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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 12-090-9006
Robert Young Center

INTRODUCTION

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

1. Inadequate treatment, including a physician making verbal/hostile threats and remarks towards a patient, a patient not being allowed to participate in his/her treatment plan, the facility not discussing treatment with the a patient's family even though a release was signed by a patient to do so, a physician asking personal questions of the family that were unrelated to treatment, a patient being told he/she could not see an outside physician for alternative services when she/he was satisfied with current physician, and inadequate access for patients to medical treatment while on unit.
2. Retaliation against a patient for disagreeing with his/her treatment plan.
3. Inadequate admission process, including a physician making fraudulent claims to receive petition for transfer to a nursing home.
4. Inadequate discharge, including patient being kept at facility although she functioning well enough to be discharged home. Also, at a previous admission, patient was released before being ready for discharge.
5. Inadequate grievance process, including a complaint was made to the facility but no resolution was given regarding the complaint.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-100) and the Center for Medicare and Medicaid Services regulations (42 CFR 482).

The Robert Young Center is a community mental health center that typically serves Mercer and Rock Island counties. They serve 9,000 individuals per year through outpatient and inpatient treatment, including a chemical dependency treatment program. The Robert Young Center has 200 employees including psychiatrists, registered nurses, licensed practitioners, Master's level and Bachelor's level case managers, and Qualified Mental Health Professionals (QMHP). This review focuses on the adult inpatient program, an affiliate of the Trinity Medical Center in Rock Island.

To investigate the allegations, the HRA met with the Robert Young Center staff and reviewed documents relevant to the investigation.

Complaint Statement

The first complaint states that there was inadequate treatment of a patient in the facility. The complaint states that a physician continuously made verbal and hostile remarks/threats which caused the patient emotional distress and harm. During an interaction between the patient's family and the physician, it was alleged that a family member questioned how long it took for a patient to become stabilized on medication and the physician stated that he did not know and said to a family member "What are you a doctor?" The physician then became agitated and went on to say that he did not have to speak with the family even though there was written consent to involve the family in medical treatment. The physician also made discouraging statements to the patient such as "You have no one and nothing to blame for your illness but yourself." The complaint alleges that the physician used his power and authority to "bully" and "punish" the patient. The physician allegedly stated to the patient's family that "You don't know all the things that she has said to me over the years." The physician even said to a family member that the patient was "cocky" because she spoke her mind about her treatment plan. The physician also said that "she will give her family a fit" if she was discharged from the facility. The complaint also states that the patient was not allowed to participate in the development of her treatment plan. The complaint alleges that the patient never received treatment or further diagnosis for shortness of breath which may have been heart related. The patient's physician would not seek medical attention for pain she was having with her teeth and a reoccurring eye infection. The patient was also allegedly not allowed to visit another psychiatrist, who was not related with the hospital, while she was at the Robert Young Center. And, the patient was not allowed a pass to leave the facility after stabilization on her medication. The physician also allegedly asked personal questions of the family that were unrelated to the patient's treatment.

The second complaint states that the physician disliked the patient because of her desire to participate in her medical treatment plan and that the physician's actions were retaliation against the patient for speaking her mind about her medical treatment.

The third complaint states that the patient was admitted to the facility based on fraudulent claims made by the physician. The statements allegedly caused the patient to be at to the facility for a longer period of time and be transferred to a nursing home. At the involuntary hearing, the physician stated that the patient had conjunctivitis, Stage 3 Kidney Disease, high blood pressure, and Chronic Obstructive Pulmonary Disease (COPD) but did not present valid evidence regarding the kidney issues. A report also stated that the patient remained hospitalized involuntarily due to her bipolar disorder creating life-threatening conditions even though the conditions were controlled with medication at the time. The report also stated the patient had "potential renal failure" but at the commitment hearing it was stated that the patient has Stage 3 Kidney Disease. The allegations state that at the hearing for alternative placement, the physician presented no valid evidence that the patient's bipolar disorder was not under control and only stated that the patient was still showing signs of grandiosity.

Other allegations state the physician had the patient admitted into the psychiatric unit to alter her medication because they were dangerous and to do this, the patient must be admitted to the hospital. The complaint states while the patient was in the facility, she was given more medication than what was originally discussed with the physician. The patient agreed to this but then when the patient signed a 5 day discharge document to leave the facility he had her committed because of hand tremors caused by the medication that he gave her. The physician had previously told the patient that when she was voluntarily admitted, she could sign a 5 day to leave the facility.

The fourth complaint states that the patient was being kept at a facility even though she was functioning well enough to be discharged home. The complaint states that the patient's mental and medical conditions were improved and her blood pressure was under control but at the hearing she was committed to a nursing home because she still had Bi-polar Disorder. On another occasion, the patient's family attempted an involuntary commitment to the Robert Young Center (May 30, 2011) but the patient was voluntarily admitted and then was released within a week but was not stabilized.

The fifth allegation states that a complaint was made to the facility regarding the patient but no resolution was given regarding the complaint. The patient's family called the hospital inpatient services and was referred to the hospital's Risk Management. The family made complaints to the Risk Management staff regarding not being allowed a different physician, the commitment process, and the current physician treating the family and patient poorly among other complaints but the family never received a response from the facility.

Staff Interviews (1/19/2012)

The staff began the interview by stating that none of the complaints were substantiated by the hospital during the hospital's own investigation. The patient had voluntarily come to the hospital in March and the hospital had discharged her home to see if the family and patient could take care of the patient outside of the hospital. The facility stated that, during her most recent admit, the patient objected to taking medication even when the importance of taking medication was discussed with her. The patient told the facility staff that she would not take the medication if they sent her home. When that facility petitioned for alternative treatment the patient petitioned for a second opinion and the physician providing the second opinion agreed with sending her for alternative treatment. The staff explained that the patient's health was failing because she had been taking Lithium for such a long period of time. The facility had not seen the patient for several years and she had begun coming in for medication. The patient was at the facility emergency department often but was not part of the outpatient program. The staff said that she was having physical issues because of the Lithium and the patient had been on Lithium for 15 years or longer. The Robert Young Center staff stated that on 7/27/2011 the patient came in with medical and behavioral problems and she was admitted into the psychiatric unit. When she was first admitted, it was voluntarily and on the same day she signed a 5 day release from the facility, the facility petitioned for the involuntary commitment. The staff explained that the patient was admitted involuntarily because she was not taking care of herself due to the fact that she was not in the state of mind to take care of herself because of her diagnosis.

The first hearing involving the patient was for the involuntary commitment. The patient initially came into the facility because she stated that that her family was going to commit her, but at the hearing, the family stated that they did not want the patient committed. The Judge stated that the involuntary commitment was due to the fact that they had previously attempted treatment from home but that did not work so they would try treatment at the facility. The family petitioned for an alternative opinion (second opinion) which they received and the physician conducting the second opinion agreed with the commitment.

The family made a grievance directly to the hospital's Risk Manager. In the process of making the grievance, they said that they would send a letter of their complaints to other agencies. The Robert Young Center staff said that they would wait for the letter. Then the staff received the letter as well as the other agencies. The staff did not receive any other correspondence but then a Joint Commission complaint was received. On 9/23/2011, the family called the facility. The staff spoke with the family who said that the patient had no disease and that the physician lied in court along with other complaints. A family member stated that her issue was the actual court hearing. Staff explained that if there is an issue with the court proceeding family members need to contact Risk Management and contact the patient's legal counsel. Staff referred the family to the Risk Manager because the complaint did not directly deal with the hospital therefore it was not considered an inpatient complaint. On 9/26/2011, there was another complaint made to the hospital from the same individuals and the complaint dealt with court and the judge's decision. The staff directed the individuals back to the Risk Manager and public defender. On 10/4/2011, the staff received the letter that the Risk Manager discussed with the family. When the Risk Manager discussed the letter with the family, they stated that they were going to send the letter to the Illinois Guardianship and Advocacy Commission (GAC), so the facility decided not to take action on the complaint because the GAC would be a good 3rd party investigator.

The physician at Robert Young stated that the patient never requested another psychiatrist but rather he asked if the family wanted another physician and said that he would send them the documentation for transferring to another physician. The staff stated that this was never documented in the records. The family thought that no other physicians would take Medicaid. The facility stated that they have documentation regarding the patient's concern over being transferred to the nursing home and that she said she would not take medication when discharged. The staff stated that they attempted to contact the family to discuss options like obtaining guardianship.

The facility staff explained that their grievance policy is the Joint Commission standard. If the complaint is inpatient, then they try and resolve the grievance during the patient's stay and if not, the facility responds to the grievance within 7 days. The staff also stated that no letter is required if the individual is inpatient. The staff explained that they actually did not have an inpatient grievance when speaking with the family. The staff did state that when they spoke with Risk Management, the family was upset with the patient's physician.

The staff discussed the complaints concerning the physician. The staff stated that there is no evidence in the record documenting poor treatment. The staff did say that there were confrontational situations with the physician creating boundaries documented and the patient was

also documented as being rude to the physician. The patient participated in treatment planning but, after awhile, she stopped. The care plan team met 3 times a week with an interdisciplinary team. The staff said that she did not participate and meet in every team meeting but she did participate with the physician and the family. The staff explained that patients are not required to meet with the team. The patient disagreed with the treatment plan, medication, and being transferred to the nursing home. The staff stated that the patient made grandiose statements while at the hospital and she also did not believe that the Lithium caused her problems. The family believed that the facility lied in court but the facility did recieve a renal physician's opinion to prove that Lithium was causing problems. The patient visited the hospital 16 times and all of the visits were to the emergency department. The patient had four admissions into the hospital. The facility attempted using a visiting nurse at the patient's home to assure that the patient was taking care of herself but that situation did not work. The facility said that this was an attempt to try and assist the patient to improve.

The patient was involuntarily committed to the facility and was there for 57 days. Robert Young Center never gave the patient involuntary medication; the patient chose what she received. The staff explained that the patient did have bad tremors from some of the medication. The Lithium toxicity was diagnosed by the patient's physician at Robert Young. Although the physician knew the diagnosis, he had specialists officially diagnose and examine all the issues that were not non-psychiatric.

The staff stated that the family thought that the patient did not have kidney problems but the facility has documentation on how the Lithium was impacting the patient The staff stated that the physician may have asked about the patient's home situation but that was to gauge the patient's needs at home

The staff stated that the facility has an anti-retaliation policy and rights statements which are given to the patients. The staff also said that employees have an anti-retaliation policy. The facility staff did not receive a complaint from the family or the patient stating that the treatment was because of retaliation. The staff said that the facility practice is to explain all admission procedures. The staff explain voluntary versus involuntary commitment and the staff found evidence in the documentation that the facility discussed admission practices. The facility stated that they felt as though the family did not understand that the patient had kidney disease or that the Lithium was hurting the patient.

Findings (Including record review, mandates, and conclusion)

The HRA reviewed records and policies pertinent to the complaints cited in this report. The HRA reviewed two documents that provide background into the situation concerning the patient. A forensic report dictated by the physician, dated 8/22/11, reads "This [description of patient] remains hospitalized involuntarily on the psychiatric unit due to her bipolar disorder creating serious impairment in judgment with the consequence of inadequate management of life-threatening conditions involving severe hypertension, chronic obstructive pulmonary disease, and potential renal failure. It is this physician's recommendation that she be transferred to a lesser level of intensity care of service as her condition is chronic. It is this physician's opinion that due to the fluctuating level of cooperation the patient continues to require

professional medical supervision of her day-to-day needs. The patient does not realize that she has serious problems. She denies need for care. She continues to have fluctuation in her blood pressure that requires close monitoring to be sure that the prescribed medications adequately control her blood pressure. There are periods of time when she becomes slightly somnolent and needs to be have [sic] assistance with ambulation. The patient is continually needing a walker in order not to fall and has to be reminded in order to use that to assist her with her walking … Without continued medical supervision it can be expected that the patient will oppose medical treatment and will be inconsistent in taking medication. It is our understanding that there is a sister who is now voicing a willingness to assume responsibility as a guardian. However, she is already also expressing the conclusion that the patient does not need nursing home care."

Another document, also dictated by the physician, and dated 9/27/2011, reads "This [description of patient] was admitted involuntarily to the psychiatric unit because of bipolar manic symptomatology with agitation, impulsive behavior, inability to care for her medical needs, grandiosity, argumentativeness, and episodes of physical aggression directed at her family when they were attempting to limit her dangerous behavior. The patient was admitted to the hospital and taken in front of the court and found to be subject to involuntary care, which was continued during the two months of her hospitalization. The patient was felt appropriate for discharge to a lesser setting. However, she objected to this and a second opinion was sought from [physician]. A second court hearing was had in which again it was felt appropriate for her to be maintained on an involuntary status due to the findings of [second physician], her continued incontinence, and serious medical problems. Finally, the patient was felt suitable for nursing home placement and was discharged to [nursing home] on an involuntary basis. During the hospitalization, there were repeated efforts made to work with the family regarding the situation. Their position, however, was that they did not see a need for continued hospitalization and wanted her turned over directly to them. They appeared in court on several different occasions en masse regarding these issues, submitting a petition to the judge for her involuntary care to be given at home. The patient's family was advised repeatedly after the first court hearing that she needed a guardian. Only at the juncture just before discharge did one of the siblings decide to take responsibility for the situation and become her guardian." The document also reads "The patient's attitude throughout the entire 60 day stay was one of subtle and at other times obvious defiance about her need for care. She was demonstrating poor retention of information having been repeatedly advised, one that she was not a good candidate for the use of Lithium and two that she needed strict control of her blood pressure. The patient never gained competence during the hospitalization as to managing her medical problems."

Complaint #1 - Inadequate treatment, including physician making verbal/hostile threats and remarks towards patient, patient not allowed to participate in treatment plan, facility not discussing treatment with family even though a release was signed by patient to do so, physician asking personal questions of the family that were unrelated to treatment, patient told she could not see an outside physician for alternative services when dissatisfied with current physician , inadequate access to medical treatment while on unit

The HRA reviewed each aspect of this complaint separately within this report. The first aspect of the complaint stated that the physician made *verbal/hostile threats and remarks towards patient.* In this report's complaint statement, it was stated that the physician made

statements such as asking the family if they are doctors, informing the patient that she has nothing to blame on the illness but herself, informing the family that they did not know what the patient has said to the physician over the years, stating that the patient will give the family a "fit" if she is released. It was also alleged that the physician became agitated when he had to speak with the family and that he used his power and authority to "bully" and "punish" the patient. The HRA reviewed physician notes, nurse's notes, treatment plans, contact notes, as well as other parts of the patient's record and saw no evidence of the actions alleged above occurring.

Part of the complaint statement indicates that the physician stated that the patient was "cocky" because she spoke her mind about her treatment plan. In reviewing the physician's progress notes (that were dictated from handwritten notes to typed notes by the facility), the HRA read a progress note, dated 8/20/2011, which states "Sleepy. Reluctant to speak with me, but cooperates somewhat in a cocky fashion." Although this was written in the notes, there is no evidence that the physician directly stated that the patient was "cocky." Another section, dated 8/29/11 reads "… only concern is when will she be discharged. Affirmed my willingness to do that as soon as everyone else does their job." This notation indicates that there may be some irreverence on the physician's behalf but, again, there is no evidence that this statement was said directly to the patient or the family although the statement is located in the documents which the patient has access too.

The HRA is concerned regarding a section of the nursing notes in the patient's records. On 9/22/2011, a passage reads "Patient refused her am Haldol and Depakote. Informed [physician]. He wanted patient to be informed that if she refuses medications, we can take her back to court and have medications ordered. Explained this to patient, she became irate [sic] and stated 'I am a human being, take me to court. I don't have to take any medications I don't want to. I have a choice.' Patient unpersuaded. Patient with concrete thought process. Emotional support given. Encouragement given to talk to Dr. about her feelings, thoughts, and concerns." According to the notes, the medication was not taken by the patient until 9/24/2012 and the passage reads "She is very angry after her visit with [physician] but she came up and asked to take the depakote and Haldol she had earlier refused. This was reported to the doctor. Patient said something about there is no more slavery, referring [sic] to her thoughts that [physician] is trying to control her." Although this action does not appear to be forced medication in the traditional sense, the HRA feels as though this could be construed as coercion on the part of the physician and hospital staff.

The HRA also reviewed two previous HRA complaints that dealt with physician's treatment towards patients. A previous report from 2009 (case #09-090-9006) that deals with a complaint that the attending physician was rude to a recipient's spouse and this allegation dealt with the same physician noted in this complaint. There was another report from 2009 (case #09-090-9002) that dealt with the facility not acting responsive when a patient expressed dissatisfaction with the patient's physician. This was not the physician dealt with in this report. The complaint from report 09-090-9006 was not substantiated due to lack of evidence and 09-090-9002 was not a direct complaint regarding the physician's care but rather dealt with the facility grievance process.

The second aspect of the complaint states that *the patient was not allowed to participate in the treatment plan.* The HRA reviewed 26 review sessions for the patient's treatment plan between 7.27.11 and 9.26.11. During that time, only the first treatment plan was signed by the patient on 7.27.11 and the rest where not signed with no reasoning given for the missing signature. On the first treatment plan sheet, it reads that the client was unable to participate and that there was no family participation. It is written on the sheet that this was "reviewed and agreed" upon. There are no other sheets making statements like this with regard to the other treatment plans. On the sheet, it reads "Signatures Below Reflect Agreement with my/our Treatment Goals and Plans for my/our Recovery Along With an Estimated Discharge Date from my/our Current Level of Care. I (We) Helped Write this Treatment Plan and Assume Responsibility to Complete this Plan." The HRA saw no direct evidence that the patient was not allowed to participate in treatment planning.

The third aspect of this complaint states that *the facility did not discuss treatment with the family even though a release was signed by the patient to do so.* The HRA reviewed consents and it did appear that some of the patient's family members had consents signed to be allowed information regarding the patient's treatment. Other family members had consent only to know that the patient was in the facility and one family member had consent changed from being allowed information regarding treatment to only having the knowledge that the patient is at the facility. The consents were signed between 7/27/11 and 8/17/11.

The HRA saw indications in the patient's records that the patient's treatment was discussed with the patient's family but at times it was not specific as to which family member the information was disclosed. The nursing notes read on 9/24/12 that "Family session held this afternoon with patient, [family member], [family member] and [family member]. Counselor went over all of patient's medications and reason for medication." This exchange was only 3 days prior to the patient being transferred to a nursing home. Also, in the nursing notes on 9/24/11, it reads "[Patient] had a family meeting concerning her meds and counselor said that it went well." A physician/nurse communication sheet dated 7/27/11 reads "Received a message from [patient] sister [sister's name] requesting a return call. Nurse returned call, [sister] states she was aware that [patient] 'checked herself in' to the hospital. [Sister] states she heard from the visiting nurse and a friend from work that there is a long-acting injectible form of lithium and she wonders whether this would be a possibility in treating [patient] … She asks that [physician] be consulted about the existence of the long-acting injectible version of lithium and whether this would be an appropriate treatment, will consult with [physician]." A physician's note reads dated 8/3/11 "[Family member] advised to seek guardianship for purposes of nursing home placement due to patient's lack of cooperation with family." On 9/26/11 the nursing notes read "Eye looks less red today and splint stayed on all night. [Physician] would like to speak to [family member] about the left eye if she comes to visit patient." The HRA saw no documentation indicating that information was kept from family or that family was not to be allowed to discuss treatment.

In the physician's notes, on 9/8/11, it reads "Family unaware of second opinion being ordered by judge." Although this may indicate that the family is not being communicated with, it is not enough evidence to substantiate because their could be a number of reasons why the family is unaware of the second opinion.

Another part of the complaint states that *the physician asked the family personal questions that were unrelated to treatment.* The HRA saw no evidence that the physician asked the family personal questions, and as stated in the interview portion of this report, the HRA did see indications that the physician discussed guardianship and the patient needing resources in the home. Although this is prior to the patient's admission into the facility, a contact note dated 7/22/2011, which was an occasion in which the patient came to the facility prior to the 7/27/2011 admission, states that "The family was notified about the situation. They indicate that they will have people administer the medication to her. The patient will be seen in 21 days with the understanding that if she does not cooperate with the treatment the family should go to the states attorney's office and petition for involuntary care." A physician's note dated 8/3/11 reads "[Family member] advised to seek guardianship for purposes of nursing home placement due to patient's lack of cooperation with family."

Another aspect of the complaint states that *the patient never received treatment or further diagnosis for her shortness of breath which could have been heart related.* The HRA reviewed evidence indicating that at times the patient accepted treatments but on other occasions the treatment was not even accepted. In the physician's notes there were references to the patient's breathing such as an entry on 8/4/11 which read "Conversation is a little accelerated, interspersed with short, frequent breaths and delayed expiration." Another entry on 8/7/11 states that the patient "Talks about having bronchitis" while other entries state that the patient is "Slightly dyspneic" (8/12/11) and has "Slight dyspnea" (8/14/11).

An entry in the nursing notes on 7/31/12 reads "Patient making humming noise when exhaling. States this is normal for her and denies shortness of breath … Patient is med compliant as prescribed (except Albuterol inhaler)." Another note on 8/12/12 reads "Patient is refusing to take her inhalers for asthma, she is taking all other medications." There are other occasions where the patient accepted the inhaler, for example, on 8/6/12 the nurses' notes read "Pt was handed her inhaler at 1540 upon request because she had refused it earlier." Another note on 8/14/12 reads "Pt continues to get breathing treatment and inhaler …" Another statement on 9/5/12 indicates that the patient was associating the use of her inhaler with being committed to a nursing home. The passage reads "Pt refused to take her inhaler. She states that the reason she doesn't want it is because she doesn't want to go to a nursing home."

In the patient's record, there are other documented occasions where the patient received medical treatment. On 8/12/12, there is a passage that reads "Patient focused on getting eye drops. Stated her eyes are like sand paper. Patient did have a small amount of yellow drainage from left eye … Doctor notified of patients complaint and eye drops ordered." Another note from 9/11/11 reads "Pt asks for ASA for a headache, and R jaw pain from a bad tooth. States that she has a dental app't for the 18th (which is a Sunday), and doesn't want to still be a pt. then. Rated her pain as 8/10. [Patient] was asleep by 0115, after taking the ASA." According to the notes, the patient received more medication for the tooth pain on 9/12/11 and 9/13/11. The tooth pain is not mentioned again after that date. There is another nursing note on 9/25/11 where the patient received medical attention for an eyeball issue.

Another part of the complaint states that *the patient was also allegedly not allowed to visit another psychiatrist, while she was at the Robert Young Center.* In reviewing the

documentation, the HRA saw no request made by the patient to be allowed to visit another psychiatrist. The HRA did review evidence that the patient had a second opinion regarding alternative placement. The HRA also reviewed a blank form presented by the hospital titled "Request for Transfer of Physician" which indicates that the hospital would possibly allow a physician transfer.

In the Patient's Bill of Rights, which is located in the Admission Guide, it reads that patients have the right "To consult with another doctor or specialist at his/her own request and expense."

The final aspect of the complaint states that *the patient was not allowed any pass after stabilization on her medication.* In the nursing notes, on 7/30/12 it reads that the patient "Argued with [physician] thinking that she needed a pass today and none was ordered." In the physician's notes, on 8/2/11, it reads "Making repetitious humming sound; reports this is to calm her nerves down. Focusing on being discharged and having a pass with male peer." Another physician's note on 8/4/11 reads "Wants a pass to get car."

The patient signed an application for voluntary admission on 7/27/11, and according to the nurses' notes, the patient signed a 5 day discharge on same day. In reviewing the patient's record, the HRA read a petition for involuntary admission dated 7/29/11 and two certificates both dated 7/29/11. There is also a notice for a court hearing on 10/4/11. The certificates indicate that the patient was detained because of an emergency and to prevent the patient from causing self harm. The process of committal that was taken above indicate that the patient would not be allowed a pass to leave the facility.

The Mental Health and Development Disabilities Code reads "§ 2-102. (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. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient" (405 ILCS 5/2-102). The 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).

Conclusion - Complaint #1

Due to lack of evidence, the HRA finds this complaint **unsubstantiated** but offers the following **suggestions:**

- Because it is a patient's right to review their records and they could see what is written about them, when writing notes about a patient, use the same discretion and thoughtfulness that would be used when speaking directly to a patient and avoid the use of subjective references and language that could be perceived as abusive or derogatory.
- The HRA feels as though the passage from the nurse's notes cited above regarding reminding the patient that they could petition a court order for medication if she

does not comply with medication is bordering on coercion of the recipient and forcing medication without following the rights restriction process. The HRA suggests the staff be educated on coercion and forced medication and discuss avoiding these types of situations.

- Although initial treatment plan was signed, the rest of the plans were unsigned by the recipient with no reason given as to why the plans were unsigned. The HRA suggests that the facility give an explanation as to why the plans are unsigned in the future.
- The staff stated that the facility asked the patient if she would like to be transferred to another physician but did not document that this occurred. The HRA suggests that facility remind staff to document all recipient milestones especially situations as important as this.
- Because this complaint is very similar to complaints made in previous reports, the HRA has some concerns regarding possible patterns in the physician's treatment towards patients. Although the complaints were all unsubstantiated due to lack of evidence, the HRA still feels as though this may be an issue that the facility should investigate due to the possibility of physician to patient patterns of interaction that are not conducive to therapeutic interventions.
- Although the passage regarding the family not being aware of the second opinion cited above is not enough to substantiate the complaint, the HRA is concerned as to why this was not being relayed to the family. The HRA suggests the facility assures that information is being provided to individuals who have been given consent.
- A passage in the physician's notes reads "[Family member] advised to seek guardianship for purposes of nursing home placement due to patient's lack of cooperation with family." (date 8/3/11). The HRA is concerned that the passage indicates that the physician believes that a guardianship would force nursing home placement, however the Illinois Probate Act requires decisions made by the guardian be made in accordance with an individual's wishes whenever possible (755 ILCS 5/11a-17). Guardianship decisions against an individual's wishes may require further court involvement, and most courts do not grant placement authority to private guardians (755 ILCS 5/11a-14.1). The HRA suggests that the facility review the role, responsibilities and limitations of adult guardianship.

Complaint #2 - Retaliation against patient for disagreeing with treatment plan

In reviewing the records, the HRA found no evidence that there was retaliation against the patient for disagreeing with the treatment plan. The HRA did review multiple instances where the patient disagreed with the treatment. For example, the nursing notes on 7/28/11 read "Patient has poor insight and judgment. Patient refuses psych medication stating 'I'm not psychotic, I don't need that.'" Another nurse's note, dated 8/14/11 reads "Patient also believes we are trying to poison her with the medications. Feels it is a punishment to be here." A note on 8/23/11 reads "She wants to go home and is upset that no one will listen to her and let her go home. Report states her sister doesn't want her to go to a nursing home." Another note on 9/23/11 states "Pt has been refusing to take her Depakote and Haldol today stating she doesn't have any of the 'side effect' and doesn't need it."

In the Patient's Bill of Rights located in the patient admitting guide, it reads that patients have the right "To complain without fear of compromising his/her care."

The facility grievance policy also states "At no time shall a concern or grievance be used to deny a patient current or future access to services provided by Trinity Regional Health System" and "Patients and their families have the right to communicate any complaints or grievances that arise in the provision of their care, without the threat of discrimination or reprisal."

If allegations were substantiated, they would be in violation of the Mental Health and Developmental Disabilities Code as stated in the previous complaint (405 ILCS 5/2-102 & 112).

Conclusion - Complaint #2

Due to the lack of evidence, the HRA finds this complaint **unsubstantiated** but offers the following **suggestion:**

- In reviewing the facility policy, the HRA feels as though there could be more emphasis on the facility's stance against retaliation provided to the patient. The patients may feel more empowered and comfortable to participate in their own treatment if they feel that the facility will not retaliate against them for expressing grievances, complaints, and opinions.

Complaint #3 - Inadequate admission process, including physician making fraudulent claims to receive petition for transfer to nursing home & Complaint #4 - Inadequate discharge, patient is being kept at facility although she is functioning well enough to be discharged home and at a previous admission, patient was released before being ready for discharge

The HRA combined complaints number 3 and 4 because of their relation.

As previously stated, the patient signed an application for voluntary admission on 7/27/11, and according to the nurses notes, the patient signed a 5 day notice on the same day. In reviewing the patient's record, the HRA reviewed a petition for involuntary admission dated 7/29/11 and two certificates both dated 7/29/11 (both certificates were from separate physicians). There is also a notice for a court hearing on 8/4/11. The certificates indicate that the patient was detained because of an emergency and to prevent the patient from causing self harm. A note in the record states that at the August 4th hearing, the Assistant Public Defender motioned for continuance on August 9th. The admission process was followed in accordance with the Mental Health and Developmental Disabilities Code as far as action taken for petitions, certificates and hearings.

The petition for the patient, dated 7/29/11, indicates that the individual is "a person with mental illness who: refuses treatment or is not adhering adequately to prescribed treatment; because of the nature of his or her illness is unable to understand his or her need for treatment;

and if not treated on an inpatient basis, is reasonably expected based on his or her behavioral history, to suffer mental or emotional deterioration and is reasonably expected, after such deterioration, to meet the criteria of either paragraph one or paragraph two above." The paragraphs cited in the passage state that the person my place themselves or another in physical harm or engage in conduct placing themselves in a situation where they may become physically harmed, or that the person cannot tend to their basic needs without assistance or inpatient care. The written section of the petition reads "Patient is not accepting treatment for her hypertension and emphazema. This becomes life threatening. She has bipolar disorder and is not accepting treatment for that. She is manic paranoid."

The HRA reviewed a petition for alternative treatment dated 8/30/11. On that petition, it reads "Those persons in charge of Respondent's care at the RYC have since determined that, while Respondent still requires treatment for her bipolar condition, manic type, her continued needs could be met in the less restrictive environment of a nursing home." Another petition that is not dated reads "Those persons in charge of Respondent's care at the RYC have since determined that Respondent's continued needs could be met in the less restrictive environment of a nursing home."

The HRA reviewed a court order (the date of the order was illegible) for independent evaluation to determine least restrictive environment for continued care. The evaluation states that the patient was administered the Wechsler Adult Intelligence Scale. The evaluation states "All [patient's name] subtest scores fell within the average to well below average ranges … Her relatively more intact verbal skills likely mask extremely poor nonverbal or spatial-pattern information processing ability. Her style of functioning might be described as one allowing her to see the proverbial 'trees' but not the 'forest.' Her probable ability to plan, organize, multitask, and keep an appropriate perspective in her day-to-day world seems to be extremely impaired … [Patient's] evident marked cognitive deterioration may result from age, chronic high blood pressure, and/or her bipolar disorder individually or in combination. Her very poor (deteriorated) functioning likely would leave her quite incapable of managing her daily affairs, including her health, and exhibiting good judgment, even during times when her medication is well adjusted, as was true during this evaluation." The evaluation proceeds to state that "It is recommended that [Patient] be regarded as functioning so poorly in the manners described above as to be unable to manage her mental and physical health needs such that continued intense mental health treatment assistance for her, as is available at the Robert Young Center, is both warranted and necessary at this time … It is recommended that the Robert Young Center not be regarded as the least restrictive environment for [Patient] in the event that she is afforded an opportunity to reside in a setting providing daily intense skilled nursing care and periodic mental health assistance, such as would be the case in an appropriate licensed nursing home setting." The evaluation also states "It is recommended that it also be explored whether said level of care might be adequately effected within [the patient's] home setting, e.g., with the assistance of visiting nurses." The evaluation also states "It is recommended that physicians treating [the patient] consider the benefit of referring her for a sleep study to rule out the possibility of an untreated sleep disorder perhaps exacerbating her negative symptoms."

The HRA reviewed documentation of a consultation dated 8/6/2011 for "acute kidney injury, hypertension and difficult to manage hypertension [sic]" which reads "The patient has a

history of bipolar disorder and she has been on lithium for 30 years which has recently discontinued because of concerns for the elevated cretonne." In the assessment and plan it reads "Chronic kidney disease, stage 3. Her baseline creatinine is around 1.6. The etiology of her chronic kidney disease is hypertensive nephrosclerosis and lithium chronic nephrotoxicity." This evaluation was conducted by a physician other than the patient's primary psychiatric physician.

In reviewing the records, it appears that the patient was not kept at the facility or transferred to the other facility directly because of physical medical issues but because of her mental health issues that had shown signs of affecting her physically and potentially being dangerous. The HRA did not see any evidence that the patient had to remain hospitalized due to her bipolar disorder creating life-threatening conditions but more because the patient did not have the capacity for self care that could potentially lead to possible life threatening conditions. The HRA saw no evidence of fraudulent claims made by the physician at the hearing and it would be out of the HRA's jurisdiction to evaluate the patient's medical needs. The HRA did not review any transcripts of the actual hearing because the information provided within the records was enough to determine if there were findings. Part of the complaint states that at the hearing for alternative placement, the physician presented no valid evidence that the patient's bipolar disorder was not under control and only stated that the patient was still showing signs of grandiosity. Although the HRA did not see evidence of the actual hearing, the HRA did review the petition for alternative placement and the evaluation that was completed by the independent physician which indicates that the facility and the independent physician felt as though the patient needed continued care.

The HRA also did not see evidence that the patient was given more medication than what was originally discussed and then was denied release because of hand tremors. The HRA did not review any evidence that the physician discussed any amount of medication that was to be taken. The HRA also saw no evidence that the patient was admitted to alter the medications and the HRA saw no evidence that the patient was told with certainty that she would be able to leave the facility once the drugs were altered. The nurse's notes between 7/27/11 and 7/29/11 indicate that the patient stated she was only their to alter her medication, then she would not take medication that was not Lithium and signed a 5 day notice, and on 7/29/11 the facility petitioned for voluntary commitment. What the HRA reviewed (as shown in this report) indicated that the patient was displaying behaviors that the facility felt would endanger her due to her lacking the ability to care for herself.

Because the HRA did not review transcripts from the commitment hearing, no evidence was seen that indicated whether it was stated at the hearing that the patient has Stage 3 Kidney Disease or potential renal failure but, as stated previously in this section of the report, the patient was petitioned for alternative treatment because of her bipolar diagnosis and the fact that the facility still felt as though the patient needed assistance in treating that diagnosis not directly because of physical medical issues.

Regarding the fourth complaint, in reviewing the records cited in this report, the HRA saw evidence that the facility did not feel as though the patient was functioning well enough to be discharged home. This fact was seconded by an independent physician and also was determined by the court in the involuntary commitment hearing as well as the hearing for

alternative placement. The documentation did indicate that the patient had improved and that was actually the reasoning for the alternative placement; to place the patient in a less restrictive environment than the hospital setting because of the patient's progress.

In regard to the aspect of the complaint that states on one occasion, the patient was released from the facility before being ready for release, the HRA reviewed physician paperwork for an admission of 5/29/11 and discharge of 6/2/11. The physician's summary stated that the patient was admitted into the psychiatric ward but because of persistent dyspnea, the patient was moved to a medical floor. After the patient was stabilized and ready to return to the psychiatric ward, the notes, dated 5/30/2011, read "She resisted doing that and her family maintained that they would take her home rather than insist that she return to the psychiatric unit. Upon discharge, the patient became somewhat erratic and uncooperative with her family, having not had any provisions made for continuation of treatment. The patient was brought back to the hospital by police intervention and was demonstrating shifts in attitude about her situation sometimes being agreeable and other occasions being oppositional, attempting to dictate to medical staff what she would do, namely be able to smoke if she was going to be admitted to the hospital." There is another set of the physician's summary dated 6/15/2011 that explains that the patient was readmitted to the hospital. The note explains that medication was administered and "The patient became calm, quiet, polite, cooperative and was not oppositional, defiant, demanding. She was not showing any pressured speech. There was no evidence of sedation. Her sleep-wake cycle was normal. It was felt the patient could be discharged again … The patient will be followed on an outpatient basis for follow-up for consideration of revision of bipolar medicines when necessary." The documentation indicates that the patient was released when the facility felt that she was stabilized.

The that HRA reviewed a form titled Psychiatric Voluntary Admission. On the form there is a completed section stating that the facility investigated the presence of a Healthcare Power of Attorney with the patient. Another section of the same form has a section dedicated to documenting that it was determined that the patient has capacity to consent to voluntary admission. In this case, the section was not completed. The HRA saw no other area or form determining that the patient had the capacity to consent to voluntary admission.

The HRA would also like to reference a previous HRA report (10-090-9032) where the complaint stated " … the patient was taken upstairs to Robert Young to 'stabilize' and was allegedly told she was just going to be there overnight; then the next day was told she could not leave. The complaint states that Robert Young told a patient that she was involuntary but never explained to her that she could not leave whenever she wanted. The complaint states that a doctor told the patient she would be there 3-7 days and she was in Robert Young for a month without knowing why she was there." There were no substantiated findings in that report.

The HRA reviewed mandates in accordance with the complaints. The Mental Health and Developmental Disabilities Codes states "(a) Any person 16 or older, including a person adjudicated a disabled person, may be admitted to a mental health facility as a voluntary recipient for treatment of a mental illness upon the filing of an application with the facility director of the facility if the facility director determines and documents in the recipient's medical record that the person (1) is clinically suitable for admission as a voluntary recipient and (2) has

the capacity to consent to voluntary admission. (b) For purposes of consenting to voluntary admission, a person has the capacity to consent to voluntary admission if, in the professional judgment of the facility director or his or her designee, the person is able to understand that: (1) He or she is being admitted to a mental health facility. (2) He or she may request discharge at any time. The request must be in writing, and discharge is not automatic. (3) Within 5 business days after receipt of the written request for discharge, the facility must either discharge the person or initiate commitment proceedings" (405 ILCS 5/3-400).

In regard to voluntary patient discharge, the Code states "A voluntary recipient shall be allowed to be discharged from the facility at the earliest appropriate time, not to exceed 5 days, excluding Saturdays, Sundays and holidays, after he gives any treatment staff person written notice of his desire to be discharged unless he either withdraws the notice in writing or unless within the 5 day period a petition and 2 certificates conforming to the requirements of paragraph (b) of Section 3-601 and Section 3-602 are filed with the court. Upon receipt of the petition, the court shall order a hearing to be held within 5 days, excluding Saturdays, Sundays and holidays, and to be conducted pursuant to Article IX of this Chapter. Hospitalization of the recipient may continue pending further order of the court" (405 ILCS 5/3-403).

Conclusion - Complaint #3 and #4

The HRA did not find that the physician had made fraudulent claims, that the patient was kept at the facility although she was functioning well enough to be discharged home, or that the patient was released before being ready for discharge in a previous admission. The HRA also did not substantiate the other aspects of the complaint that are stated within this report. However, the HRA did discover that the facility failed in obtaining the patient's capacity to consent to voluntary commitment, which is a direct violation of the admission process as stated in the Mental Health and Developmental Disabilities Code (405 ILCS 5/3-400) and therefore finds the complaint **substantiated.** The HRA notes that the complaint is only substantiated regarding the failure to obtain capacity to consent to admission. The HRA offers the following **recommendations:**

- Per the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-400), create policy/procedure that follows the Code's regulation that the capacity for consent to voluntary commitment is followed by staff and educate staff in the policy/procedure. Provide the HRA with evidence of the education. If policy/procedure already exists, re-educate staff in obtaining capacity for consent and provide the HRA with evidence of the education.

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

- In reference to the previous HRA report (10-090-9032), the HRA would like to state that this is a very similar complaint and although there were no findings, the HRA still feels as though this is bordering on becoming a pattern. The HRA suggests that the facility investigate this possible pattern and make needed changes.

- In reviewing the case, the HRA has some concerns regarding communication between the facility and the patient/family. There seems to be a definite disconnect regarding the information provided in the patient's record and the HRA suggests that the facility work on creating a more open communication track between the facility and the patients/caregivers.
- The HRA reviewed the second opinion evaluation and saw that the physician had stated recommending exploring home care with the patient, which is what was desired by the family. The HRA acknowledges that the facility had attempted home care in the past but this was also known by the physician providing the second opinion and presumptively that physician was also aware that this technique had been tried because but still felt as though it would be a good recommendation for the patient. The HRA is not an agency that provides medical services and recognizes that the reasoning for not providing the patient the least restrictive environment recommended is out of their jurisdiction but the HRA would still like to mention that this occurred and there was no direct reasoning in the documentation as to why the recommendation from the second opinion was not followed. There is also a recommendation that the patient receive a sleep study and the HRA saw no documentation regarding as to why that recommendation was not followed. The HRA suggests that when recommendations are not followed, the reasoning should be documented within the record.

Complaint #5 - Inadequate grievance process, a complaint was made to the facility but no resolution was given regarding the complaint

The HRA reviewed documents dealing with the grievance process at the facility. The HRA reviewed the hospital's grievance policy comparatively to the Center for Medicare and Medicaid Services (CMS) interpretive guidelines (which are found on the CMS website), and CMS regulations.

The HRA viewed the "Patients' Bill of Rights" which states "An administrator is available 24 hours a day, seven days a week to help resolve issues concerning hospital stay. Call [phone number] for personal attention from an individual ready to listen to your concerns." The HRA did not review a copy of the other documents listed in the grievance policy as mechanisms for notification for complaint/grievance resolution. The HRA did review a document given at admission to patients regarding contacts to report a complaint to the Joint Commission on Accreditation of Healthcare Organizations.

The HRA saw no documentation regarding the complaints that the facility stated were referred to the Risk Manager in the interview. What occurred in the complaint statement does match the events explained by the Robert Young Center staff regarding the facility being contacted and being referred to the Risk Manager.

The HRA reviewed a letter sent to the Robert Young Center which reads "We, the undersigned [relationship to the patient] of [patient] are writing to file a formal complaint against [physician] for wrongful confinement of our sister [patient] at the Robert Young Center, Rock

Island, IL for 53 days and his petition to transfer her to a nursing home for continued alternative treatment … [Physician] continuously makes verbal and hostile remarks/threats to our [gender/relation of patient] constituting 'emotional cornering.'" The letter proceeds to illustrate complaints. The letter is dated 9/28/11 and addressed to the President of the Robert Young Center with copies being furnished to other agencies and individuals. The HRA also reviewed a similar letter that was addressed to a different agency dated 10/4/11. Both letters are signed by people that were not the patient. The HRA reviewed three letters (both letters were unsigned; with no proof that the letters were sent) from the facility to the individuals making the complaint. Two of the letters where very similar and looked to be drafts of the same letter and was dated 11/08/11. The letter begins by stating "This is to confirm our conversation of 11/08/2011 regarding your complaints against Robert Young Center." The end of the letter reads "We anticipate due to the number of complaints that this will probably take a minimum of 30 days … We wanted to apologize for the delay. I had talked with [relation to the patient] on the day of [Patient's] discharge. I was told at that time that the letter would be coming and that the letter was directed to [agency]. In my conversation with [relation to patient], we had anticipated we would hear from [agency] and they would be doing an independent investigation and we were going to use that as vehicle for response; however, with the [second agency] complaint, we are required to response within 30 days so there will probably be a series of responses here." The HRA reviewed another letter on January 3rd, 2012 from the facility to the patient and individuals involved in the complaint. The letter begins "We have completed an internal investigation of your family's complaints. As part of that investigation we reviewed your records, talked with key personnel and talked with both you and your family representative. We are also awaiting the [agency] review that will offer an independent evaluation. Using the concerns you've raised we are looking at our communication with patients and families especially in conjunction with the legal process."

The letter proceeds to ask the family for feedback. The letter never really states a defined outcome of the investigation but rather states that "Using the concerns you've raised we are looking at our communication with patients and families especially in conjunction with the legal process" and then asks to meet with the family and states that Robert Young is waiting for this agency to complete a review. The facility asks that the individuals addressed in the letter respond as to how they would like to proceed.

The facility policy states that the "Grievance should be acknowledged within 7 calendar days." The policy also states "If a resolution cannot be completed within 7 calendar days, then an acknowledgement letter will be sent to the complainant within the time frame of receipt of the grievance, stating that a resolution letter will be sent within 30 days … If resolution cannot be completed within 30 days, a letter will be sent to the complainant as to when to expect the resolution." The first complaint letter was dated 9/28/11 and the first letter from the facility in response to the complaints was dated 11/08/11. The facility response does not fall into the 7 days stated in the facility policy.

The CMS interpretive guidelines read "On average, a timeframe of 7 days for the provision of the response would be considered appropriate. We do not require that every grievance be resolved during the specified timeframe although most should be resolved … If the grievance will not be resolved, or if the investigation is not or will not be completed within 7

days, the hospital should inform the patient or the patient's representative that the hospital is still working to resolve the grievance and that the hospital will follow-up with a written response within a stated number of days in accordance with each hospital's grievance policy."

The facility policy states that at a minimum, the resolution of the grievance must provide the patient with a written notice of a decision, and contain the name of the Trinity contact person, a review or statement identifying what the grievance is from the complainants' point of view, steps taken on behalf of the facility to investigate the grievance, the result of the grievance process and the date of completion. As stated above, the facility never states a defined outcome of the investigation. The complaint also does not present an exact completion date of the investigation.

The CMS interpretive guidelines also read "The written notice of the hospital's determination regarding the grievance must be communicated appropriately to the patient or the patient's representative in a language and manner the patient or the patient's representative understands … The hospital may use additional tools to resolve a grievance, such as meeting with the patient and his family, or other methods it finds effective. The regulatory requirements for the grievance process are minimum standards, and do not inhibit the use of additional effective approaches in handling grievances. However, in all cases the hospital must provide a written notice (response) to each patient's grievance(s). The written response must contain the elements listed in this requirement."

The HRA reviewed sections of the CMS interpretive guidelines that state "All verbal and written complaints regarding abuse, neglect, patient harm, or hospital compliance with CMS requirements are considered grievances for the purposes of these requirements" but this did not appear in the Robert Young Center policy. The guidelines also state that data collected must be incorporated into the hospital's Quality Assessment and Performance Improvement but this did not appear in the facility policy. The guidelines also have a statement that "grievances about situations that endanger the patient, such as neglect or abuse, should be reviewed immediately, given the seriousness of the allegations and the potential for harm to the patient(s)" but this is not covered in the Robert Young Center grievance statement.

There is also a statement in the CMS guidelines that if the hospital has taken appropriate actions to resolve a complaint but the complainant is still not satisfied, then the hospital can close the case and also that the hospital is not required to include statements that could be used in legal action against the hospital. There is also a statement that the hospital is not required to provide an "exhaustive explanation of every action the hospital has taken to investigate the grievance, resolve the grievance, or other actions taken by the hospital." These sections did not appear in the Robert Young Center grievance policy.

The Centers for Medicare & Medicaid Services regulations read "(2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding

quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum: (i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital. (ii) The grievance process must specify time frames for review of the grievance and the provision of a response. (iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion" (42 CFR 482.13).

Conclusion - Complaint #5

The first letter that acknowledged the grievance was not sent within the 7 day timeframe that is cited in the facility policy indicating that the facility did not follow its own policy regarding response time for the grievance. The facility also did not follow policy and review/identify the grievance from the patient's point of view, nor was there an exact date of completion. The facility also had omissions in their grievance policy making it noncompliant with the with the CMS interpretive guidelines. Because of these factors, the HRA finds the complaint **substantiated.** Regarding the facility not following its own policy, the HRA does recognize that the complaint comes under possibly unusual circumstances for the facility in the fact that the complaint letter was also sent to other agencies who would deal with complaints and recognizes that this may be part of the reason for the non-compliance with timeframes. Regardless, the HRA still feels as though the facility policy should have been followed in this instance. The HRA offers the following **recommendations:**

- The HRA recommends that the facility review the CMS interpretive guidelines regarding grievances and update the policy to acknowledge all aspects of the guidelines. The HRA also requests that the facility staff are educated on the revised grievance policy and evidence is sent to the HRA that this education has been completed.

The HRA also would like to offer the following **suggestions** regarding other concerns discovered through its investigation:

- In reviewing the patient's treatment plan, the HRA saw that a section titled "Barriers to discharge" and the "Plan to overcome barriers" had not been completed on any of the plans. The HRA has concerns that these areas were not being completed in the treatment plan process in this case when, in fact, it could have helped the situation due to the fact that improper commitment was one of the main complaints of the patient. The HRA suggests that with future patients this section of the treatment plan is completed especially if it is a situation where the patient feels as though they have been unfairly detained.
- The Mental Health and Developmental Disabilities Code states "Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation" and "(c) Unimpeded, private and uncensored communication by mail,

telephone, and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission. When communications are restricted, the facility shall advise the recipient that he has the right to require the facility to notify the affected parties of the restriction, and to notify such affected party when the restrictions are no longer in effect." The same section of the Code proceeds to state that "However, all letters addressed by a recipient to the Governor, members of the General Assembly, Attorney General, judges, … or licensed attorneys at law must be forwarded at once to the persons to whom they are addressed without examination by the facility authorities. Letters in reply from the officials and attorneys mentioned above must be delivered to the recipient without examination by the facility authorities" (405 ILCS 5/2-103). The HRA feels as though there are passages that were reviewed in the record which may violate this area of the Code. In the physician's notes, on 9/7/11, it states "Makes cryptic comments about kangaroo court working at [prison name]. Will not elaborate on what she discussed with her attorney." The HRA is concerned because this statement may be bordering on violating the patient's privacy. A nurse's note on 8/30/11 reads "Client gets on the phone and calls the court house, speaks with someone there concerning her being on the unit." This is another example of the patient not receiving her right to private conversation as afforded by the Code because the nurse should not know who the patient is speaking with on the phone. Another note reads "Pt was irritable earlier during this shift, requesting to call her brother to help her contact her lawyer and report to him that her Doctor woke her up to talk to her while she was sleeping. Pt was however redirected and encouraged to talk to her brother after group therapy." This is bordering on violation of the Code due to the patient possibly not being allowed contact with her lawyer and communication with her brother. The HRA suggests that the facility educate staff in the patient's communication rights per the Code (405 ILCS 5/2-103).

- In reviewing the patient's rights form, it was noticed that under the section "Restriction of Rights Persons Notified" the address for the offices of the Guardianship and Advocacy Commissions is incorrect. The HRA suggests/requests that these addresses are updated so that patients receive the correct information.

RESPONSE

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

ROBERT YOUNG CENTER RESPONSE

TO

GUARDIANSHIP & ADVOCACY COMMISSION

RE: HRA No. 12-090-9006

The contents of this report are for the public response subject to review by the Guardianship and Advocacy Commission

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BACKGROUND

We appreciate the extent and thoroughness of the investigation conducted by the Guardianship and Advocacy Commission (G&A). The original complaint letter had approximately 20 identifiable issues which were winnowed down to the 5 areas addressed in the investigation and which contained 16 recommendations with 2 substantiated complaints.

From the numerous [redacted] complaints there is a very clear pattern of exception taken by the [redacted] and [redacted] against the plan of recommended treatment to the extent that there are accusations of misrepresentation, coercion and falsification of records. The perception of the [redacted] and [redacted] essentially being that the patient was railroaded into treatment against her will and against families will and that treatment was unnecessary and contra productive to the patients psychiatric condition.

On our facility side there was a perception of a pattern of deterioration of the patient's mental status and refusal of the patient and family to recognize the significance of the problems and the need for treatment. This pattern was evidenced in the increased emergency department and inpatient psych visits ([redacted] total visits in the [redacted] months prior to the hospitalization subject to the complaints) and included several discussions with patient and family regarding her condition and attempts to treat on an outpatient, voluntary and home care basis all of which failed.

It was this situation that set the stage for the admission under review. The core issue, however, was this chasm of perception and how we connect with patients and families to bridge it. We have interdisciplinary staffing meetings three times per week for which family and patients are invited for participation. TAs noted in the G&A report family and patient did not participate. The solution we developed was to have a mandatory meeting with staff, patients and family triggered when a patient has been on the unit for 14 days and every 7 days thereafter. This automatic review has the function of refocusing individual efforts to coordinate care and address issues for treatment globally with patients and their families.

While this addresses in general many of the concerns raised by the G&A (also discussed below) we want to specifically address the two substantiated complaints.

SUBSTANTIATED COMPLAINTS

One of the substantiated findings is that our facility was not in compliance with the grievance policy regarding these complaints. We dispute this finding.

As noted in the G&A investigation, administration, both for Robert Young and Trinity Risk Management was in contact with the patient and family during admission (page 4 of G&A report).

The attached policy was in effect at the time of the complaint letter. Under our policy a complaint is considered resolved when... "the patient is satisfied with the action taken on his or her behalf <u>or the hospital has taken appropriate and reasonable action to resolve</u>" (underline added page 1 bullet point 3 of attachment A).

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The original complaints from [redacted] was received prior to discharge of the patient and after confirmation with the patient Risk Management talked with the [redacted] and [redacted] at which time [redacted] discussed [redacted] letter and concerns and that [redacted] were sending this to G&A for investigation as well as indicating there were outstanding legal issues [redacted] were resolving through the court system. Risk informed [redacted] that G&A does an independent investigation and that we would defer to them given the number of complaints and pending legal actions involving those complaints.

It is our contention that this is an appropriate and reasonable action and under the policy did not call for additional written response. Our policy states:

> "B. Handling of the grievance/complaint while the patient is still here (inpatient or outpatient):
>
> The first step to resolution is at the point of contact. If the patient/client complains to staff present (staff, department manager, supervisor, Patient Relations, Risk Manager, or administrative staff) and he/she is able to remedy the situation that day or as soon as possible, this is the best and quickest was to resolve the situation." (attachment A page 3)

Given the chasm between the patient/family's perceptions and the facilities regarding the patient's needs the most viable resolution for [redacted] was going to be through the independent review of G&A and through the legal process The patient and family were not interested in working with us when we requested their involvement both verbally and in our letter to them. It is our contention that this plan as expressed to the family and patient at the time of discharge meets CMS and our policy requirements.

Under our policy there was no additional contact necessary until the second written complaint was received through the Joint Commission on [redacted] and which triggered the letter to the family on [redacted] within the 7 day period. A second letter with our results was sent to [redacted] on [redacted] and again cited the pending G&A investigation as well as a brief description of our results focusing on communication issues. These letters are cited in the G&A report but are not put in context of the complaints.

It is our belief that Communication is at the heart of all these complaints. The second substantiated complaint is with regard to how we communicated patient rights and our assessment of the patient's capacity to understand those rights with regard to a voluntary admission.

In the G&A report the foundation of this substantiated complaint was that our form for voluntary admission (Attachment B, page 4) was not filled out with the patient's name. You will note, however, that the page is stamped with the patient's identification and that there is no signature line other than at the bottom of the same page below a Power of Attorney section which is signed by the physician and witnessed (attached B, page 4). This signature is supposed to be

applicable to the entire patient right section but is not readily apparent due to the forms set up. This will be modified.

The G&A report notes there was no other section that addressed this issue (page 15). This is incorrect. There are assessments for level of understanding on preceding pages of the Patient Rights section (attachment B). Page 3 of our attachment notes level of comprehension is fair with regard to the rights for voluntary admit. In addition and most significantly page 2 states "I have read the above statement of rights or have had them read and explained to me" signed by the patient and witnessed by two registered nurses with the affirmation: "It was the opinion of the witness that [Patients Name deleted] had a general understanding of the rights reviewed."" This appears to have been missed in the review of the patient's voluminous records.

There is also no doubt patient understood the process since she subsequently exercised her rights that same day with a written 5 day notice (attached page 6).

We request that the Committee review its finding on the substantiation of these two complaints.

RECOMMENDATIONS

With regard to the recommendations presented in the G&A report we have taken the following actions. Complaints 1 and 2 which involve inadequate treatment and evaluation are addressed by our mandatory 14 day meetings. This will provide an opportunity for patients and families to vent concerns and for those concerns to be addressed in a multidisciplinary approach and have a unified treatment plan incorporating the family and patient, or triggering additional documentation when they do not participate..

In addition we have discussed with staff the lack of documentation on treatment plans, response to complaints and patient rights especially in conjunction with court proceedings. The hospital has also switched documentation systems to EPIC electronic medical records which has additional sections pertaining to patient care plan reinforcing our paper treatment plan.

In this same complaint section, there was an expressed concern that Guardianship of the patient by the family was requested by the physician to "force" nursing home placement. In clarification, the Guardianship was sought in conjunction with monitoring of involuntary meds for enforceability since there was a pattern of noncompliance with medications by patient in the family environment. That noncompliance was also the purpose of the court petitioned nursing home placement for continued treatment. It should be noted that ultimately family did seek guardianship which was subsequently used to discharge the patient from the nursing home. As pointed out in the G&A report Guardianship is monitored through the court and it was the physicians concern that there be a monitored environment for the patient. Given the history this would be reasonable and prudent and allow the family both input and control in a court monitored environment.

Complaints 3 and 4 were combined in the G&A report and center on the admission and discharge process, the substantiated portion was addressed above. The other recommendations again involve communication with the family and patient and documentation

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of these issues. We believe the new processes described above will address this issue. We also plan on additional staff education in conjunction with the new documentation system which has just been initiated in the past several weeks. With the changes in the documentation system this is an opportune time to additionally address these issues.

Complaint 5 contains the other substantiated issue which was addressed above. The additional recommendations of the G&A include updating the correct address on patient rights form. This has been recently updated by the State of Illinois which form we will be using. Attorney communication and patient rights were addressed in the monthly unit meetings the week of September 10th.

CONCLUSION

In our investigation and review process there was a great deal of discussion about how we as a facility balance treatment in conjunction with Patient Rights and facility resources. In a case such as this it is easy to become entrenched in defending the right or wrong of a position and this can obscure the underlying condition- not seeing the forest for the trees.

In this case that underlying condition is the ability of the patient to care for herself in conjunction with the family support. Our physician and staff acted in good faith and as required by law on the demonstrated history of deteriorating condition with failed attempts at home management.

The emphasis of the G&A report is how we deal with this type of situation. It is in everyone's best interest to try to engage the cooperation of the patient and family in these situations. In some cases it may be impossible and resort must be made to the legal system which by its nature is inherently adversarial. At the conclusion of this investigation we plan to share the G&A report and our response with staff to reinforce patient rights in conjunction with increasing cooperation of patients and families.

In our limited conversations with the patient and family we were able to determine that similar medication regimes were continued by her subsequent treating physician but we do not have any additional specific information. It would be helpful if the patient and family would share outcome information with G&A or if G&A could request that information. We also extend our invitation to the patient and family for their feedback on this G&A report and our response.

David L. Deopere PhD, President Robert Young Center

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