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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 11-090-9035
North Central Behavioral Health

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at the North Central Behavioral Health. Complaints alleged the following:

1. Inadequate treatment, counselor was unprofessional and would not discuss behavioral health issues with client.
2. Retaliation against client for complaints, client was asked not to come onto the property or call due to legal issues raised by the client.
3. Violation of confidentiality when two staff members discussed information that a client asked to be kept confidential.
4. Inadequate medication plan, client was given medication and then was not tapered off medication which caused withdrawal symptoms.
5. Inadequate discharge process, client was told upon discharge that the provider would refer him to another provider but this was never followed through with.
6. Inadequate complaint process, client took complaints to counselor and clinical director, who met with client and spoke to him on the phone but never provided documented resolution of the complaints. Client was also never told about provider's grievance process.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), the Department of Human Services rules for community health providers (59 Il Admin Code 132), and the Mental Health and Developmental Disabilities Code (405 ILCS 5/2).

North Central Behavioral Health services the counties of LaSalle, Bureau, Marshall, Putnam and Stark, but the Canton office primarily deals with clients from Fulton county. The facility provides services on an outpatient basis and provides such programs as psycho-social rehabilitation (PSR), community support, psychiatric and nursing services, and substance abuse services. The facility currently has 294 cases in Fulton county and 2,500 open cases total in the

entire network of facilities. The network of facilities services approximately 7,000 individuals through the year. The Canton office has 13 or 14 employees and the network has 140 total employees.

COMPLAINT STATEMENT

Concerning the allegation that there is inadequate treatment, the complaint states that a counselor was unprofessional and would not discuss behavioral health issues with the client. The counselor insisted that a client was part of the John Lennon Movement and stated that he had a problem with Jimi Hendrix and that the client could no longer wear his Jimi Hendrix t-shirt to sessions as per the complaint. The counselor would also accuse the client of being on LSD, and the client's first three visits revolved around LSD. The counselor started dressing like the client and growing a beard to prove a point on appearance and asked the client how that looked. The counselor would not talk about mental health. The complaint alleges that the counselor was more interested in getting into the client's mind and would ask him to journal every day. The complaint also states that the client was forced into a hospital because of statements he made about meeting with the Supreme Court, local politicians, and a previous employer.

In regard to the complaint that there was retaliation against a client for grievances, the client was allegedly asked not to come onto the property or call due to legal issues raised by the client. The police were reportedly called the client and said that he could no longer contact North Central or be on the facility property. Later, North Central stated that the client could come back. The complaint also stated that the client wanted to talk to executive staff and was told by the staff that if he did not handle the situation properly there would be retaliation. A client also suggested that he was going to sue North Central and he was reportedly told that he better do it in a "nice" way or they would retaliate.

The complaint alleges that the receptionist told a client that he had been committed to a hospital because of what he said about his former employer but she should not have known about the commitment because she was the receptionist. Also, the staff leaves confidential files open on their desks overnight and the cleaning crew can see the patient's information. The complaint also states there was another situation where a staff member mentioned a situation that the client had only told a staff member about, therefore breaching confidentiality.

Another complaint concerns a client's medication plan and alleges that a client was given medication and then was not tapered off the medication which, caused withdrawal symptoms for the client.

The complaint also states that the facility has an inadequate discharge process. When the client was discharged from the facility, the facility stated that they would refer the client to another provider but the referral reportedly never occurred.

The complaint also alleges the facility has an inadequate complaint process. Allegedly a client took complaints to a counselor and the clinical director, who met with the client and spoke to him on the phone but never provided the client with a documented resolution of the

complaints. The complaint also alleges that the client was never told about the provider's grievance process.

FINDINGS

Interview with staff (7/28/2011)

The HRA began the investigation by interviewing North Central Behavioral Health staff members about the complaints in the case. The staff began by explaining that the client involved in the complaint had been a client at the facility for a long time. They said that the initial counselor who is involved in the complaint, has been gone for two years. The counselor actually transferred to another North Central office and is no longer in Canton. The staff explained that the client liked the second North Central counselor, but not the first. The staff said the client was in the PSR program and benefitted from the program. The client applied to the facility as a non-Medicaid client but then the state of Illinois limited the services available to him. The staff still attempted to have the client continue services but the client did not complete the steps needed to continue services. Even after the client's services were discontinued, he was still allowed some services. The staff explained that the client had become more delusional recently, for example the client said that was talking to celebrities. The client also said that he was an angel growing wings. The client discussed these delusions in sessions with his counselors (the facility staff named two separate people as his counselors). When the staff spoke with the client about his complaints, the client also spoke about a new movement that he was beginning. The staff explained that when the supervisor talked to the client, he said he seemed satisfied with the services he was receiving.

The staff said that the client's first counselor was his acting counselor when the client was committed to a behavioral health unit and this may be part of the reason why the client did not like him. The client was concerned about the hospitalization because he thought it put his job in jeopardy. The staff said that the client never actually took legal action against the North Central. Once a police officer was called but that was the only time another agency was involved. They explained that the client was never banned from the premises. Even after he threatened legal action, the facility continued services. The client told North Central that he was going elsewhere for services. The client was discharged from the facility because he stopped attending services. He was discharged on May 26th for non-compliance. The facility stated that they made attempts to reconnect with him through letters and phone calls but he did not correspond back so they closed his case.

On March 21st, the client met with a supervisor at the facility to discuss his concerns. The complaint was actually the client's desire to discuss an out of court settlement for a lawsuit he stated he was going to file against the facility. The grievance was not an actual complaint but a discussion of the settlement. The client told the facility that in 2007 and 2008 he tried to settle out of court with a former employer. The client had told the facility that he felt this employer was associated with North Central and this was why he had been hospitalized. The client spoke with his case manager and said he wanted to talk with a supervisor about the settlement.

The staff explained that, with their complaint process, the client would talk to a clinician/case manager about the complaint. If this does not resolve the complaint, the next step

is speaking with a supervisor. The client is encouraged to put the complaint in writing. Clients receive a list of phone contacts for grievances; this is given upon admission. If the client's complaint is not resolved after the supervisor, then the complaint is reviewed by the director. If the director does not resolve the complaint, the next step would be the vice president and CEO. The staff said the grievance process is posted throughout the facility. Unusual occurrences are written up in incident reports. The staff said that the client's rights regarding retaliation are in the rights document that they receive upon admission. The facility also explained that they are not the ones that initiated the client's hospitalization but rather another organization.

The staff explained that the medical director on staff prescribes medication for the clients, and is a psychiatrist. The client was receiving medication and indicated that he was not taking some of the medication because he did not like the side effects. The facility discontinued the medications that he was not taking. The client told his case manager that the medication was "toxic." The client was seen by a physician every three months and the client received medication evaluations. The staff was unsure as to how often the medication changed. They stated that the client never complained about withdrawal symptoms. The staff said that the physician is good at weaning individuals off medication and the client was tried on several different medications throughout his stay at the facility.

The staff explained that North Central does not have a documented retaliation policy but rights against retaliation are covered in the handbook that clients are given upon admission. The North Central staff stated that there is no documentation that they have in the record regarding retaliation with the client, such as that he was told to be "nice" or there would be retaliation or to go about the complaint the right way or there would be retaliation. Everyone that worked with the client understood that his diagnosis may cause some delusions and no one on staff was interested in punishing the client.

The staff said that when the client met with the supervisor, upper management discussed the settlement and told the client that they decided the issue was covered and it did not need to proceed. The supervisor then relayed the information to the client via a telephone call. The staff said that the client knew about the grievance process because it was in the admission handbook. The staff reiterated that the complaint was not a grievance but rather the client expressing that he wanted a settlement. The staff stopped the process because they were not going to settle with the client. The staff also told the HRA stated that the client could come back to North Central if he chose to.

Regarding the confidentiality complaint, the facility has paper charts but they are locked in the front of the facility and not at the staff's desk, so the staff is not leaving files open on their desks. The facility has been electronic since 2004 with no paper charts. The North Central staff stated that they did not know about any confidentiality issues between two staff members. They stated that the staff members that were mentioned in the complaint were on the client's team so they would have access to his file. They stated that there would never be a situation where they would communicate information to the receptionist about the client.

The facility did not refer the client to another provider because the client told them that he would go to a different physician. The staff tried to engage the client until he was non-compliant and then discharged the client.

The North Central staff explained that the client complained about his former counselor during his current treatment but not when he was actually being treated by the counselor. If a client does not like a clinician, they ask that the two deal with the situation on the clinician level, then it would go above that level if the issue was not resolved. The facility takes this approach because often the issue is a misunderstanding that can be resolved between the client and counselor. The facility will change counselors if the client requests.

In regard to the complaint that the counselor dressed like the client and grew a beard, the staff stated that the client never had facial hair while working at the Canton office. They stated that the counselor has very conservative and had a "straight-laced" appearance. They also explained that they never had complaints about that specific counselor before from other clients. The staff also explained that the clients have one main counselor but they go to other counselors for different services.

The staff ended the conversation by explaining that the clients do not receive the discharge procedures ahead of time. They do have discharge planning right from the beginning of their admission at the facility and they are familiarized with the process from the beginning but they do not receive discharge procedures upon being admitted.

Record Review

The HRA began the record review by inspecting documents related to the complaints in this case. The HRA reviewed documents dealing with the first complaint that there was inadequate treatment because of unprofessional behavior by the counselor. The HRA reviewed progress notes, treatment plans, psychosocial assessments, discharge summaries, emergency assessments, and other medication related records and saw no evidence in the client's record of the allegations named in this complaint. The records all ranged between 2007 and 2011. The progress notes begin on the date of 10/15/2007. On 10/30/2007 there is a note written by the counselor named in the complaint reading "Client called agency requesting to speak with someone. This writer spoke with individual for approximately 5 minutes and his phone's battery was almost dead and stated he would call back when it was charged. Several minutes later he called and stated he was just going to come to the facility to talk. Upon arriving he commented on several complaints of his previous job, finally stating he had been terminated with little information as to why. He dialogued at length about how his rights had been violated and how he had contacted several government agencies to voice his grievance. He exhibited delusions of talking with the governor of California and the governor of Illinois and was going to hold a press conference to discuss his concerns about the environment. It was difficult to get him to focus and he required several redirections." The same entry reads "Client reports feeling depressed though he feels these feelings are probably mild. He also reports anxiety at times but could not say if he experiences any physical symptoms when he is anxious. He also reports that he has experienced highs in the past as well as lows with the most recent being high. The high has been present for several weeks and doesn't want to experience the low again. A diagnosis of

Schizoaffective disorder should be considered over the next several attended appointments and ruled out."

Another progress note, on 11/26/2007 that was written by the counselor named in this complaint reads "Met with client for scheduled appointment. Processed with client his coping skills and how well they were working for him. Client stated he was coping fairly well. He was very talkative and was resistant to focusing on his goal. He was preoccupied with social and environmental issues. Client was encouraged to focus on his goals and be less concerned with issues outside his control." Another note on 12/20/2007 reads "Client was frustrated over the feeling that others were not taking him seriously and he felt that others in the community were trying to prove he is 'crazy.' He was encouraged to process his feelings of frustration. He was preoccupied with social events and what the city officials were allegedly doing wrong. He also questioned this writer's intentions. Client was assured that no one thought he was crazy. He was also assured that this writer's intentions were to help him any way possible. Processed with client his frustrations and encouraged to analyze his method of interaction with others." The rest of the interactions with the counselor were consistent with these entries and indicated that the counselor discussed mental health issues with the client.

Regarding the aspect of the complaint where the counselor was more interested in getting into the client's mind and asked him to journal everyday, a progress note from 1/22/2008 reads "[client] did reportedly develop a journal and would use it periodically. He stated it was helpful when he used it but was unable to identify the importance of using it on a regular basis. [Client] is creative and articulate. He would benefit from regular journaling of his thoughts, frustrations and feelings."

The HRA also saw mentions of LSD in drug and alcohol assessments, a diagnostic review form, and a client addictions self-assessment but saw no evidence that the first three meetings with the patient's case manager were revolved around discussions of LSD.

Another aspect of the complaint dealt with a client stating that he was forced into a hospital because of comments he had made about meeting with the Supreme Court, local politicians, and a previous employer. A progress note dated 1/25/2008 reads "The client was brought to the ER by the police due to the client asking his son to shoot him. The client had a loaded gun at his residence. The client is very delusional and said some disturbing things to the staff at the ER about using the gun if he needed to. The on-call worker determined the client needed to be hospitalized. She turned over the case to me. I made the call to [psychiatric hospital] or an intake." The passage proceeds to say that the client was hospitalized involuntarily in the psychiatric unit. The individual who called the psychiatric hospital was not the same person who is named in this complaint as being the client's first counselor. The HRA also reviewed an unusual incidence report, dated 3/21/2011, which reads that "[client] reported an extensive history of interactions when he sought legal interventions for his dismissal from [previous employer]; he was an [position at the previous employer]. He seems to believe that his attempts to gain 'justice' in that case caused him to be hospitalized at [psychiatric hospital] and subsequently [psychiatric hospital] by our crisis worker. In fact, the [town] police delivered him to the [psychiatric hospital] ER (1/25/08) after he asked his son to shoot him with the loaded shotgun he kept at home." The unusual incident report also reads "He also believes his then

therapist [therapist name] had increased his depression by telling him he was being punished, though it was unclear for what." The HRA also saw no evidence of the client being told that he was being punished in the documentation.

There are mentions of the client's appearance within mental status examinations. For example, one note for 3/15/11 reads "[Client] presented in jeans, jacket, t-shirt with wings on it, and cowboy hat. He has long hair and a beard. Some eye contact. Clean." Another from 3/21/11 reads "[Client] is a 56 y.o. Caucasian male who appears to be his stated age. He is tall and of average weight with long dk brown hair and beard. Dressed in jeans, sweatshirt and hat."

The HRA reviewed a crisis call report, where the client had called the facility after hours, which read "I encouraged the caller to work with his counselor, [counselor's name], for support and the caller states he is starting to get upset with [counselor] for questioning him when he is afraid for his life."

In regard to the complaint that there was retaliation against the client for the grievance, including the client being asked not to come on the property, the police telling him he cannot come onto the property, and the client being told by the facility that they would retaliate against him if a lawsuit was filed; the HRA saw no evidence of the allegations occurring. Although the facility does not have a specific retaliation policy, the individual rights and responsibilities that the patient receives reads that the clients have the right "To terminate treatment at any time, and you shall not be denied, suspended or terminated from services or have services reduced for exercising any of your rights." The rights also state that the clients have the right to "Present grievances either verbally or in writing and appeal any decisions up to and including the President of the agency with no reduction or termination of services." The HRA saw no documentation that anyone spoke to the client about retaliating against him. The HRA reviewed the patient signing several documents stating that he received the rights documentation on two occasions, the most recent being 6/28/2010. The statement that the patient received the document is not dated.

There is also a complaint that the facility has an inadequate discharge process. In reviewing the progress notes, on 3/30/2011 a staff member encouraged the client to maintain contact with a counselor in order to try and re-initiate Medicaid services. On 4/11/2011, that counselor wrote that they tried to contact client to re-engage services. On that day, the client called back and the passage reads "Writer recommends follow up with supervisor and encouraged client to re-engage in services. [Client] expressed that he may be transferring all services. Writer explained that this is within his rights." On 4/18/2011 the client did not show up for an appointment but on 5/2/2011 the client called and left a message that he wanted to re-engage in counseling, then on 5/5/2011 the client called and stated that "while he wanted to return to counseling he felt it was not appropriate that he return to NCBHS [North Central Behavioral Health Services]; I advised him the choice was his and that [caseworker] would work with him to re-gain Medicaid and linkage to appropriate services. He said he wasn't planning to spend much time in [town] because he was going on a world music tour. It was apparent his delusions remain; however, they don't seem to be harmful to himself or anyone else. He did not wish to engage in discussion more than a couple of minutes." The next notation was on 5/26/2011 and the progress note reads "[Client] presented with symptoms of bipolar, most

recently manic and delusional. [Client] was to manage symptoms of bipolar. He was managing depressive symptoms, when he then stopped taking much of his medication, and became manic and delusional, referencing the Messiah and the government. [Client] blamed a former therapist at MCBHS for his last hospitalization, and threatened to sue the agency, during his delusional state, and did not speak with a supervisor during that time. [Client] was working with the adult community support worker to obtain a medical card. [Client] identified also, at one point, he was seeking services elsewhere. He then ceased contact with this agency and did not respond to outreach efforts. Prognosis is guarded. Case closed at this date." There is no indication that police were contacted regarding the situation.

There is also a discharge summary that was reviewed by the facility which reads "[Client] was to manage symptoms of bipolar. He was managing depressive symptoms, when he then stopped taking much of his medication, and became manic and delusional, referencing the Messiah and the government. [Client] blamed a former therapist at NCBHS for his last hospitalization, and threatened to sue the agency, during his delusional state. He then ceased contact with this agency and did not respond to outreach efforts."

The HRA reviewed the facility discharge process. The policy states that the discharge process begins at admission and is considered throughout treatment. The policy also states that the process "Results in a continuing recovery plan post discharge for the consumer and indicates recommended activities, support groups and/or referrals that can support and enhance progress towards discharge." The policy proceeds to read that "The discharge process is completed by the Single Accountable Individual at the time of closing. Documented communication with the consumer informing him/her that the case is being closed including medication services is required." The HRA did not view a discharge letter to the client and, upon requesting verification, discovered that the facility did not have a discharge letter on file. The HRA saw no other evidence of communicating discharge to the patient.

In the individual's rights and responsibilities, it reads that the client is responsible "For making and attending your appointment(s) as well as notification of the need to cancel any scheduled appointments at least 24 hours in advance of the appointment to be scheduled." The responsibilities also reads that the client is responsible "For the consequences of your actions if you refuse treatment or do not follow your individual treatment plan recommendations" as well as "For keeping all scheduled treatment appointments and understanding that failure to keep your scheduled treatment appointments can result in the cancellation of any scheduled Doctor appointments." The responsibilities finally read that the client is responsible "For recognizing that your treatment may be terminated for failure to participate in treatment or failure to keep scheduled appointments."

The third complaint states that a client's confidentiality was violated when a receptionist told a client that he had to go to the hospital because of comments that he had made. The complaint also states that staff leaves confidential files open on their desks so a cleaning crew can see the information and that two staff members were discussing confidential information about the client. The HRA received a copy of an Administration confidentiality policy which reads "All employees of North Central Behavioral Health Systems, Inc., independent contractors, students and all other service providers are required to maintain strict adherence to

confidentiality as specified in the Confidentiality of Alcohol and Drug Abuse Client Records and the Department of Mental Health and Developmental Disabilities Confidentiality Act and the confidentiality of HIV/AIDS status and testing." Another section of the policy reads "Client cases shall be discussed by clinical staff behind closed office doors. Hallways, the Copy/Fax Room, Staff Lounges, Front Office areas and the Clinical Records Department are not appropriate locations for discussing client cases. Information regarding client cases shall be shared on a need-to-know basis only. Client information will not be shared with other staff unless the information is necessary to the completion of their jobs."

The HRA also reviewed a North Central Behavioral Health Systems confidentiality agreement which states "I understand that as an employee, student, or visitor of North Central Behavioral Health Systems, Inc., I am legally and ethically obligated to keep confidential all information related to clients as specified in the Confidentiality of Alcohol and Drug Client Records, the Department of Mental Health and Developmental Disabilities Confidentiality Act, the Health Insurance Portability and Accountability Act and confidentiality of HIV/AIDS status and testing, including: The fact that someone has sought services from North Central Behavioral Health Systems, Inc., the specifics of the services received, the clinical information related to that client ...". The HRA also reviewed a notice of privacy practices that is given to the clients which outlines the facility rules and dictates the use and disclosure of protected treatment information and also the client's rights to privacy. Nothing in the document illustrates that there may be use of confidential information with individuals that are not required to have the client's information and nothing in the document indicates that the confidential info can be discussed with non-essential staff.

There is another statement in the treatment plan, dated 8/18/2010 through 2/14/2011, which reads "[client] permits his therapist to communicate with inter and intra agency staff to promote his wellness and recovery." This statement appears on several treatment plans.

In reviewing the documentation, the HRA reviewed that both names that were cited in the confidentiality complaint were possibly writers in the client's progress notes. With the complaint, there were only first names provided so the HRA cannot be sure that they are the same individuals.

The fourth complaint states that a client's medication plan was inadequate and a client was not tapered off medication which caused withdrawal symptoms. The HRA reviewed Medication Evaluations and Nursing Summary Forms and saw no indication of withdrawal symptoms occurring with the client. The HRA also did not see situations where the client was weaned from medication. The HRA did review descriptions of the client having symptoms that were possibly from the medication. For example, a routine vital signs document in the medication evaluations, dated 4/1/2010, reads "Haldol makes him drowsy, wasn't taking cogentin prior to Tuesday. He reports he is fatigued all the time and is in bed by 6pm and has never done that before in his life, gaining a lot of weight and is not happy about it." Another report regarding Haldol states, from 12/28/09, reads "Reports taking meds as prescribed. He says he is doing better now with meds he is taking but Haldol is causing some muscle aching." On 7/30/09 it reads "Meds as prescribed. Shakiness, weakness, lack of coordination and concentration, no energy, itchy all over, wobbly arms, dizziness, disorientated, trouble walking even a couple of

blocks." Another on 7/17/08 reports "Sleeps 10-14 hours per day, intense dreaming, never feels rested despite sleep, loss of energy, shaking and muscle stiffness, blurred vision, dry mouth, weight change, changes in sexual functioning, problems with memory and concentration. Not taking meds as prescribed." The HRA also reviewed where the client was not taking the medication as prescribed by the facility. One instance, in a medications update dated 7/17/08, it states "client has decreased on his own" and another entry from the same day states that the "client has stopped on own." On the same date, there is an entry that reads "stopped because of possible side effects." In the nursing summary form, on 1/6/11, it states that there are two separate medications that are listed as current medications that the client does not take. The HRA also saw an instance where the client changed his pill intake on his own. In the progress notes, on 6/17/08, it reads "Client states that he is now taking ½ of a Wellbutrin XL daily due to the whole pill causing anger outbursts and overstimulation. He feels like 75mg is working better for him. RN will report this to [physician]. Client also states that his Lamictal orange starter pack is running out and he only has 2 pills left. He is breaking them in ½ (taking 50mg) daily instead of 100mg and feels this works well for him as well."

The final complaint states that the facility has an inadequate complaint process, and that the client was never informed of the grievance process. The Client Complaint process reads "North Central Behavioral Health Systems, Inc. considers the concerns, complaints, and grievances of clients/consumers to be of prime importance. Clients/consumers are supported in communicating/reporting concerns, complaints or grievances to their assigned staff member, department manager, or Administration of North Central Behavioral Health Systems. It is the intent of the following to ensure that all complaints/grievances on the part of clients are handled consistently and in a timely manner." The policy explains the grievance process as follows: the first step is that the staff member and the client attempt to resolve the situation. If it cannot be resolved within a "reasonable time period" the staff will inform the client of a supervisor's name and contact information as well as the telephone numbers for the Guardianship and Advocacy Commission and Office of the Inspector General. They ask that the client communicate the grievance in writing to the supervisor and, if requested, they will get help in writing the grievance. The supervisor will inform the Vice President of Operation, and then, within 5 days the supervisor will review the complaint, provide a verbal or written response to the complaint, forward a copy to the VP of Operations, and put a copy in the client's file. The supervisor will then document the process on an Unusual Occurrence Form. If the complaint is still unresolved, the complaint will be forwarded to the President of North Central who will provide a written response within 5 working days. As stated in the rights and responsibility documentation that that the patients receive (see above regarding retaliation), the patients have the right to present grievances either verbally or in writing.

The HRA reviewed an Unusual Occurrence Report, dated 3/21/11, which reads that the complainant "asked to meet with me to discuss previous issues with treatment. He reported he knows he is in significant mania, but that he is about to manage his sx [symptoms] with the techniques he learned both at [hospital] during his two hospitalizations and at NCBHS in PSR and with his counselor. He spoke highly of both [staff] and [staff]; however, he denied any delusions - rather he presented a range of grandiose plans/contacts as fact ... He reported an extensive history of interactions when he sought legal interventions for his dismissal from [company] ... [Client's] bottom line is that he is seeking an out of court settlement from NCBHS

for \$1.5 million, but is willing to reduce that amount if the agency will 'roll over' on [former company]; he is seeking \$32.6 million from them in damages. I advised him I was not a decision maker in this issue and would pass his information/request on." In the evaluation/action section of the unusual occurrence report, it reads "received supervisor will advise [client] that there is no legal action." As written earlier in this report, the unusual occurrence report also states that the client believes that his attempts at "justice" caused his hospitalization and his caseworker increased his depression.

As stated in the review of the retaliation complaint, the rights given to the client state that the clients have the ability to present grievances verbally or in writing and appeal any decisions up to and including the President of the agency. The HRA also reviewed two documents titled "Consent for services, verification of individual rights and responsibilities, verification of individual rights and responsibilities for telebehavioral healthcare services, and acknowledgement of notice of privacy practices." One document was signed on 6/28/2010 by the client and reads that the client affirms that he is receiving services from North Central and that "I [client] have received, reviewed and understood my 'Individual Rights and Responsibilities.'" The HRA reviewed another form with a similar title (minus the telebehavioral services) that is also signed by the client, but not dated, which affirms that the client has received and reviewed a copy of the client rights and responsibilities statement.

In reviewing the treatment plans, the HRA also discovered a section of the treatment plan where there is a name in the goals that is not the client's. In a treatment plan dated 11/17/2008-1/10/2009, an objective reads "[inaccurate name] will learn 3 new coping skills to improve his ability to reduce his tendency to become overly emotional involved. [inaccurate name] will identify and utilize these coping skills each day as needed at least 80% of the time. [inaccurate name] will discuss his progress with this in his scheduled individual therapy and in group sessions. Client will allow mental health team to consult regarding his progress." This same section appears in the treatment plan and written the exact same way in 12 of 15 treatment plans reviewed. The error appears in all treatment plans between 11/19/2007 through 1/18/2008 until 3/15/2010 through 8/17/2010. The HRA did not see many changes at all in the treatment plans during that span, only small updates. The more recent plans, dated 8/18/2010 through 3/14/2011, had more prevalent changes in the treatment planning.

MANDATES

The HRA reviewed mandates related to the complaints in this report. The Department of Human Services (DHS) Rule 132 reads "To assure that a client's rights are protected and that all services provided to clients comply with the law, providers shall ensure that: a) A client's rights shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code [405 ILCS 5] ... b) The right of a client to confidentiality shall be governed by the Confidentiality Act and the Health Insurance Portability and Accountability Act of 1996" (59 Il Admn Code 132.142).

In regard to the first complaint dealing with treatment and the fourth complaint dealing with medication, the (DHS) Rule 132 reads that clients have "3) The right to be free from abuse, neglect, and exploitation;" (59 Il Admn Code 132.142). The Mental Health and Developmental

Disabilities Code reads "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan" (405 ILCS 5/2-102).

The mandates relating to the second complaint are from the DHS Rule 132 and read that the client has "(6) The right not to be denied, suspended or terminated from services or have services reduced for exercising any rights" (59 Il Admn Code 132.142).

In regard to the complaint that confidentiality was breached, the Mental Health and Developmental Disabilities Confidentiality Act states "All records and communications shall be confidential and shall not be disclosed except as provided in this Act" (740 ILCS 110/4).

The fifth complaint investigated dealt with inadequate discharge services. The DHS Rule 132 reads that "2) Service termination criteria shall include: A) Determination that the client's acute symptomatology has improved and improvement can be maintained; B) Determination that the client's lever of role functioning has significantly deteriorated to a degree where referral or transfer to a more intensive mental health treatment is indicated; or C) Documentation in the client's clinical record that the client terminated participation in the program" (59 ILCS 132.150). The Illinois Administrative Code states that "A provider shall comply with the following: ... f) When discharging a client from services, the provider shall ensure the continuity and coordination of services as provided in the client's ITP. The provider shall: 1) Communicate, consistent with the requirements of Section 132.142, relevant treatment and service information prior to or at the time that the client is transferred to a receiving program of the provider or is terminated from service and referred to a program operated by another service provider, if the client, or parent or guardian, as appropriate, provides written authorization; and 2) Document in the client's record the referrals to other human service providers and follow-up efforts to link the clients to services" (59 Il Admin Code 132.145).

Concerning the allegation that the facility has an inadequate grievance process, the DHS Rule 132 reads that providers shall provide the clients with "The right or the guardian's right to present grievances up to and including the provider's executive director or comparable position. The client or guardian will be informed on how his or her grievances will be handled at the provider level. A record of such grievances and the response to those grievances shall be maintained by the provider. The executive director's decision on the grievance shall constitute a final administrative decision (except when such decisions are reviewable by the provider's governing board, in which case the governing board's decision is the final authority at the provider level)" (59 Il Admin Code 132.142).

FINDINGS

Complaint #1 - Inadequate treatment, counselor was unprofessional and would not discuss behavioral health issues with client

The complaint states that the facility provided inadequate treatment to a client. The allegation states that the counselor was unprofessional and would not discuss behavioral health issues with client. The complaint also states that a client was forced into a hospital because of statements

made about the Supreme Court, local politicians, and a previous employer. The facility explained that they never had any complaints regarding the counselor and that the counselor had a "straight-laced" appearance and never wore a beard or dressed like the client. In reviewing the documentation, it is evident that mental health matters were discussed with the client because of summaries in the progress sheets and treatment plans that were written by the counselor. Also, there is documentation stating that the client was hospitalized for reasons other than statements made. Due to the fact that the HRA found no evidence supporting this complaint, the allegation is **unsubstantiated** but offers the following **suggestion**:

- The treatment plan looks unchanged to the point where an error in an individual's name appears in 12 plans. The HRA suggests the case workers are educated in updating the plans and making changes if the goals are not being met so that the clients are given a chance to progress.

Complaint #2 - Retaliation against client for complaints, client was asked not to come onto the property or call due to legal issues raised by the client

The complaint states that there was retaliation against a client for grievances made by the client, also the client was asked not to come onto the facility property due to legal issues raised by the client. The facility stated that they have no record of retaliation and, although there is no specific retaliation policy, in the documentation provided to the clients on admission, there is a statement that services will not be cut due to exercising rights. The HRA reviewed the documents and saw no evidence that the client was prohibited from the facility property. The documentation revealed that the client eventually stopped attending appointments and meetings at the facility on his own. Due to the fact that the HRA saw no evidence of retaliation with the client, the HRA finds the allegations **unsubstantiated** but offers the following **suggestion**:

- Retaliation is often a very real fear among clients and others in treatment programs. This fear will, at times, keep the client from speaking up regarding grievances or aspects of their treatment about which they are unhappy. The HRA suggests that, even though the facility has fulfilled their obligation regarding retaliation within the regulations, the facility should consider emphasizing their retaliation policy to new and existing clients more so that they are comfortable with discussing issues.

Complaint #3 - Violation of confidentiality when two staff members discussed information that a client asked to be kept confidential

The complaint alleges that the client's confidentiality was violated when two staff members discussed information regarding the client that was intended to be confidential. Also, the allegations state that the facility staff leave confidential documents on their desks where they can be seen by the cleaning crew at night. The facility staff stated that the individuals named in the complaint who discussed the client were part of this team and there would never be a situation in which the client's information would be given to the receptionist. The facility also stated that the facility keeps all paper documents in locked files away from their desks so there would not be a situation where the file would be left open on a desk. There is also a statement in the client's treatment plan which says the client permits his therapist to communicate with staff to promote

his wellness and recovery and, although there are not documents where the client signed each plan, there are several plans that were signed which indicates that the client had been provided access to the treatment plan. Both first names stated by the client were located as writers in the progress notes but the last names of the staff members were not given. The facility also has policy regarding staff discussing clients. Due to the fact that the HRA found no evidence that confidentiality was violated, the HRA finds this complaint **unsubstantiated**.

Complaint #4 - Inadequate medication plan, client was given medication and then was not tapered off medication which caused withdrawal symptoms

The complaint alleges that a facility psychiatrist gave a client medication and then did not taper the client from the medication. The staff stated that the client was not taking some of the medication because he did not like the side effects. The facility discontinued the medications that he was not taking. The staff explained that the client was seen by a physician every three months and the client received medication evaluations. The staff was unsure as to how often the medication changed. They stated that the client never complained about withdrawal but he did complain about the side effects of the medication and, during his last year with the facility, the client ceased taking the medication before the physician discontinued the medication. The staff said that the physician is good at weaning individuals off medication. The staff said that the client was tried on several different medications while at the facility. In reviewing the documentation, the HRA discovered that the client did complain about side effects and often changed his dosage of medication on his own because of the side effects. The HRA did not see any evidence that the client was having withdrawal symptoms within the documentation, and, due to this lack of evidence, the HRA finds this complaint **unsubstantiated**.

Complaint #5 - Inadequate discharge process, client was told upon discharge that the provider would refer him to another provider but this was never followed through with.

The complaint states that a client was discharged from the facility and was promised a referral that never occurred. The staff said that the client was discharged from the facility for non-compliance. The facility stated that they never sent a referral because the client stated he was going to another physician. In reviewing the documentation, the HRA read the facility discharge process which states that "The discharge process is completed by the Single Accountable Individual at the time of closing. Documented communication with the consumer informing him/her that the case is being closed including medication services is required." The HRA saw no evidence that the facility communicated that the case was closed. Also the DHS Rule 132 reads that when discharging clients, the provider shall ensure the continuity and coordination of services as provided on the ITP and the provider should communicate treatment information to the receiving provider. The rule also reads "document in the client's record the referrals to other human service providers and follow-up efforts to link the clients to services" (59 Il Admin Code 132.145). Due to the fact that the facility policy and the DHS Rule 132 were not followed, the HRA **substantiates** this complaint and offers the following **recommendations**:

- The HRA does recognize that the client stated that he was going to utilize another service physician, and understands the logic of the facility regarding the decision to not refer the client, but in this instance, the HRA did not see an indication that the facility knew that

the client was definitely enrolled with another physician when the client was discharged. The HRA recommends following existing North Central procedure and re-educate staff in this procedure to assure clients are receiving notice of discharge, unless it is known for certain that the client is transferring to another physician or the facility follows the regulation to refer the client to another facility.

Compliant #6 - Inadequate complaint process, client took complaints to counselor and clinical director, who met with client and spoke to him on the phone but never provided documented resolution of the complaints. Client was also never told about provider's grievance process.

The complaint alleges that that North Central Behavioral Health has an inadequate complaint process. The allegations are that a client brought complaints to a counselor and the Clinical Director; they then met with the client over the phone but never provided the client with a documented resolution of complaints. The complaint also alleges that the client was never told about the provider's grievance process. The staff explained that they have a grievance process but the client wanted a monetary settlement with the facility, which they did not consider a grievance. The staff also explained that clients receive a copy of the grievance process when admitted. The HRA reviewed the documentation and saw that the grievance process is in the resident rights document. There is also a sheet that is signed by the client stating that he has reviewed the client's rights, even though it is not the most recent copy of the signature, it is still signed. The HRA also reviewed an unusual incident report that indicates that the client did want a settlement. The facility policy states that the client can receive the resolution verbally or in writing, which the incident report indicates that they were going to advise the client that there would be no legal action. The DHS Rule 132 does not state that the resolution must be in written form. Due to the fact that the facility did take action on the request by the client, and because the request by the client was not actually a grievance but rather a request for a cash settlement, the HRA finds the case **unsubstantiated** but offers the following **suggestions**:

- Although the main request of the client was to receive a cash settlement, there is still mention of the client disliking his case manager throughout the documentation but the HRA did not see evidence of the facility taking action on the complaints. Even though the client specifically requested a settlement, allegations were made against a NCHS employee there appear to have not been investigated. The HRA suggests that with any future allegations against staff members, the facility investigate the situation even though the client did not ask for that in the specific complaint.
- The rights and responsibilities document that the patients receive explains the complaint process differently than the client complaint policy for the facility; the rights document received by patients states they can present grievances either verbally or in writing while the complaint policy states that clients will be requested to communicate grievances in writing. The HRA suggests that the two descriptions of the process mirror each other as to not cause confusion for clients.
- Although the clients receive the rights statement which explains the grievance policy to a certain extent, the HRA did not see where the client receives a step-by-step explanation like the client complaint policy for the facility. The HRA suggests the facility provide

the patients with an in depth, step-by-step policy of the client complaint process much like the policy that was reviewed by the HRA.

- Even though it is technically not required by the DHS to respond to in writing, the HRA suggests that the facility incorporate the practice of responding to complaints in writing. It is good practice to have a copy on file of what was provided and stated to the client.

RESPONSE

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

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**Gene Seaman
HRA Coordinator
Human Rights Authority
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Peoria, Illinois 61202**

RE: HRA No. 11-090-9035

Date: 12-12-11

Enclosed is North Central Behavioral Health Systems Inc. (NCBHS) formal response to the HRA investigation with regard to case No. 11-090-9035. If you have any questions feel free to contact me at the information provided below.

Sincerely,



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The following is a formal response to the Regional Human Rights Authority of the Illinois Guardianship and Advocacy Commission (HRA) investigation with regard to case No. 11-090-9035. The response will address the substantiated finding per Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq.*) as identified in the report of findings.

As indicated within the report of findings by the HRA, complaint #5 states: **Inadequate discharge process, client was told upon discharge that the provider would refer him to another provider but this was never followed through with.** Furthermore, the HRA indicated upon review that the facilities discharge process states, "The discharge process is completed by the Single Accountable Individual at the time of closing. Documented communication with the consumer informing him/her that the case is being closed including medication services is required." The HRA reported there was no evidence that the facility communicated the case was closed. DHS Rule 132 reads that when discharging clients, the provider shall ensure the continuity and coordination of services as provided on the ITP and the provider should communicate treatment information to the receiving provider. The rule also states, "Document in the client's record the referrals to other human service providers and follow-up efforts to link the clients to services" (59 IL Admin Code 132.145).

The agency has addressed the above complaint through the following plan:

- 1) A review of the above incident at the agencies weekly Service Coordination meeting with all Clinical Supervisors and Clinical Management staff. This was completed on 12-5-11.
- 2) The agencies *Discharge from Treatment Policy and Procedure* was reviewed and changed to reflect the recommendation of the HRA. This process will be completed by 1-1-12.
- 3) The individual staff member involved in the case will be counseled on corrective action. This process will be completed by 1-1-12.
- 4) All clinical staff will be internally re-trained according to and consistent with the new *Discharge from Treatment Policy and Procedure*. This process will be completed by 2-1-12.

In addition to the above, the agency will take into consideration other recommendations by the HRA.