FOR IMMEDIATE RELEASE

East Central Human Rights Authority
Report of Findings
Case 11-060-9017
The Pavilion

The East Central Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning behavioral health services at The Pavilion located in Champaign, Illinois:

Complaints:

1. A patient was not notified of his rights.
2. The provider limited the patient's access to third party advocacy.
3. A patient was not given a rights restriction notice when his phone rights were restricted.
4. A patient was not allowed to participate in his care and treatment plan.
5. A patient was not allowed to exercise his right to refuse medication.
6. A patient was restrained and not given notice.
7. A patient was not allowed to leave the provider's facility when he was not a danger to himself and others.
8. A patient was not provided adequate treatment.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1 et seq.) and the Code of Federal Regulations, Centers for Medicare & Medicaid Services, Conditions of Participation for Hospitals (42 C.F.R. 482.13).

Per the complaint, a patient had endured multiple rights violations. The complaint alleges that a veteran was admitted as a patient to the facility, and wanted to access the free services of the Veteran's Administration (VA). No one shared with the patient the cost of his stay at the facility. Allegedly the patient had two male staff sit on top of him and was forced to receive an injection of Haldol by a third male staff member. The patient was not provided information about the medication he was given. There was allegedly a video made of this experience. The complaint alleges the patient could not communicate privately because he was only allowed two phone calls per day at the nursing stations which did not allow privacy because there were other staff and patients around at all times. This patient had chronic pain in his feet and was not provided adequate pain relief. The patient was not allowed to participate in his treatment plan. The patient was not allowed to leave even though he was not a danger to himself or others and the facility sought an involuntary commitment. The patient claimed that he had no way to access third party assistance or the facility's grievance or help lines.

The HRA coordinator prior to the investigation had observed patient rights displayed outside of the locked ward of the facility, but not on the inside where patients could observe them. She asked about rights being displayed on the inside of the ward. The staff person working at the nursing station addressed a patient by name and stated that the patient had his rights previously explained to him and a copy was in his file. The coordinator asked nothing about the patient's personal information, but a general question about where was a copy of rights, with third party advocacy information, was displayed for all of the patients.

INVESTIGATIVE INFORMATION

The HRA proceeded with the investigation having received written authorization to review the patient's record. The HRA visited the hospital, where the hospital and behavioral health representatives were interviewed. Relevant practices, policies and sections of the patient's record were reviewed.

Interviews

The HRA team met with the patient advocate, the licensed clinical social worker (LCSW), the assistant administrator, and the director of nursing (DON). The HRA asked what type of services were provided at the Pavilion. The staff explained that the Pavilion provides inpatient mental health services with therapy case management. There is a 4 to 1 staff to patient ratio. There are 17 adult inpatient beds and 30 for children. There are also nurses, case managers, social workers and teachers on the unit. The average length of stay for most patients is 10-14 days. This patient was admitted from 10/12 to 11/01.

The geographical area served is mostly downstate Illinois, but the Pavilion has had patients come from as far away as Carbondale and Chicago. Most people come in through a crisis team, emergency room or Department of Human Services Screening, Assessment and Support Services (SASS). They are usually transferred by ambulance.

The HRA asked why the patient was admitted. Staff responded that the patient was brought by the police from an out-of-county hospital. The patient presented with delusional ideations and he tried to cause several vehicle accidents. When arrested he had asked the police to shoot him in the head because he was wearing a bullet proof vest. The police department reportedly had received numerous complaints about him. In his case he had no insight into his illness. He asked for his medication, but was still psychotic because he had stopped taking his psychotropic medications.

Since he had been a veteran the HRA asked why he was admitted to The Pavilion instead of a Veterans Administration (VA) facility. Staff explained that the VA may be selective regarding whom they will admit and may have been at full capacity. The Pavilion tends to take more severe cases; that is a decision made by the referring agency. They may not have known that he was eligible for the VA. Transfers to facilities have to be the same voluntary to voluntary or involuntary to involuntary.

Staff stated his admission criteria was suicidal ideation and he was put on 15 minute observations. He was very intelligent, but was very delusional. He believed he was part of the FBI and was undercover so much so he actually called the White House during his stay. They completed evaluations starting with a psychiatric evaluation. His admitting diagnoses were Schizophrenia Paranoid type and suicidal ideation. The treatment plan included elopement and self harm prevention. He reported his family's history as classified.

The HRA asked how a patient accesses rights information on the unit. Staff explained that rights information would be read to patients at admission and that they are given a copy. Patients and their families are informed of the policies at admission. Anything that would need consent, the staff would go over at admission. He had received copies of rights information including the Pavilion Patient handbook. When asked about patient rights being displayed outside of the patient's wards, the response was rights postings had been moved inside the patient wards. The assistant administrator stated that she makes monthly rounds to ensure that rights are appropriately displayed. She also stated that recently she completed a round and found the posted rights missing; allegedly this was due to someone "attacking" the display of patient rights. Since this time, they updated their display, enlarged the font, framed them, and posted them conspicuously for all patients to see.

The HRA asked what information was provided to the patient at admission. Staff explained that patient rights, copies of the court order, handouts and packets are given at admission. They were pursuing a court order which is why he was not allowed to leave. The patient was made aware of his rights and, in fact, he often walked around the facility clutching a copy in his hands. The patient was highly intelligent, well-aware of his rights, and often showed he was able to locate any needed information from a variety of sources. Additionally, the patient apparently met often with the patient advocate to discuss his rights.

The HRA asked why the staff member addressed the individual by name when the coordinator was there asking where rights information was displayed. Staff explained that the individual was a very challenging individual and was unrelenting and stated that perhaps the staff person reacted out of frustration. Management asked the coordinator who the worker was to address the issue, but the coordinator explained she did not obtain the staff person's name. It was explained to the HRA that staff receive training to be observant and document interactions; there are two weeks training at hiring and additional training later. Staff are provided an extensive list of training and performance improvement training.

The HRA asked about the Pavilion's visitation and telephone policies. Staff explained that a patient just has to walk to the nurse's station and ask to be given a cordless phone to use privately. Many phone calls are received throughout the day. They might ask a visitor if they can call back if programming is interrupted. It is completely open, however if it is group time it is not phone time as per staff. As far as visitation, particular days and times are set aside, but the facility accommodates requests for visitations outside of these times. This particular patient ran up $500-600 in telephone calls to an alleged wife in China. The patient ~~had~~ told staff, including the Director of Nursing (DON), he would be calling China, but no one quite believed him—until they received the bill. After this, the decision was made to monitor who he was calling, but never to limit or prevent his access to the telephone. Normally he could take a cordless phone into his

room specifically for privacy. He reported he was with the CIA or FBI. He was delusional. He did actually call the White House. He had private insurance and Medicare so he did not receive a bill for services. The Pavilion absorbed the costs of the phone calls and they accommodated his needs as per staff.

Regarding the treatment plan, staff would ask the patient about the problem of suicidal ideation, delusions, and to assess if he was a moderate fall risk. Staff explained that what was identified in the initial assessment determined what needs the patient had. In this case the patient had delusional thoughts. The goal was that he would increase his understanding of his mental illness. The physician would be responsible for overseeing treatment. Every morning the treatment team, (nurse manager, case manager, and psychiatrist) would meet with the patient and give their perspective.

The HRA asked about the psychotropic drug administration policy. Staff explained that a patient must be in imminent risk for emergency forced medications. The patient did not have a court order to take psychotropic medications. The HRA asked staff to explain if the patient received the Haldol injection. It was explained that he did receive Haldol and Ativan on four occasions; each time the patient agreed to receive this medicine. Benadryl was given to prevent any negative symptoms; it has been proven to prevent permanent side effects as per staff. Staff explained that if emergency medication is administered they continue to try to work with the individual. Staff stated that the patient was agitated and needed redirection to be appropriate. Sometimes medications were not given because the patient had calmed down. Facility representatives also stated that the patient generally refused all treatment and his regular medication.

The HRA asked about the allegation that the patient was held down by 2 male staff and given the injection. Staff stated there was nowhere in the record that this patient was restrained while he received treatment. Facility participants stated that this sounded like mechanical, four-point restraints—when a patient is tied down to a bed which is something the facility has not done in a long time, is not taught to or used by staff, and would not be used on a patient.

The HRA asked about the type of restraints administered by staff. Staff explained that they use a therapeutic crisis intervention (TCI) protective hold. The HRA was informed that the only form of involuntary restraint utilized by facility staff is to place dangerous patients in a "protective hold." This is where several nurses will lay their bodies across the patient to prevent his movement. Staff provided information about the types of training provided regarding restraints. The HRA asked how staff keeps appraised of treatment ideas/evidenced based treatment. Staff explained that staff receive TCI at initial training. Then, every 12 months they have to be recertified. A refresher course is held every three months. They also review any new information as it comes to their attention.

The HRA asked if there was a video of any incident involving the patient. Staff responded that if they found something that was a concern they would save it. The video system itself removes any video taped material after it is 30 days old. It requires a lot of space to maintain. Almost all cameras are used to maintain safety in the facility.

The HRA asked about pain management for the patient's feet. Staff explained that no medication was given because there was nothing under past medical history for pain in his feet. He did have ibuprofen every 6 hours. On the 14th he had pain equal to a number 1 that went down to 0 after he was given Tylenol. Staff explained that they usually intervene if a patient's pain level is at 4.

The HRA asked why medications would be delayed or withheld. Staff explained that none would be given unless a physician orders it. The HRA asked if a patient's request to see a physician can be accommodated. Staff explained that a patient can see a physician every day because he is in the facility. The HRA asked if the facility checks with community providers or physicians regarding treatment needs, medications, etc. The response from staff was that in this case, it was a single emergency room visit that brought the patient to the Pavilion.

Regarding the discharge process for this patient, on 10/12/10, he would have been considered an involuntary patient and would have needed a court hearing. He requested at admission to be a voluntarily admitted. On the 15th he signed a request to be discharged in 5 days. At that point the Pavilion sought an involuntary commitment because the patient would not be safe. They petitioned the court for the patient's involuntary commitment and he requested a trial by jury which postponed his hearing. He withdrew his request for discharge, but because his condition improved he was discharged on 11/01/10. He was provided the typical components of a discharge plan which would include: discharge instructions, prescriptions, and a referral for a psychiatrist. For this patient, he was recommended to have therapy and counseling. He had two appointments scheduled, one in three days, and an appointment with the psychiatrist was made to adjust medications.

The HRA asked if the patient registered any complaints and if so how were they addressed. Staff explained that his main complaint was he did not want to be there. There is a Patient’s Advocacy Log that would have documented any complaints. The Patient's Advocacy Log documented one complaint. The HRA was provided a copy of it. Staff did receive another call on 01-27-11 when the patient asked to return to the facility.

It was explained to the HRA that, for quality assurance purposes, the hospital utilizes a performance improvement (PI) plan and committee, patient bill of rights, assessment, and pain treatment. They review plan and conduct monthly audits. Compliance is 90% through accreditation with the Joint Commission. They identify, gather and track quality assurance data.

The HRA was provided a tour of the facility. The lobby of the facility was slightly dated in appearance, but clean. The facility had posted patient rights as required by Illinois Mental Health Code 5/2-200. HRA members saw rights posted inside both the adult and juvenile units; it was observed that the phone number for the HRA was not listed. Facility representatives justified this by saying that this was to reduce copious updating of the display. However after discussion with staff the rights were reposted and updated to include phone numbers of third party advocacy groups including the Guardianship and Advocacy Commission. The facility staff appeared to be uniformly friendly, professional, and passionate about their work.

Record Reviews

10/12/10 - An involuntary petition was completed by a local sheriff department who ~~had~~ brought the patient to the Pavilion. Along with the petition, the Rights of Admittee was completed and signed by a Pavilion RN documenting that a copy was given to the individual and that his rights were explained to him. A certificate had been completed and signed by the physician. In the petition it stated that the individual had a history of Bipolar Disorder and ~~had~~ a history of not taking his medication. The patient had attempted to rear-end his car into a county deputy's vehicle twice. The patient believed he was in the FBI and called the FBI office on a daily basis. He had threatened to take out the FBI building. He asked a deputy to shoot him in the head because he was wearing a bullet proof vest.

When brought to the Pavilion an application for voluntary admission was signed by the patient. It included the time and signature of the RN. A photograph consent form was signed by the patient. A comprehensive assessment and an adult-psychiatric nursing assessment were completed. In the nursing assessment the patient was given an orientation which would have included having rights read to him and a copy was provided along with a patient handbook. In the psychiatric nursing assessment the patient was asked if he had any pain or any medical condition that was causing him pain and he answered no to both.

A physician prescribed an order for Haldol and Ativan injections at 9:30 pm. The record shows the patient had given consent to take the medication and was informed of the risks and benefits of the medication.

10/13/10 - A consent for treatment of services was signed by the patient at 3:00 am. Later that morning the record indicated that the psychiatrist completed a psychiatric evaluation. Case management staff completed an assessment. A history and physical were completed. The history and physical completed by the physician on 10/13/10 documented no acute medical issues per the patient. A master treatment plan was initiated by an RN and signed by the psychiatrist, the physician and case-management on 10/13/10. Per the master treatment plan that was signed by the patient at his release, it was documented that he both contributed to the plan and refused to participate.

At 12:00 pm the physician order (PO) for Risperdal and Depakote was documented, and the medical administration record (MAR) documented that they were administered at 12:00 pm. The record documented that the patient had given consent to take the medication and was informed of the risks and benefits of the medication.

10/14/10 - At 1:20 pm, documentation on the MAR showed that the patient had given consent to take the medication and was informed of the risks and benefits of the medication. The psychiatrist had completed a certificate for involuntary admission; it documented his clinical observations and factual information: "47 year old male with a history of psychosis admitted in paranoid delusions and suicidal ideation. The patient tried to cause several motor vehicle accidents by slamming his breaks in high speed traffic. When he was stopped by the police the patient requested to be shot in the head. Since his admission he has been paranoid and oppositional. He has refused medication changes. He has made threats of physically hurting female staff. The patient is impulsive and makes phone calls to the police department, the White House and China."

At 4:00 pm the medication administration record documented that he was given Tylenol for a pain level that was at a 1 afterwards his pain was a 0 at 5:00 pm.

It was documented that the patient was upset that he was only able to make 2 phone calls. He demanded more and threatened staff that they would go to federal prison for violating his rights.

10/15/10 - At 10:13 am the patient signed a request for discharge within 5 days.

At 11:15 am the MAR documented that Haldol and Ativan injections were given. The patient had given consent to take the medication and was informed of the risks and benefits of the medication. At 1:20 pm the MAR showed a physician's order for Risperdal and Depakote and that they were given. The patient had given consent to take the medication and was informed of the risks and benefits of the medication.

At 12:15 it was documented by the DON: "The patient is demanding that staff allow him to make calls in excess and to persons in China and France. The patient will take the phones from the nurse's station without authorization and makes calls to various people and speak loudly and inappropriately much of the time. He has been observed making calls to the White House in attempts to speak to President Obama. He has called the police on at least 2 occasions, the FBI, called a Veterans Administration (VA) to speak to their security staff. He stated to the VA operator, 'Let me speak to a male, any male staff person.' He was very harassing to the operator. He just kept stating random names (first names) and asking to speak to them despite the operator informing him that she had no one by that name employed there. On numerous occasions, he would state that he is going to call one person and ends up calling someone totally different. He usually is harassing to the person on other end of the phone. Because the patient has been inappropriate with the phones, making harassing phone calls, stealing the phones from the nurse's station and making unapproved international calls, the patient has been limited to two calls per shift, for a total of 4 calls per day. The patient and staff are aware of the treatment plan." (The HRA did not observe a rights restriction in the record.)

At 2:50 an involuntary petition was initiated by the social worker; the director of nursing and a mental health professional were listed as witnesses. The patient was informed of his rights and given third party contact information. A close family member's contact information was documented on behalf of the patient. On the second page of the petition it was documented under the signs and symptoms of mental illness: "That the individual was admitted to the facility on 10/12/10 and on 10/15/10 he signed a 5 day release. He was admitted for attempting to ram his vehicle into a police officer's car and for having delusions. During his stay at the hospital he has been aggressive verbally to staff and to this writer he threatened 'I will dot your eye you dumb a__.' He was also verbally abusive to co-patients. He continues to be noncompliant with his treatment program and remains delusional. The individual has been stealing from the nursing station (phone and the camera.) He has been calling the police multiple times as well as the White House due to his diagnosis of schizoaffective disorder bi-polar type….." The patient bill of rights was given to the patient and was signed by the patient that he received a copy.

The Patient Advocacy Log completed this day documents that: "The patient reports that he believes his rights are being violated. He had made several complaints that document that he did not sign photo consent, consent for admission. It was noted that patient is actively psychotic with delusional thoughts and extremely agitated." In the section marked how it was resolved it stated: "That the advocate reviewed the chart with the patient, consent, and photo consent. Patient was agreeable and reported that his concerns had been 'mostly addressed.'"

10/16/10 - At 2:45 pm the MAR states that the PO for Depakote was increased and given. The patient had given consent to take the medication and was informed of the risks and benefits of the medication.

Nursing notes documented that the patient announced that he owns the facility. He also made comments about working for the FBI and the CIA. The patient is noncompliant with his phone program.

10/17/10 - It was documented in the MAR that an order for Haldol and Ativan with Benedryl ~~which~~ was not given, but held per nursing judgement, because patient had become calm. The patient had given consent to take the medication and was informed of the risks and benefits of the medication.

Nursing notes document that the patient stated he was the CEO of the Pavilion, that he was a Marine and he would attempt to grab the phone to make more calls, than his phone program allowed.

10/18/10 - At 7:45 am an order for Haldol and Ativan injections was documented on the MAR. The patient had given consent to take the medication and was informed of the risks and benefits of the medication. It was documented in the MAR a new PO for Clozapine. The patient had given consent to take the medication and was informed of the risks and benefits of the medication. The patient had made numerous threats to call the FBI to have the facility investigated. Psychiatry notes documented that he believed that he was the CEO of a major international company.

10/19/10 - A second certificate was completed by another psychiatrist documenting that: "The patient was paranoid, very delusional, believes he is in the FBI and involved in a 'sting operation'. He had contacted the police alleging he has been harmed, when in reality he has been labile, agitated, and assaultive to staff and requiring emergency medication."

The patient requested to withdraw his request for discharge and completed the Request for Withdrawal of Discharge document.

10/21/10 - Psychiatry notes documented that the patient stated he was there for much needed rest and was compliant with the phone program. The patient continues to steal items from the nursing desk.

10/22/10 - Psychiatry notes documented the patient believes that he is working undercover for the army. He reports that he has to make phone calls to his lawyers and the White House due to his work. The patient reports he is unhappy with the phone program.

10/25/10 - Psychiatry notes documented that the patient requested a jury trial for his involuntary hearing which was postponed until 11/2/10. The patient requests to make multiple phone calls. Nursing notes documented that the patient was demanding to talk to his attorney at 9:30 pm stating he does not have any phone restrictions if he is calling his attorney.

10/26/10 - At 10:00 am Haldol and Ativan injections were given. It was documented on the MAR that the patient had given consent to take the medication and was informed of the risks and benefits of the medication.

Psychiatry notes documented asking the patient why he had not been compliant with taking his regular medication and the patient responded by stating he "because had a right not to."

Nursing notes documented that the patient had attempted to steal the phones from the nursing station, asked visitors for the use of their phones, and returned the cordless phone late in the evening.

10/28/10 - Nursing notes documented the patient had followed his phone program with no problems.

10/29/10 - Psychiatry notes documented that the patient demands to be discharged from the hospital and/or transferred to the VA hospital.

10/31/10 - Nursing notes documented the patient wanted to call a spy he knew in Moscow.

11/1/10 - Psychiatry notes documented that the patient described his mood as better. "He has had a very good weekend….The patient denies any suicidal thoughts. He admitted that his behavior that brought him to the Pavilion was inappropriate. He denies any current intentions of hurting anybody else." The discharge summary completed by psychiatrist documented: "The patient started presenting significant changes in his behavior after 10/26/10. He became calmer and less intrusive….He was able to elaborate on events that brought the patient to the hospital. The patient was compliant and denied any side effects."

The case-manager notes documented: "discussion with patient the option of discharge plans for today. Patient has been compliant with medications. He is no longer demanding or threatening. Aftercare was set and documented on the discharge summary sheet. The patient agreed that it was in his best interest to be discharged."

The phone log from 10/15/10 to 10/28/10 documented $501.06 in charges for phone calls to China from this patient.

Policy Reviews

The HRA reviewed the following policies:

The Patient Bill of Rights (recently updated as of 3/2011)

Interdisciplinary Treatment Planning Process (09/06/2010
Patient Advocacy and Grievance Resolution (10/14/2010)
The Adult Unit Patient Handbook (09/2010)
Visitation Hours (6/17/2010)
The Pavilion Foundation Competency Checklist for Employees 2010 (recently updated as of 4/8/11)
Policy 861 Medication ordering, Dispensing and Administration (8/2010)

The HRA reviewed the *Patient Advocacy and Grievance Resolution (10/14/2010)* which states: "The Pavilion provides an effective mechanism for handling patient, resident, student and family concerns. All patients and their families have access to clear process by which they may voice and resolve concerns if they believe rights or other privileges have not been respected or a situation has been handled appropriately by the Pavilion Staff.

Presentation of a grievance will not, in and of itself, compromise someone's current or future access to care…."

In the procedure section of the document it states "…Patients, residents, and their family members are informed of their rights and responsibilities upon admission, and the process by which they can voice any concerns related to their rights and/or treatment. This information includes the procedure by which a grievance can be submitted, the name and method to access the Patient Advocate, the time frame for review of the grievance, the provision of a written response to the complainant and the time frame for that response…."

It went on to explain that a time frame for a patient advocate contacting a complainant was within 24 hours of the formal complaint; the advocate is to gather additional information and provide a 72 hour time frame for investigation and a written response in 7 days. It further stated "…The written response will include:

- The name of the contact person,
- The steps taken to investigate the grievance on behalf of the patient,
- The results of the grievance process (how the grievance was resolved)
- And the process to follow if the person is not satisfied with the response.

Documentation of each step in the investigation will be recorded thoroughly and then forwarded to the Patient Advocate, who will put information into the grievance log…."

Per review of *The Pavilion Foundation Competency Checklist for Employees 2010 (recently updated as of 4/8/11),* it listed TCI training/restraint as one of the annual competencies that all workers at the facility would have to be fully trained within 30 days of employment and annually recertified.

Summary

Regarding **Complaint 1. That a patient was not notified of his rights**, it is documented in the record that the individual had been given a copy of his rights several times and it was documented that these rights were explained to him verbally at the initiation of services. Per the Mental Health Code in section 405 ILCS 5/2-200 " Upon commencement of services, or as soon

thereafter as the condition of the recipient permits, every adult recipient, … shall be informed orally and in writing of the rights guaranteed by this Chapter which are relevant to the nature of the recipient's services program…."

The Code further states: "Every facility shall also post conspicuously in public areas a summary of the rights which are relevant to the services delivered by that facility." When the HRA came to complete the site visit, the patient rights were posted inside of patients' wards. They were also updated to include third party contact information including phone numbers. Based on the evidence in the record and the observations of the HRA, **Complaint 1. A patient was not notified of his rights <u>is unsubstantiated.</u>**

Complaint 2. & Complaint 3. The provider limited the patient's access to third party advocacy and a patient was not given a rights restriction when his phone rights were restricted. The HRA reviewed the Patient Advocacy Log. It documented that the patient reported that he believed his rights were being violated. He had made several complaints that he did not sign a photo consent or consent for admission. It was noted that patient is actively psychotic with delusional thoughts and extremely agitated. In the section marked how the complaint was resolved it stated: "That the advocate reviewed the chart with the patient. The patient observed his consent for treatment and his photo consent. The patient was agreeable and reported that his concerns had been 'mostly addressed.'"

The Code of Federal Regulations regarding participation in Medicare/Medicaid for hospitals, state in section 42 CFR 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:

(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."

In this case the hospital had policies that would allow for prompt resolution of the grievances. The patient's right to file a grievance was explained verbally and in writing. The grievance process followed specific time frames for review of the grievance and there was the provision of response. In the procedure section of the document it states "…Patients, residents, and their family members are informed of their rights and responsibilities upon admission, and the process by which they can voice any concerns related to their rights and/or treatment. This information includes the procedure by which a grievance can be submitted, the name and method

to access the Patient Advocate, the time frame for review of the grievance, the provision of a written response to the complainant and the time frame for that response…."

Per review of the patient advocacy log it listed the name of the contact person and the steps taken to investigate the grievance on behalf of the patient which included showing the patient documents that he had signed. It documented how the grievance was resolved and the patient's response that he was mostly satisfied. The record of the patient supported all statements in the patient advocacy log. The patient was also given a copy of the patient advocacy log.

The patient had also contacted the police while at the Pavilion who came and met with the patient. The patient had some complaints concerning only being allowed to use the phone to make 2 outgoing calls 2 times per day. There was also documented in the record that the patient wanted to call his attorney at 9:30 pm and 11:00 pm in the evening and may have not been able to. Per the Mental Health Code section 405 ILCS 5/2-103 regarding **Mail; telephone; visits** states: "Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation. (a) The facility director shall ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible, and that space for visits is available….

It further states that "(b) Reasonable times and places for the use of telephones and for visits may be established in writing by the facility director. (c) Unimpeded, private and uncensored communication by mail, telephone, and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission. When communications are restricted, the facility shall advise the recipient that he has the right to require the facility to notify the affected parties of the restriction, and to notify such affected party when the restrictions are no longer in effect. However, all letters addressed by a recipient to the Governor, members of the General Assembly, Attorney General, judges, state's attorneys, Guardianship and Advocacy Commission, … licensed attorneys at law must be forwarded at once to the persons to whom they are addressed without examination by the facility authorities….

(d) No facility shall prevent any attorney who represents a recipient or who has been requested to do so by any relative or family member of the recipient, from visiting a recipient during normal business hours, unless that recipient refuses to meet with the attorney." Based on the record it did not appear at any time that the Pavilion prevented the patient from receiving mail, phone calls or meeting with any one who wanted to meet with the patient. As far as the patient wanting to contact an attorney at 9:30 pm or 11:00 pm that would not fall into regular business hours.

The record does show that the patient was put on a "phone program which limited his outgoing calls to 2 calls per shift, or 4 calls per day," after he accumulated **$501.06 in charges for phone calls to China which the Pavilion paid for on behalf of this patient.** Per the Code "(b) Reasonable times and places for the use of telephones and for visits may be established in writing by the facility director." The record also shows that he was unable to make phone calls to his attorney late in the evening, but there was no evidence that the Pavilion prevented him from receiving phone calls from anyone. Based on the evidence in the record, **Complaint 2. The provider limited the patient's access to third party advocacy <u>is unsubstantiated.</u>**

Per the Mental Health Code in section 405 ILCS 5/2-201 (a): "Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to:(1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian;(2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice; (3) the facility director; (4) the Guardianship and Advocacy Commission….(5) the recipient's substitute decision maker, if any."

Per the Code: "The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefore in the recipient's record. (b) The facility director shall maintain a file of all notices of restrictions of rights, or the use of restraint or seclusion for the past 3 years…" There was no evidence in the record that the patient was issued a rights restriction when his phone rights were restricted. The HRA can appreciate the need to restrict the individual's phone rights because of the individual accumulating a large bill by calling China, the FBI, the White House and by making harassing calls, but per the Code he should have been issued a rights restriction. **Complaint 3. A patient was not given a rights restriction when his phone rights were restricted is substantiated.**

The HRA makes the following recommendation:

> **Complete a rights restriction notice and issue them to anyone designated (405 ILCS 5/2-201) whenever telephone communication or any right under the Code is restricted and be sure that all rights related policies may amplify or expand but not restrict or limit these rights (405 ILCS 5/2-202).**

Complaints 4. & 5. A patient was not allowed to participate in his care and treatment plan or exercise his right to refuse medication. In the record the patient had signed the consent to treatment and applied for voluntary admission to the Pavilion. Per the master treatment plan that was signed by the patient at his release, it was documented that he had both contributed to the plan and refused to participate. Per the Mental Health Code in section 405 ILCS 5/2-102 (a) Care and services; psychotropic medication; religion, it states**:** "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible…" The Code further states: "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…." Per discussion with staff, every morning the treatment team, (nurse manager, case manager, and psychiatrist) would meet with the patient and each could give their perspective on his treatment.

Per documentation by the psychiatrist the patient was allowed to exercise his right to refuse medication or allow his medication to be changed. It was very clear that the patient exercised his right to refuse medication on 10/17/10 and it was not given on an emergency basis because he had calmed down.

The Code further states in section (a-5) "If the services include the administration of psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to

understand the information communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment." Per the record at any time that psychotropic medication was administered it was documented that risk/benefits information was provided and consent was obtained. In the patient's discharge summary the psychiatrist documented that "the patient started presenting significant change in his behavior after 10/26/10. He became calmer and less intrusive. He was able to elaborate on events that brought the patient to the hospital. The patient was compliant and denied any side effects."

The record documented that the patient had the opportunity by his own admission to participate in his treatment plan. It was also documented that he exercised his right to refuse medication. He was informed of the medication risks/benefits. He was also allowed to calm down on his own when he could and was not given emergency medication. Per the evidence in the record **Complaints 4. & 5. A patient was not allowed to participate in his care and treatment plan or exercise his right to refuse medication are <u>not substantiated.</u>**

Complaint 6. A patient was restrained and not given notice. Per the record there was no evidence that the individual was restrained**.** During the interview portion of the investigation staff stated that the type of restraint the individual described was not even a restraint that would be used at their facility. The staff did provide evidence of the type of restraints and the training used at the Pavilion, but per the record and staff statements they did not use any restraints on this individual. The HRA reviewed specifically the dates that emergency medication was given and the notations by staff which stated that that the medication was given with consent and risks/benefits were discussed with the individual. There was no documentation of the individual being restrained and medication forcibly given.

Per the Mental Health Code in section 405 ILCS 5/2-108 "The use of restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to him self or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for the staff…."

It further states: "That except as provided in this Section, restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of restraint is justified to prevent the recipient from causing physical harm to himself or others. …"

The Code in section 5/2-201(a) states: "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…" However if restraint is not used there would be no reason to give notice of the restriction. Based on the lack of evidence in the record to substantiate the complaint, the evidence of the type restraint that the facility uses and staff training on restraint references a different restraint than was alleged in the complaint, the HRA **<u>cannot substantiate</u> Complaint 6. A patient was restrained and was not given notice.**

Compliant 7. A patient was not allowed to leave the provider's facility when he was not a danger to himself and others. Per documentation by the psychiatrist: "The patient was admitted with paranoid delusions and suicidal ideation. The patient tried to cause several motor vehicle accidents by slamming his breaks in high speed traffic. When he was stopped by the police the patient requested to be shot in the head. Since his admission he has been paranoid and oppositional. He has refused medication changes. He has made threats of physically hurting female staff. The patient is impulsive and makes phone calls to the police department, the white house and China." The social worker documented: "the patient was admitted to the facility on 10/12/10 and on 10/15/10 he signed a 5 day release. He was admitted due to attempting to ram his vehicle into a police officer's car and for having delusions. During his stay at the hospital he has been aggressive verbally to staff and to this writer he threatened 'I will dot your eye you dumb a__.' He was also verbally abusive to co-patients. He continues to be noncompliant with his treatment program and remains delusional. The individual has been stealing from the nursing station (phone and the camera.) He has been calling the police multiple times as well as the white house due to his diagnosis of schizoaffective disorder bi-polar type…"

Another psychiatrist documented "The patient was paranoid, very delusional, believes he is in the FBI and involved in a 'sting operation'. He has contacted the police alleging he has been harmed, when in reality he has labile, agitated, and assaultive to staff requiring emergency medication." The police department, 2 psychiatrists, a social worker, the DON and a MHP all alleged and provided documentation that this patient was a danger to himself and others."

Per 405 ILCS 5/3-400 of the Mental Health Code for Voluntary Admission to mental health facility: "(a) Any person 16 or older, including a person adjudicated a disabled person, may be admitted to a mental health facility as a voluntary recipient for treatment of a mental illness upon the filing of an application with the facility director of the facility if the facility director determines and documents in the recipient's medical record that the person (1) is clinically suitable for admission as a voluntary recipient and (2) has the capacity to consent to voluntary admission. (b) For purposes of consenting to voluntary admission, a person has the capacity to consent to voluntary admission if, in the professional judgment of the facility director or his or her designee, the person is able to understand that:(1) He or she is being admitted to a mental health facility. (2) He or she may request discharge at any time. The request must be in writing, and discharge is not automatic. (3) Within 5 business days after receipt of the written request for discharge, the facility must either discharge the person or initiate commitment proceedings…." In this case the patient had the capacity to understand that he was being treated at a mental health facility. However, there was sufficient evidence that when the patient requested to be discharged within 5 days, he may have been a danger to himself or others per the documentation of two psychiatrists and the social worker. As per the Code in section 405 ILCS 5/3-403, a petition and 2 certificates conforming to the requirements of paragraph (b) of Section 3-601 and Section 3-602 were filed with the court by the Pavilion staff. The patient later withdrew his request for discharge on 10/19/10. He continued to received treatment by the facility and he was discharged when it was determined that it was safe on 11/01/10 before the court date for involuntary commitment. Based on this evidence the HRA **cannot substantiate Complaint 7. A patient was not allowed to leave the provider's facility when he was not a danger to himself and others.**

Complaint 8. A patient was not provided adequate treatment. Per the Code in 405 ILCS 5/1-101.2: "Adequate and humane care and services" means services reasonably calculated

to result in a significant improvement of the condition of a recipient of services confined in an inpatient mental health facility so that he or she may be released or services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others." The record of the patient showed that he received the care he needed to prevent further decline in his clinical condition so he was not a danger to himself or others.

The HRA asked about pain management for the patient's feet. Staff explained that no medication was given because nothing was documented under past medical history for pain. The MAR documented on 10/14/10 that he was given Tylenol when his pain was a level 1, and his pain was a 0 an hour later. Staff explained that they usually intervene if pain level is at 4. Patients at the facility meet with a doctor at least once a day and have almost constant contact with nurses or trained staff, who themselves have immediate access to medical professionals able and willing to discuss the patient’s treatment. Doctors are always nearby, and additional appointments can be made as necessary.

In the psychiatric nursing assessment the patient was asked if he had any pain or any medical condition that was causing him pain and he answered no to both. He stated he had no difficulty with ambulation. The history and physical completed by the physician on 10/13/10 documented no acute medical issues per the patient. He repeated these statements in response to a nursing review on 10/28/10. Based on the evidence in the record **Complaint 8. A patient was not provided adequate treatment <u>is unsubstantiated.</u>**

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