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**FOR IMMEDIATE RELEASE**

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**HUMAN RIGHTS AUTHORITY - PEORIA REGION**  
**REPORT OF FINDINGS**

**Case # 11-090-9042**  
**Human Service Center**

**INTRODUCTION**

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

1. Abuse and inhumane care in the form of physical and verbal abuse against a client
2. Inadequate discharge from services
3. Retaliation against client for voicing a grievance against facility
4. Inadequate grievance process

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) and Community Mental Health Provider Regulations (59 Il Admin Code 132).

The Human Service Center, operated by Fayette Companies, provides mental health services to the Peoria County area with some exceptions. The facility has 18 buildings in the Peoria area and employs approximately 260 staff members. They provide services such as an emergency response service (ERS), wellness team, supported employment, mental health court, and data link with the local jail. The Human Service Center provided services to 1,822 unduplicated clients last year.

**COMPLAINT STATEMENT**

The complaint states that a client had been receiving services from the Human Service Center since 2002. The client discovered that the Human Service Center moved her long-time therapist to another position in the facility and the client became panicked and begged to continue services with the counselor. The complaint alleges the new counselor cancelled 4 or 5 appointments in a row. According to the complaint, the client went to a psychiatry meeting and the former counselor met her before the meeting and took her to see the medical director instead. Allegedly, the medical director began screaming at the client and said that she would have to see the new counselor and the former counselor was unavailable. While he was screaming at her, he reportedly poked her nose and spat on her and her glasses while screaming at her. When the medical director finished yelling at the client, he allegedly said "If you don't like it then get out,"

and slapped her on the leg. The client's former counselor reportedly allowed this to happen. This incident occurred in January 2011.

The complaint also alleges that the client was discharged for complaining about a staff member to the head of the Fayette Companies. The complaint states that a client wrote a letter to the President of the Fayette Company. The letter explained the incident with the medical director and that the client did not think that it was right that the incident occurred. The client received a response letter stating the facility would investigate and the next letter that was received by the client stated that she was no longer receiving services from the facility. The client was allegedly never informed of the investigation results. The client was reportedly never explained exactly why she was discharged and never received any discharge paperwork. The client was sent a list of referrals but they were all for physicians and not social workers. The client never received a discharge plan, only a letter in March saying that her services were discontinued. The letter said not to contact the facility and she could no longer receive services. The letter was received in March 2011.

The allegations state that the client tried to contact the new counselor in October, November, and December but could not reach her. The allegations state that the client repeatedly contacted the program Director and another staff member but they did not return the calls. The complaint also states that, with the referrals, she was denied because of long waiting lists.

The HRA saw evidence that the Office of Inspector General was contacted regarding the abuse allegations within the complaint.

## **FINDINGS**

### **Staff Interviews (8.31.2011)**

The HRA began the investigation by interviewing Human Service Center staff. The staff members began by explaining that they have several levels of care. The Assertive Community Treatment (ACT) is their highest level of care. The next levels are Community Recovery, Out client Treatment Program, and then Medication Only Treatment. A client can graduate to lower levels of care from more intensive programs. The clients are placed in different areas based on the level of care needed. This client was in the Out client Treatment Program. The client's diagnosis was major depressive disorder with borderline personality.

The staff explained the background of the situation with the client. The staff stated that the client has a history of being adversarial with staff and physicians. The client was with one counselor for an extended period of time. While the client was with that counselor, she was seeing a local community physician. Because of the client's adversarial actions, the physician discharged the client from his services and she had to be physically removed from his office location by the police. The staff stated that the client got upset with her counselor at the Human Service Center because she felt that the counselor did not advocate for her in the situation.

State of Illinois changes eliminated funding for clients without Medicaid. The facility still wanted to offer services to clients without Medicaid, so they reorganized to cover those

individuals. The client's counselor was moved to the non-Medicaid coverage and could not work with the client any longer because the client was covered by Medicaid. When this occurred the client became upset. Because the client was upset, the staff scheduled an appointment to discuss the change. The case manager and medical director were at the meeting. The client was told at the meeting that she must be compliant with medications and be compliant in meeting with her new counselor. After the meeting, the client left the office but continued to stand outside and "rant and rave" according to the staff. Because she was being disruptive to the operations at the facility, the medical director told the client that she must leave. The client was outside the door saying that she was staying with her old counselor and expressing that she received unfair treatment, and, according to the staff, she scared people in the waiting room. The staff stated that the medical director spoke firmly, with authority, but was not yelling. The staff said that in the process of the director telling the client that she must leave, he may have inadvertently had spit come from his mouth and land on her glasses but they could not verify that this occurred. The staff explained that the client is taller than the medical director so it seemed doubtful that spit would have hit her face or glasses. Also, it was stated that the counselor was standing between the two of them. The staff explained that the client did not say anything about the spit at the time. The staff stated that the medical director never touched the client and that nothing physical occurred.

According to the staff, the facility then mailed the client a Medicaid co-pay for 2 dollars which the client sent back stating that she would not pay because the doctor spit in her face. The client actually wrote that she refused to pay the bill on the bill itself and sent it back to the facility. After the Human Service Center received the letter, they decided to discharge the client. The grounds for discharge was the client's history of behaviors, the fact that they felt that the client was not happy with their services, and her refusal to pay the co-pay. The staff stated that the client would also not follow the treatment plan and she was not medication compliant. The staff also discovered that the client was seeing a community physician in another city while at the Human Service Center but did not inform the facility of this. They discovered this because the facility received a call from the physician's office. The staff speculated that the client would not get what she wanted from the local community physician so she would go to the physician in the other town. The staff also stated they were not positive what services she received from the other physician.

When the client was discharged, she was referred to two other community mental health facilities and the Human Service Center staff discovered that she is now receiving services at one of those facilities. The staff also stated that not only was the client referred to those agencies but they also sent her a list of other providers she could contact. The facility stated that the client was sent letters explaining the discharge. The staff explained that after the discharge letters were sent, the client called and asked to return to the facility. The staff stated the client would also call and say that she was suicidal. The staff asserted that the client became fixated with calling the facility and lodging complaints against the facility. She even contacted a local politician with a complaint. The client contacted the CEO of the facility with her complaints. The staff stated complaints started when she was discharged and facility staff became unresponsive to the client. The staff said the client would make multiple calls to the facility staff and she would be angry and yell at them that they did not call her back. The staff stated that the client spent a tremendous amount of energy on calling and making complaints. The staff stated that she had

displayed this obsessive behavior previously with a chiropractor and a delivery person. She became fanatical about lodging complaints against them. The Human Service Center sent the client a letter stating that they would not be answering phone calls from her any longer and also stated that they would be deleting any messages left as an attempt to dissuade her from putting forth more energy into the calls.

After the letters were sent, the calls finally lessened and stopped. The last time a staff member spoke to the client, she said they lied about intake at the community mental health center that she was referred to and they would not take her. The Human Service Center staff member called the facility and discovered that the client actually cancelled the appointment. The staff stated that they wanted the client to have a fresh start at the new center and had worked with the center staff to have the client placed there.

The staff explained that every phone call that the client made would be a grievance. They stated that even the CEO spoke with her several times regarding her complaints. The staff said nothing was put in writing as far as the grievances. The staff said that part of the reason for the grievances not being put in writing was because when they would try to talk to her, she would hang up or if they called her back after she left a message, she would not answer. They said that in the beginning of her grievance calls, there was an upper management staff member that the client would talk to but she would still always hang up on that staff member. The staff stated they because she hung up and would not answer they could never resolve the issues. The staff said that they were following the grievance process with the client. She would call and they would follow-up. When she had discussions about the incident with the medical director it was never about physical abuse, it was about being spit on. At first she did not mention being physically touched but then later she started to complain that she was hit.

The staff stated that they would try to schedule an appointment with the client but she always had a barrier. The staff also said that the new counselor could have missed a couple of days because she lives in Bloomington. The client met with the new counselor once and would not come back because she got mad at the counselor. She became angry with the counselor because the counselor would not fill out her Circuit Breaker form at the meeting and asked to wait to complete the form at the next meeting. Circuit Breaker is a program for seniors where they receive state money for different items they must pay for such as license plates, or medication assistance, or tax grants. After the meeting with the medical director, where the alleged spitting occurred, the client met with the new counselor once and an advanced practice nurse once. It was after the two appointments when she refused to pay because of the spitting.

When asked about missing appointments, the staff stated that she did not miss many appointments overall (prior to when she stopped coming) and only missed one appointment with the advanced practice nurse (APN). The staff stated that the bottom line, final reason for the discharge was the refusal to pay for services. They said even though that was the final straw, it was cumulative. The staff reiterated that the client would not take medication, was dissatisfied with services, verbally abusive towards staff when she would call and abusive when she was at the facility. They stated that she just was not happy with the services that Human Service Center was providing.

The staff stated that in the letter they sent to the client, the complaint that they were referring to was her refusal to pay the 2 dollar co-pay. The staff explained that the CEO was aware of the situation with the client. The staff stated that the letter discussed in the complaint statement was the returned bill on which the client wrote a message. The staff said that the client was never sent a letter saying that they would investigate the complaint. The staff also said that the client would not complain about the medical director to the staff that were present during the incident. Her direct complaints were about the community doctor that she was discharged from and the state system.

The staff stated that they would often send the emergency response system (ERS) to check on the client because she would say that she was suicidal. The staff said that if she called, and they called her back and she would not answer, they would send out the ERS. The staff explained that they thought the client wanted the spend down from Human Service Center. The bills that the facility send the client helped her meet her spend down so she would receive public aid. The staff interjected that if she did not make her spend down, her rent would go up because of the subsidized housing that she lived in. The Center would always bill therefore she would meet her spend down. The staff said they thought that she felt as though she had to stay at the Human Service Center for the spend down and that she thought there were barriers for the spend down at other facilities. The staff thought that, even though she was unhappy with the service, she wanted to stay because of the spend down.

The staff said that they do not have any proof regarding the client trying to contact the new counselor and the counselor not calling her back. They said that by looking at the notes, it seems as though she said that she had not connected yet but it did not say that the counselor would not call back. On January 12<sup>th</sup>, the new counselor called the client. They cannot prove that the client was not called back for three months but the staff stated that it was unlikely. The client was still with the old counselor during October, November, and December and had not transitioned to the new counselor yet, and these dates were the times that she said that she tried to contact the new counselor. When the old counselor would call her, it was a situation where the client would hang up on her.

The staff has training that they are required to complete. The trainings include ethics training, safety training, disaster training, infection control, etc. The trainings would cover what happened in this situation as far as the abuse and yelling. The trainings meet Joint Commission on Accreditation of Healthcare Organizations and Department of Mental Health rule 132 requirements. The staff explained there is also a chain of command that monitors staff, so everyone has a supervisor to whom they are accountable.

The staff stated that the letters to the client indicate that this was not retaliation. The client was dissatisfied with services so they discharged the client. The retaliation policy/procedure is in the rights statement that the clients receive in the handbook. It was the CEO's decision to discharge the client with the support from the staff. The CEO, medical director and others met to discuss the situation. The staff said that they have never had a retaliation complaint before. The client never accused them of retaliation when speaking with them about her complaints. The staff did not recall staff training on retaliation but there is training regarding the grievance process.

## **FINDINGS (Including record review, mandates, and conclusion)**

According to a Summary of Services and Progress form dated 3/21/11, the client's admission date is 10/29/2007 and the date of program enrollment ended 3/21/11.

### **Complaint #1 - Abuse and inhumane care in the form of physical and verbal abuse against a client**

The HRA reviewed a copy of the Medicaid bill on which the client wrote the complaint. The note reads "I was verbally and emotionally abused by a [Medical Director], I have his spit on my glasses. I will never pay this. I will pay anything by [Recovery Specialist]. I was also threatened. That sure is a great way to treat a client at a mental health ctr."

The HRA also reviewed a physician progress note written by the Medical Director who has been accused of the abuse. The note is dated 1/31/11 and reads "I met with client to outline changes in her treatment, particularly in her recovery specialist. Due to the reorganization, she has been assigned a new recovery specialist and refuses to be cooperative with her, indication that she only wants to talk to [previous Recovery Specialist]. She also indicates that she feels like she has been treated very unfairly in this organization and that we did not assist her with her continuing her relationship with [primary care physician]." The note proceeds to read "She was tearful, intermittently, with repeated returning to the same pattern of thinking and refusal to move forward. She accused us of not caring. She accused us of treating her poorly. She indicated that she has not been taking her medicine, because none of it helps." Another section of the note reads "I encouraged client to re-start her medicine; take them as prescribed; return for a follow-up visit with [staff] in two weeks; and to work, cooperatively, with her recovery specialist. I did indicate to her that if she chose not to do this, we would be obliged to discharge her from the clinic as she was not being very cooperative with treatment. Client left here very angry at me."

Another note, written by a Recovery Specialist, dated 1/12/11, with the goal written of "introduce myself to client," reads "RS called [client] to introduce myself as her new RS. [Client] started crying and stated that she wants [previous RS] to continue to be her RS. She complained about her RS not calling her and nobody contacting her since September. She states that she was told yesterday that she can no longer see her RS and has to talk to ERS only. She states that she is probably dying of cancer. When RS stated, 'I am sorry to hear that,' she yelled 'no, you are not'. She continued yelling throughout our conversation and finally yelled 'I am tired of people calling me out of the blue' and hang up." Another note, dated 1/12/11 reads "Client called ERS questioning why she wasn't getting services from HSC and thinking her case was being closed. Client stated she was told by two HSC staff [staff names] in the last two days, that she couldn't come to HSC and she could go elsewhere with her medical card." The HRA saw no evidence in the documents that this statement was true. Another note, dated 1/21/11 reads "Individual had left sobbing on voice mail, so RS returned the call. She became angry and said she hadn't done anything wrong and why are we throwing her away. She did stop and let RS talk so we discussed our inability to talk with her as she hangs up on us when we call. Also discussed that she is so angry with this RS the relationship would no longer benefit her."

The HRA saw no evidence that a facility staff member canceled appointments and saw that the client had canceled 6 appointments one of which was due to a family emergency and did not show for one appointment.

The HRA reviewed a treatment note on 1/13/11 indicating that the medical director and others met to discuss scheduling a meeting to talk to the client about assisting her with continuation of treatment on 1/31. The passage did state that the medical director would meet with the client at her next appointment with another staff member on 1/31, which seems to indicate that the appointment was pre-existing. There was also no evidence that the client knew that she was going to meet with the medical director and the HRA did not find evidence in the documentation where she was told that this was going to occur.

The HRA reviewed a note on 11/18/10 that read "[client] called and left a message that she was too sick to get out of bed to come into her appts with RS today. She said she would call RS for another appt when she felt like it." The HRA reviewed another note on 12/2/10 that reads "RS called individual as she has not connected with RS. She says she is still in bed and that 'we put her there' due to not trying to get [primary care physician] to change his mind about keeping her as a client. RS then referred her to [medical facility] for medical care and she refused the referral. She says it is all my fault as sided with [primary care physician] rather than fighting for her to remain as his client. She says she 'can't get out of bed because of it.' She accused the RS of not calling her. When RS said that I had left messages on her phone, she accused RS of lying and hung up the phone." These passages indicate that there was some interaction between the facility and the client in two of the months noted in the complaint statement as being months in which the RS did not contact the client.

In another passage from the client's treatment notes, dated 1/11/11, the HRA reviewed a passage that read "clt [client] increasingly became more upset/angry esp when wkr reported that her hsc rs had spoken to her last week; clt denied such contact; that hsc rs was 'lying' clt reported that she has only been seen her 'psychiatrist' [name]; that clt has not seen/spoken to anyone since sept (10); that her hsc rs had 'embarrassed' her at her dr's office; that hsc rs 'stabbed me in the back ...' ... wkr attempted to re-direct/calm clt; clt repeated that she did not want to talk w/ hsc/ers; 'don't come (to her apt) or have the police come ...' wkr attempted to ask if clt was willing to talk w/hsc rs [staff initials] or another hsc rs clt again repeated the above; then hung up."

In a treatment note, dated 3/15/2011, it reads "... client reported receiving a letter from HSC saying that she could no longer receive services there and her case was being closed. Client reported she was going to an appointment with [case manager], but was taken, by [former case manager], into see [Medical Director] instead. Client reported [Medical Director] yelled at her and spit on her and was told she could get services elsewhere. Client stated she had contacted Fayette companies [CEO] and then later received a letter saying her services were being terminated. Client claimed she did not do anything wrong, that no one likes her, and no one wants to help her ... Client begged this writer to fix the situation with HSC because she needs a case worker to help her; she cannot do things on her own."

The Human Service Center's client handbook reads that each individual "Shall have their personal dignity recognized and respected in the provision of all care and treatment" and "will be free from mental, physical, sexual, and verbal abuse, neglect, and exploitation in the treatment relationship."

The facility also has an abuse policy which reads "Clients have the right to be free from mental, physical, sexual, and verbal abuse, neglect, and exploitation." The policy then refers to the Fayette Companies' Code of Ethics. The policy also states that "Staff having direct contact with clients receive initial training with annual updates about abuse, neglect, and exploitation, and how to identify, and refer appropriately."

A summary of services and a progress note dated 3/21/11 reads "[client] goal was to get out more and socialize with others as she has difficulty with being around people and has panic attacks. She was not working toward this goal and was satisfied with staying in her apartment most of the time ... [client] did not complete treatment at HSC but was discharged due to her dissatisfaction with her treatment at HSC. She would benefit from engaging with a new pcp and counselor to assist with medications and counseling. She was informed that she should not return to HSC for treatment."

The Department of Human Services (DHS) regulation 132 reads that clients have "3) The right to be free from abuse, neglect, and exploitation" (59 Il Admin Code 132.142). The Mental Health and Developmental Code also states "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect" (405 ILCS 5/2-112).

*Compliant #1 conclusion:*

The HRA found no evidence supporting the allegation that there was physical or verbal abuse against the client in reviewing the documentation and interviewing the staff, and due to this lack of evidence, the HRA finds this complaint **unsubstantiated** but offers the following **suggestion**:

- The HRA did not review much documentation regarding the incident where the Medical Director was accused of abuse, nor did the HRA see evidence that the patient knew whether or not she was meeting with the Medical Director. This poses a concern with the HRA because these are milestone events in the client's recovery yet there was not much documented by the staff regarding these events. The HRA suggests that the agency review these milestone events with those who document them to ensure an adequate accounting of significant incidents.

**Complaint #2 - Inadequate discharge from services, Complaint #3 - Retaliation against client for voicing a grievance against facility & Complaint #4 - Inadequate grievance process**

Because the last three complaints in this case are so closely aligned, the HRA chose to place them all together in this section.



The HRA reviewed the discharge letter that was sent to the client. As stated in the previous complaint, the client wrote a message on a Medicaid bill stating she was abused and she would not pay the bill. That message was sent from the client to the facility CEO. A 3/11/11 discharge letter to the client (the HRA reviewed an unsigned copy that was not on letterhead) reads "Despite our best efforts to move into the future on a more positive note it appears from your recent complaint to [CEO] that you continue to be unhappy with the services we are providing you at the Human Service Center. It appears that you have very little confidence in our ability to help you with your recovery within the constraints of our system. I am therefore writing to inform you that we will be terminating your services here at the Human Service Center. We will provide you with a 30 day supply of medicine and the names of other providers that you can apply to for services should you want it. The termination of services is non negotiable please use your energies to seek services elsewhere and not in effort to be reinstated."

Another letter, that was also unsigned and not on letterhead, that is dated 4/17/11, reads "I did receive your call on Thursday May 5, 2011. It is unfortunate that you feel you must insist upon calling us as we having nothing further to offer you. We have made the referral to [facility]; it is time for you to move forward. Please be aware that if you call me in the future I will not be taking your calls, additionally should you leave a message I will delete it without listening to it so it leaves no anticipation on your behalf that any particular call will result in me calling back. If you persist, in spite, of this letter on calling us, we will have to explore our avenues to protect ourselves from your intrusions that disrupt our work day."

Based on the HRA's knowledge of the facility to which the client was referred, the facility is not just comprised of all physicians with no social workers but rather a community mental health provider much like the Human Service Center.

A physician's progress note, dated 5/11/2010, reads "She ran out of medicine because she missed two appointments, prior." Another treatment plan overview dated 9/28/2010 reads "[client] met with [case manager] on 9/17/10, but left the session before completion. She is supposed to continue Prozac 40 mg. daily for depression and zolpidem. She was on 0.5 mg. of Klonopin t.i.d. p.r.n from [primary care physician]. She did not make an appointment to continue to be seen at HSC. She has made complaints against her RS regarding her pcp releasing her from his practice. She had an ERS contact on 9/28/10 due to statements made on a phone call to program manager that she feels worthless."

In another treatment note, dated 8/31/2010, it reads "[Client] was upset when she came in due to her difficulties with Public Aid medical card. She reports they sent back all of the receipts she turned in for her spend down and they didn't use them. She said they told her 'it was easier to use HSC spend down and not to put each of the receipts into her computer.' She was adamant that they should use the receipts. She then said she was tired of fighting these fights alone. She accused the RS of not helping her ... She said RS should of offered to go with her to DHS and straighten it out."

In a treatment note dated 3/16/11, it is written that the client "begged this writer to have her reinstated to the HSC. Client stated she needs to go HSC because of the 'credits' she gets

which enable her to not have a spend down." Another treatment note on 6/2/11, reads that the client contacted the facility and left a message that she "... needs to see us in order to meet her spend down for Medicaid." The same note reads "... it would be fraudulent to see [client] in order to bill her in order to meet her spend down as it is not clinically indicated/warranted."

Another treatment note, dated 9/28/2010, reads "[staff member] asked ERS to contact client who has been having treatment difficulties. Client reported she is distressed over treatment issues with [family member] her primary care physician and HSC. She reported cancelling her appointment to meet [staff member] tomorrow. She has stopped taking her medications and does not plan on seeking a new physician. Client stated that if no one cares about her then what is the point. Client reported having medical problems since she is off her medications. Client was asked why she returned medications to her physician. Client upset saying the wrong medications were ordered at the pharmacy and she never had them filled. She was upset at the lack of accurate information. Client stated she was upset that ERS called at this time of night, as a family member was having medical problems and she thought the call was about them."

Another treatment note, from 12/10/10 reads "RS will consult with her supervisor for next step in care of [client] as she is unwilling to engage in treatment." Also, please see previous complaint for treatment note dated 12/10/10 regarding client re-engagement and lack of connection.

On a physician progress note, dated 2/21/2011, it reads "[client] stated that in the beginning, she started with people not caring; people here don't care, the [staff that she is no longer allowed to work with] story, that [medical director] yelled at her and she has a lawyer. She said she sits around and cries. She gets anxious. She tried to kill herself, but she has no plan right now. She says she is trying to get public aid, get a circuit breaker, and nobody is willing to fill the forms for her. She said that she and [staff] have rescheduled a time to meet ... She feels she is made to see [staff]. She is willing to see her, and they have an appointment on Thursday at 2:15 this week. She needs help with her public aid and needs a letter. She also mentioned that she has to come here. When I asked her why she continues to come here if we don't care. She said she has to come here because she gets points from public aid for coming here. She also said she has no primary care doctor."

The HRA reviewed the facility's policy and procedure on the discharge of AMH (Adult Mental Health) clients due to refusal of psychiatric services. The procedure states that "All individuals enrolled to adult mental health programs are expected to have contact with psychiatric staff at a minimum of every three months. This includes those clients who are not taking psychotropic medications, as well as those for whom medications are prescribed. Although clients maintain the right to refuse medications or specific treatment options, it is an expectation that all individuals enrolled to adult mental health treatment programs participate on a regular basis with psychiatric services." The procedure for discharging states that when an individual refuses services, the recovery specialist shall review the situation with psychiatric staff to assure there are no alternatives to the prescribed treatments. An appointment will be scheduled between the client, medical provider, and recovery specialist to address the refusal. Based on the specific circumstances, if the individual continues to refuse services, they will be

unenrolled from the agency. If services are ended, the individual will receive a referral to another provider. The policy proceeds to read "Should the individual wish to return to active mental health treatment, the reassessment for re-enrollment will address the issues of their previous refusal of psychiatric services as a condition of re-enrollment."

The HRA also reviewed the policy and procedure for discharge due to lack of contact (no show) in adult programs. The policy states "In order to make the best use of available resources, it is important to distinguish between individuals who have actively engaged in services and those who are not actively engaged. Individuals will be advised of pending discharge due to lack of contact with the program, and if no response, enrollment will be ended." The policy and procedure illustrates procedures for out client mental health programs with items such as attempts to contact by phone, mail, or in the community. Then the staff must obtain approval for discharge from supervisor and prescribing MD/APN for clients enrolled in ACT or Community Recovery Programs. The policy lays out some date ranges that the staff must wait for the client to respond to first and second letters before discharge. The policy also states that "Individuals who have been un-enrolled from services may seek re-enrollment at any time by contacting Intake and Assessment, ERS, IHC [Integrated Health Clinic], or Whitman Medical Unit."

The Human Service Center handbook reads "Individuals have the right at any time to refuse treatment and to discontinue services. Similarly, the recovery specialist may decide to terminate services for good cause, which shall be communicated to the client in writing. If an individual refuses to actively participate in treatment, or if an individual places a facility or other clients at risk, Human Service Center/[name of another company in the Fayette systems] may discharge that person."

Regarding the retaliation aspect of the complaint, the client handbook reads "Clients who exercise the right of filing a grievance shall be protected from any retribution or clinical interference as a result of the grievance."

The HRA reviewed a letter from the President/CEO of the facility regarding the letter that the client sent on her bill which reads "I am in receipt of your handwritten note relating concerns about the care you received from [medical director] and [recovery specialist]. Please know that we take client complaints very seriously, and we will be looking into your complaint." The HRA saw no response regarding the complaint, only the discharge letter to the client.

The Human Service Center handbook illustrates the steps involved in filing a grievance. The grievance section of the handbook begins by stating "Every Human Service Center/[name of another Fayette service] client, family member, visitor, or other consumer of services has the right to make a complaint or grievance. A formal complaint, however, must be in writing." The section proceeds to explain the process. The first step deals with the original staff member involved in dealing with the grievance should explain the grievance procedure and document the grievance in the client's chart. The staff member will contact the client within 72 hours to arrange an appointment to resolve the grievance. If an individual does not want to bring the issue to his/her recovery specialist, he/she can bring it to the next staff level or initiate the complaint with another person. The procedure also states that clients may get assistance with writing the grievance and can even receive a blank form to complete. The procedure proceeds to

say that if a resolution is not reached to the satisfaction of the client and staff, a completed Grievance Report Form and Grievance Resolution Form shall be sent to the next staff level and end at the Fayette Companies' President. If no resolution is attained, the client will be given the names and contact information for client advocacy and/or arbitration organizations. The handbook has a list of advocacy organizations.

Also, in reviewing the treatment notes, the HRA saw that one of the individuals named in the complaint as not returning calls talked to the client at least 3 times in January 2011 and left messages with the client twice. The HRA saw no evidence of the second staff member named calling the client but did see that the individual was the referral source at least once for an emergency response service visit, which partially verifies the staff's claim in the interview portion of this report regarding the staff member calling the ERS for the client. The statement does not give evidence as to how many times the ERS was called. In a treatment note, dated 4/7/11, it reads that the client spoke with a Human Service Center manager whose initials are the same as the other individual named in the complaint statement as a staff member who would not return the client's calls. This shows evidence that both staff members named in the complaint returned the client's calls.

The HRA reviewed no evidence either way that the client was denied service from other facilities because of long waiting lists.

The HRA reviewed the treatment plan dated 9/28/10; the plan was not signed by the individual but rather it is written "unavailable to sign" and initialed by a staff member. No reason is given as to why the client was unavailable to sign.

The Department of Human Services (DHS) rule 132 reads "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 level 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 Il Admin Code 132.150).

The DHS Rule also states "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).

In regard to the complaint that the facility discharged an individual in retaliation for prior complaints, the Illinois Administrative Code reads that individuals have the "6) The right not to be denied, suspended or terminated from services or have services reduced for exercising any rights" (59 Il Admin Code 132.142).

The DHS Rule 132 reads " . . . Active participation by the client and/or persons of the client's choosing, which may include a parent/guardian, is required for all ITP development, whether it is the initial ITP or subsequent reviews and modifications. Participation by the client or parent/guardian shall be documented by the client's or parent's/guardian's signature on the ITP. In the event that a client or a client's parent/guardian refuses to sign the ITP [Individual Treatment Plan], the LPHA [Licensed Practitioner of the Health Arts], QMHP [Qualified Mental Health Professional] or MHP [Mental Health Professional] shall document the reason for refusal and indicate by his or her dated signature on a progress note that the ITP was reviewed with the client and that the client or his or her parent/guardian refused to sign the ITP" (59 Il Admin Code 132.148).

*Compliant #2 conclusion:*

The DHS regulations state that, in terminating a client, they must provide continuity of care, communicate with the client's new service provider, and provide referrals to the client if they do not have a new service provider and document the referrals and follow-up efforts with the referring agencies (59 Il Admin Code 132.145). In accordance to the letters sent to the client, referrals were provided and, in the second letter a specific facility was named as a referral. The client did not receive a discharge plan but there are no indications in the regulations that the client is to receive a plan, and the client's letter did state an exact reason for being discharged from the facility, which was that the client seems unhappy with services. Because the HRA found no evidence that there was an inadequate discharge, the complaint is found **unsubstantiated** but the HRA offers the following **suggestions**:

- Although the HRA reviewed a letter that stated an exact reason for discharge, during the staff interview, the HRA was explained further reasons for discharge that did not appear in the letter, such as lack of compliance and refusal to pay for services. The HRA is unsure as to the reasoning for not adding this to the letter, but suggests that in future letters that any and all reasons are added to the letter sent to the client to ensure compliance with mandated discharge criteria.
- In reviewing the two discharge policies, both specifically have statements regarding re-enrollment and indicate that patients can re-enroll. The letter to the client indicates that she can no longer seek services at the facility. The HRA feels as though this is not consistent with the two discharge policies that were provided to the HRA and suggests practices consistent with policy.

The HRA also offers the following **suggestion**:

- In a previous report (11-090-9029), the HRA made the suggestion that the facility follow 59 Il Admin Code 132.148 regarding the signing of treatment plans. The HRA reviewed a treatment plan in this case which documented the statement "unavailable to sign" written into the client signature area but there was no reasoning as to why the client was unavailable to sign. The regulation states "In the event that a client or a client's parent/guardian refuses to sign the ITP, the LPHA, QMHP or MHP shall document the reason for refusal and indicate by his or her dated signature on a progress note that the ITP was reviewed with the client and that the client or his or her parent/guardian refused to sign the ITP" (59 Il Admin Code 132.148). The HRA suggests that when the client will not sign, or is unavailable to sign the treatment plan, the facility document a reason to comply with the DHS rule 132 regulation.

*Compliant #3 & #4 conclusion:*

In reviewing the evidence, the HRA discovered that the client sent a Medicaid bill to the facility CEO with the written statement on the bill that she was abused by staff. The CEO sent a letter back stating that client complaints are taken seriously and they would be reviewing the complaint. The next letter that was sent to the client was the discharge letter stating that "Despite our best efforts to move into the future on a more positive note it appears from your recent complaint to [CEO] that you continue to be unhappy with the services we are providing to you at the Human Service Center." The letter proceeds to tell the client that they are discharging. In this letter, the facility does indicate that this complaint is illustrating that the client is unhappy with the facility and that is why the client is being discharged. The letter does not directly state that the client is being discharged because of the complaint and there is a history shown that the client was not satisfied with the facility and services provided by the facility and as a result the HRA finds the retaliation complaint **unsubstantiated**. **The HRA feels as though the actions taken by the Human Service Center are walking a fine line between discharging the client for a legitimate reason and discharging the client for making, what is indicated by the facility itself, a complaint. The only reason why this is not substantiated is because of the statement in the letter that the patient "continues" to be unhappy and the history that the patient has with expressing a lack of satisfaction. Also, part of the determination that the actions taken by the facility are bordering on retaliation is the fact that the HRA saw no evidence that the grievance process was completely followed even though a letter was sent by the facility CEO stating that "we take client complaints seriously, and we will be looking into your complaint." The HRA strongly suggests that the facility review its discharge process in the future and are more careful in documenting actions taken when discharging clients in the future.**

As far as the complaint that the facility has an inadequate grievance process, the HRA finds this complaint **substantiated** because there was no follow through or resolution of the complaint at least in writing and provided to the client. We provide the following **recommendation**:

- The facility policy is in compliance with the requirements of DHS Rule 132 (59 Il Admin Code 132.142) but the staff did not follow the policy in this case. The facility CEO stated that they would be looking into the complaint, essentially recognizing that there was a complaint and stating the complaint would be investigated. The HRA saw no evidence of the process being followed or a response to the grievance being provided to the client. This is the second complaint that has occurred with facility staff failing to follow their own grievance process (see report 11-090-9029). The HRA recommends the facility re-educate staff in following the facility grievance process and review 59 Il Admin Code 132.142 with staff. The HRA also requests evidence that this staff re-education and review occurred.

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## **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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February 24, 2012

Mr. Gene Seaman  
Guardianship & Advocacy Commission  
401 Main Street  
Suite 620  
Peoria, Illinois 61602

RE: HRA Case # 11-090-9042

Dear Mr. Seaman,

We are in receipt of the comprehensive investigation and subsequent report related to the above referenced HRA case. We concur with your representation of what you believe to be the facts of the incident and many of your conclusions. Having been personally involved with the review of this case immediately prior to when this consumer cites her complaints, I believe that the staff were fair, well-intentioned and professional in their interactions throughout.

1. Clearly there were incidents in which the staff could have been more diligent in documenting the occurrences and content of the multiple communications with this individual. A discussion with staff has ensued to review and refresh them of the critical issues (milestones events) which require notation from both a clinical and legal perspective.
2. By written HSC policy, a complaint must be submitted in writing for there to be a written response. The staff, under the direction of the medical director, clinically reviewed this consumer's assertions and concluded what she was asking the staff to do, was not appropriate and were clear in their verbal response to her. Human Service Center believes that though a formal documentation was not made of the outcome of this complaint, the results were conveyed in the discharge letter. A formal process exists and did occur by convening a group of clinical staff to review requests when continuation of treatment or re-admission may be believed to be counter-indicated.
3. Staff have been directed, and will be reminded, that in the event a consumer is not available to sign any document, it should be noted that they were not available and a brief reason as to why they did not sign.

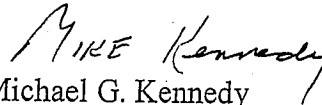
4. As stated in the discharge letter, though the primary basis the consumer was being discharged from service was the result the consumer had articulated a lack of confidence in the organization's ability to meet her needs, the organization choose clinically not to list all the factors that had been taken into consideration. It is correct that any individual can request consideration to be re-enrolled in mental health services with the organization, but clinically unless she is assessed to have a significant change in her attitude toward the staff and services provided by the organization, re-enrollment would be clinically counterproductive for her.

5. Enclosed you will find the documentation of program staff training in the current HSC grievance process as recommended. The current protocol was reviewed and staff had the opportunity to ask questions using this case as an illustration of the importance to insure all steps are completed. All outpatient mental health staff will be provided with the same training at the monthly April staff meeting.

We appreciate your review and recommendations.

Cc: enclosure

Sincerely,

A handwritten signature in cursive script that reads "MIKE Kennedy". The word "MIKE" is in all caps, and "Kennedy" is in title case.

Michael G. Kennedy

Vice-President &

Chief Operating Officer