolone Forte, one drop to the right eye four times daily, Nasal Afrin Spray twice daily for three days and Vicodin one tablet or Tylenol #3 every four hours were recommended by the eye clinic. The facility's medication records indicated that the above medications including Zolpidem (for sleep) 5 mg were ordered on that same day. The next day, the physician ordered a check with the pharmacy regarding the availability of the eye drops and nasal spray. It was recorded that Keflex and Vicodin are non-formulary and Cefadroxil 500 mg orally twice daily for seven days was ordered.

The recipient was transported to the eye clinic for a CT Scan on November 20th. An order for phone restriction was written on that same day. A form indicated that the recipient's telephone rights were restricted from November 20th at 5:30 p.m. to November 21st at 5:30 p.m. for making calls to the police again. According to a nursing note, the recipient was very angry during the community meeting, and he argued with the peer involved in the November 18th incident. Subsequently, his peer found a cup of urine in his bed and verbally threatened the recipient. The recipient's psychiatrist was informed about the situation. The note also referenced that the recipient refused to move to another unit for safety reasons.

According to medication records, Tobramycin was administered four times on November 19th and the 20th, one time on the 21st and twice on the 22nd. Prednisolone Forte was administered three times on the 20th and four times on the 21st, 22nd and 23rd. The nasal spray was administered twice on the 20th, 21st and 22nd and discontinued. Cefadroxil was given twice for six days starting on the 20th, and the medication was given one time on the 26th and discontinued. He accepted medication for pain as needed. He was seen at the outside eye clinic for follow-up care on November 24th. The same day, an order was written for eye drops four times daily for two weeks and stated that the medication should be started as soon as available. MARs indicated that eye drops were administered one time on the 24th, four times from November 25th through December 5th, twice on the 6th, four times on the 7th and the 8th, one time on the 9th and four times on the 10th. There was no documentation that the eye drops were refused.

A report dated December 11th stated that the recipient was seen in the eye clinic, and that right orbital fractures were found on the CT Scan. Prednisolone Forte, one drop to the right eye twice daily for one week and then one drop daily for one week was recommended. A follow-up visit was also scheduled in two weeks. According to MARs, eye drops were administered twice on the 11th, one time on the 12th and twice on the 13th, 14th and 15th. Ibuprofen 600 mg orally every six hours was ordered on the 15th and accepted on the 15th and 16th. The recipient was discharged on December 16th, 2008 with no acute distress from his right orbital fracture.

When the complaint was discussed with Tinley's administration, the Clinical Nurse Manager explained that the facility's standard of care for wounds includes: 1) a general assessment and cleaning of the wound, 2) the wound is examined by a physician, 3) possibly further evaluation such as outside medical care, and, 4) a treatment plan such as medicine developed by the physician. The staff asserted that recipients are allowed to make police reports regarding incidents. The recipient's phone rights were restricted for calling 911, and he was told to work with his social worker to make a police report. However, the record lacked evidence

that the recipient was referred to his social worker regarding this matter. Furthermore, the assigned social worker reported that she was probably on vacation when the incident occurred because her next progress note was written on November 25th. She said that recipients usually do not want to call the police, but she has encouraged them to do so. Recipients reportedly can use the social worker's or the nurse's phone.

On questioning, the HRA was informed that completed grievance forms are submitted to the Clinical Nurse Manager who gives the Recovery Specialist a copy of the complaint. The Recovery Specialist monitors the grievance process. All grievances are maintained by the facility for about one year after the complaint is filed. According to the Recovery Specialist, the recipient did not file a grievance with the facility concerning the altercations with his peers. The Quality Manager said that the recipient made verbal complaints, but he reportedly refused to put anything in writing when offered a grievance form.

According to the facility's policy entitled "Case Management," an individualized treatment plan will be written on each patient admitted to the facility. The assigned physician is responsible for making diagnoses and implementing a course of treatment. The assigned nurse is responsible for implementing the orders as prescribed by the physician.

The facility policy entitled "Authorization for Medical Services" states that patients will be seen in the Wellness Center if appropriate. "If the patient requires transfer to a subspecialty Outpatient facility this should be noted and authorized." For emergent and non-emergent outside medical services, the Director of Medical Ancillary Services' approval is needed.

According to the facility's grievance policy, a patient, family member or representative may file a grievance without reprisal such as termination of stay. The policy includes steps for resolution up to the Facility Director or designee. During the grievance process, the patient can choose to submit his/her complaint to an external agency such as the Guardianship & Advocacy Commission, Human Rights Authority at any point. It states that the facility must provide a written response within two to five business days depending on the grievance level. The policy does not include notification concerning what steps were taken to investigate and contact information.

CONCLUSION

Section 5/2-102 (a) of the Code guarantees all recipients of services that adequate and humane care and services shall be provided, pursuant to individual services plans.

According to the Code's Section 5/2-103 (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.

Section 5/2-201 of the Code states that whenever any rights of a recipient of services are restricted, the recipient shall be promptly given a notice of the restriction.

The Special Provisions Applying to Psychiatric Hospitals Section of the Medicaid Participation requirements states that the hospital must meet conditions specified in Sections 482.1 through 482.23 (42 C.F.R. 482.60).

Under Section 482.13,

> 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…. At a minimum:
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> (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.

The Authority finds that the recipient was provided with adequate medical evaluation given the documentation from the record. The investigation revealed that the recipient was examined by a physician within ten minutes after a peer hit him in the eye. Services were provided based on physicians' assessments that included a referral to the facility's Wellness Center and a local community eye clinic for further evaluation. The record indicated that a CT Scan was ordered by the eye clinic and timely completed on that next day. However, the HRA finds that the facility failed to provide adequate medical care completely, in that Tinley's nursing staff failed to follow physician's orders regarding the administration of eye drops. Medication records indicated that one drop four times daily was initially ordered. According to MARS, the eye drops were administered three times on the 20th, one time on the 24th, twice on December 6th and one time on the 9th. They were administered twice daily on December 11th as ordered but only one time on the 12th. Physician's entries explained that the eye drops might not have been readily available on the 20th and the 24th. However, there was no documentation that the eye drops were offered and refused on the 6th, 9th and the 12th. This violates Section 5/2-102 (a) and the facility's "Case Management" policy.

The HRA cannot substantiate that the recipient's right to telephone communication was restricted because the Code allows reasonable restriction under certain circumstances such as harassing calls. There were two physician's orders and notices found in the record for phone restrictions following his eye injury. There was documented indication that the recipient's calls to 911 might have been perceived by the police as harassment. The recipient was reportedly informed to use his social worker's phone instead of calling 911, but the staff person said that she was probably on vacation when the incident occurred. It is unclear whether another social worker was covering for the assigned social worker because of lack of documentation. It is clear that the recipient wanted to exercise his right to make his own phone call on the matter, which might have ultimately de-escalated the situation. Although there was no evidence that the recipient made a police report concerning the incident, the Authority finds no violations under Sections 5/2-103 (c) or 5/2-201.

The complaint that the facility did not respond to the recipient's grievances concerning abuse is unsubstantiated. There was no evidence that he filed grievances concerning the altercations. No violations of Section 5/2-102 (a), the Code of Federal Regulations or the facility's grievance policy were found.

RECOMMENDATIONS

1. Require nursing staff to follow all physicians' orders as written to ensure that recipients are provided with appropriate medical care.

2. Document in recipients' records if medication is refused.

SUGGESTIONS

1. The staff should document when recipients are informed to call the police non-emergency number to report an incident.

2. Revise policy to state that written responses must include the steps that were taken to investigate the grievances and contact information as required by the CFR.

FINDINGS
COMPLAINT # 4: Smoking

The complaint alleged that the facility is smoke-free, but employees are permitted to smoke in view of recipients on the unit. According to the Clinical Nurse Manager, employees are informed during orientation about the facility's no smoking policy in the building and of the designated smoking area. She explained that employees are only allowed to smoke underneath a bus stop shelter located on the front side of a building that houses recipients, but it reportedly is not visible to them. She said that recipients might be able to see someone smoking in the parking lot, but the facility has not received any complaints about smoking prior to the HRA's investigation. The Authority inspected the designated smoking area and agrees that it would be very difficult for recipients to see employees smoking underneath the bus stop shelter.

While touring the facility, a Mental Health Technician said that employees are not allowed to smoke on the unit. He was informed about the facility's no smoking policy in the building through memorandums and by his supervisor. He told the investigation team that there is no designated smoking area for employees, and that he smokes outside in back of the building. Three Registered Nurses who reportedly are non-smokers denied having seen employees smoking on the unit. Recipients interviewed on the unit also denied the complaint or having observed employees smoking on the facility's grounds. One of them reported smelling smoke on employees, and one mentioned that an employee might be selling cigarettes to recipients.

The Clinical Nurse Manager confirmed that the facility had received a complaint about an employee selling cigarettes to recipients on the unit, but the person who made the complaint recanted the allegation during the facility's investigation. She said that some recipients were involved with another recipient who brought cigarettes inside the facility. A progress note written on December 15th stated that the recipient gave his peer $11.00 to bring contraband back to the unit. According to the note, the recipient was very angry because he did not get the item and several other recipients had also "lost" money with the same peer. The recipient then gave the staff person an empty cigarette box and stated that "staff was giving him cigarettes." The recipient was reportedly given a grievance form. And, the Clinical Nurse Manager and the Charge Nurse were informed.

According to Tinley Park Mental Health Center's "Smoking Policy," the facility is a smoke-free environment for patients and staff in all buildings on the campus. Additionally, through the direction of the Medical Director, smoking by patient is banned completely. Therefore, to minimize the effect and desire for patients' tobacco usage, staff members and visitors will be restricted to designated smoking areas and times where smoking will be permitted, when patients have grounds access. Although the staff are exempt from the non-smoking ban, they are reminded to refrain from smoking in areas where (and when) patients are present (e.g. while escorting patients or engaging them in outdoor activities). The policy states that the staff are allowed to smoke outside, they shall never give patients cigarettes or smoking paraphernalia, and they are directed to refrain from taking smoking materials on the units.

CONCLUSION

According to Section 5/2-102 of the Code, recipients shall receive adequate and humane care and services in the least restrictive environment.

The Authority found no evidence that employees are allowed to smoke in view of recipients on the unit. The HRA finds no violations of Section 5/2-102 (a) or the facility's policy. The complaint is not substantiated.

SUGGESTION

1. Remind all employees to smoke in the facility's designated area.

RESPONSE

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

From: Susanne Strickland
To: Smith, Rennie
Date: Tue, Mar 9, 2010 4:58 PM
Subject: Fwd: Re: re OIG response

In response to the recommendations outlined in Guardianship & Advocacy case **# 09-040-9007**:

1. "Require nursing staff to follow all physicians' orders as written to assure that recipients are provided with appropriate medical care."

2. "Document in recipients' records if medication is refused."

I have directed all Clinical Nurse Managers to retrain the facility RNs and LPNs on Policy# 312 "Medication Administration" and to forward the training sign-in sheet to Staff Development and Training Coordinator Ruby Powell by March 15, 2010. The policy addresses medication administration as well as documentation of refusal of medications.