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East Central Regional Human Rights Authority
Report of Findings
Case 13-060-9001
The Pavilion

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

Complaints:

1. A child with disabilities was denied service and was discharged while experiencing suicidal ideation and hallucinations.
2. There is an inadequate grievance process at the facility.
3. The parent of that child was denied access to the child's record or a copy of the child's rights.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1 et seq.), the Mental Health and Developmental Disabilities Confidentiality Act, (740 ILCS 110/4.) and the Code of Federal Regulations, Title 42. Public Health, Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services section 482.13.

The complaint alleges that a 7 year-old child with a diagnosis of schizophrenia, who had been experiencing active hallucinations and suicidal ideation, was discharged because the staff at the facility stated the program that they had available was not the most appropriate for the child at that time. The parent agreed that was true, but returning to his home without structure, staff, therapy opportunities and a safe unit was even more inappropriate. The child was still discharged. The parent asked which would be more appropriate and allegedly was given no answer. The parent reportedly attempted to obtain records for the child and it was denied. She asked for a copy of the child's rights and it was reportedly denied. She wanted to present a statement of grievance and it was denied. The complaint alleges that there was no way to access third party assistance or the facility's grievance or help lines.

At the time she attempted to obtain a copy of the child's records which was approximately a week after the child was discharged, she brought with her a written statement disputing the discharge plan. Allegedly the Pavilion staff refused to accept her written statement, nor would they put an explanation in writing for the records that the parent requested but was denied.

INVESTIGATIVE INFORMATION

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

Interviews

The HRA asked what type of services are provided at the Pavilion. The staff explained that the Pavilion has been made part of the Universal Health Services since 1995. The hospital that had discharged the child to the Pavilion was also part of Universal Health Services. The Pavilion provides inpatient mental health services. There are approximately 30 youth beds in the adolescent section. There is a 4 to 1 ratio staff to patient ratio. The average length of stay for most patients is 10-14 days. The average age range served in the adolescent unit is 5 to 17. The geographical area served is mostly downstate Illinois, but the Pavilion has had patients come from as far away as Carbondale and Chicago.

The staff explained that the patient was admitted for eventual transitioning back to his home from inpatient services at another Universal Health Services hospital. He was to transition to partial inpatient services at the Pavilion, with the goal of returning to his home. There were no problems related to the admission. There were numerous evaluations completed. They developed a care plan based on the evaluations. His admitting diagnoses were Axis 1 mood disorder, Schizophrenia, Autism, and ADHD. There were no new diagnoses added.

Regarding discharge, staff explained that they evaluate the patient every day for discharge. The criteria used for discharge would be safety for the patient to go home. This evaluation includes input from case management, nursing and the psychiatrist. When asked at what point would staff advise the parent of the discharge plan, the response from staff was it all varies. With partial hospitalizations it can be the same day.

The HRA asked if parents are advised of the right to object to the discharge and how they would do it. Staff explained that the patient's Bill of Rights for the Pavilion is taken from the Mental Health Code, the Center for Medicare and Medicaid Services (CMS) standards, and the Joint Commission on Accreditation of Healthcare Organizations. When asked if the criteria differs for children, the response was no. The typical process for discharge includes a step down connection to outpatient services, a referral to the psychiatrist, a month of medications, and an appointment for follow-up within two weeks.

The HRA asked why this child was discharged. The staff explained that reportedly he was doing well. He was not dangerous. When asked about changing medication, the parent had declined. The physician determined that the child's condition had improved and, since there would be no changes to the medication, there was no need to keep the child in a partial hospitalization program. In this case the patient was not experiencing suicidal ideation and his progress had improved in therapy.

The HRA explained that from an observer's point of view from reviewing the record it would appear that the Pavilion discharged the child because the parent would not agree to the medication change, and the parent may have been difficult and used inappropriate language. The HRA also pointed out that the medication change recommended by the psychiatrist was the same medication that another Universal Health Services psychiatrist had chosen to discontinue at the child's inpatient hospitalization a few weeks prior. The HRA pointed out that a former psychiatrist employed by the same organization, discontinued this medication because he believed it was the cause of the dangerous and aggressive behaviors. The HRA asked why the Pavilion psychiatrist would prescribe the same medication a couple weeks later. The response was that every psychiatrist has his/her own process for assessing medication needed for a patient. Sometimes a psychiatrist may try several combinations of medications or retry a medication to improve the condition of the patient. The staff reiterated that the patient's condition had improved.

The HRA asked if medication was the only tool to improve this child's condition. The response was that staff look at many ways they can improve services. They look at trends and alternative therapies. They now have a therapist who is trained in providing eye movement desensitization and reprocessing (EMDR) therapy for post-traumatic stress disorder (PTSD).

The HRA asked if the parent of this child had input into Crisis/Safety/Plan. Staff explained that the child's other parent had signed the crisis safety plan. The discharge plan included a referral for aftercare with the child's therapist.

When the HRA asked if the child was still experiencing auditory hallucinations at discharge, staff explained that for this child there was no evidence of suicidal ideation or evidence that the child was not safe.

The HRA inquired if the parent of the patient registered any complaints and, if so, how they were addressed. Staff explained that the child's mother had called the patient's advocacy line to complain about the discharge and stated she would send the Pavilion a letter from her lawyer. The parent had requested records on a Friday and staff explained that she could pick the records up on Monday. The copying fee would be waived because of the family's financial situation. The parent never picked up the records which is why the records were already copied and available for the HRA.

The HRA asked what quality assurance measures the agency uses. The response was that, at discharge, every patient is given a patient satisfaction survey. They try to have each patient complete a survey before he/she leaves. The surveys are monitored monthly. Staff will meet and review to determine ways to improve services. They examine verbatim statements and pass on comments regarding the need for improvement, as well as compliments pertaining to direct care staff.

The HRA asked how the patients and their families are informed of their rights. Staff explained that patient rights are posted on the unit. Patients and their families are given a copy of their rights and the patients sign that they have received a copy of their rights. The HRA was

shown a copy in the records of the patient's rights signed by the parent, stating she had received a copy. It included the right and the process to file a grievance. It included third party advocacy contact information and the Patient Advocacy Line telephone number.

The HRA inquired with staff at a later date, after reviewing records, whether the Pavilion's discharge process and notice included the individual's right to object to the discharge. The response was they do not have a written notice regarding the right to object to the discharge. The patient and/or guardian's signature on the discharge plan signifies that they agree to the discharge.

Record Reviews

Per this record, the patient was transferred from an inpatient hospital to the Pavilion for partial hospitalization on a physician's order. The HRA reviewed the records from the Pavilion for partial hospitalization.

The HRA reviewed the patient demographic profile completed at admission. It listed the mother and her insurance. It did not list another spouse/parent. Under the patient registration form, it listed the mother and the mother's partner which included her partner's insurance carrier. Under admission orders it listed the child's diagnosis as bipolar and psychotic features.

The HRA reviewed the *Patient Bill of Rights (03/11)* that was signed by the patient's mother on the day of admission. In Section 12 it states, "You have a right to review your treatment record, upon written request, (with the assistance of a clinical staff member or your physician)."

It listed third party advocates address information (it did not include phone numbers of those organizations). Section 22 listed the patient's right to be offered staff assistance in contacting these organizations. (The HRA was contacted by supervision at the Pavilion that the document was being updated to include third party advocates' phone numbers.)

Section 24 of the *Patient Bill of Rights (03/11)* states: "You have the right to voice opinions, recommendations and grievances (to the highest level) in relation to the policies and services offered by the facility, without fear or restraint, interference and coercion, discrimination, or reprisal. The highest level includes the director, chief executive or comparable position. Section 29 reiterates that right by stating "You have the right not to have services denied, suspended, reduced, or terminated for exercising your rights."

The comprehensive assessment dated 5/15/2012 stated under the chief complaint or precipitating events (includes events that occurred in previous 24 – 22 hours that prompted assessment),"… He is currently a patient with a Pavilion psychiatrist. The patient has a history of aggressive and self-harming behaviors. The patient's mother states that since his return from the hospital he has been less aggressive and more impulsive. His mother states they have had to remove furniture from the home due to the patient constantly jumping off of it. 'His mother also states that the patient might jump out of the car if she was not watching him.' His mother reports that the patient is experiencing auditory hallucinations 20 - 30% of his day. The patient denied hallucinations to the assessment group, but did state there were alligators in his head. The

patient also has a history of self-harming behaviors and in the past has cut himself with glass and scissors. The patient will not be finishing the school year because of his inability to handle unstructured activity. During the assessment the patient was climbing on chairs, throwing cans, and unwilling to follow directions given by his mother. The patient continues to experience intense feelings of anxiety and trouble sleeping. The patient has been diagnosed with a variety of conditions including high-functioning autism, obsessive-compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD), and anxiety disorder. The patient is on a variety of medications for several years and the patient's mom is unsure if they are still helping. Screening, Assessment and Support Services (SASS) also recommended the patient for partial treatment and the psychiatrist has accepted. Additionally the patient will chew on anything he can put in his mouth."

Under suicide risk factors, it stated that the patient has a history of self-injurious behavior and a family history of axis one psychiatric disorder. "The patient has a history of biting himself and head banging, as well as cutting with glass and scissors."

Under stressors/triggering events leading to shame and guilt, it listed a chronic history of debilitating illness, loss of social religious support, and significant stressors/loss. "The patient has been diagnosed with high functioning autism and developmental delay. The patient has trouble interacting appropriately with peers. Schoolwork was a major stressor for the patient and his mother stated he has missed 70 days so far this year. The patient will not be finishing out the school year at the school's request."

In the section listing current past and past psychiatric diagnoses, in the comments section, it stated that the "patient has been previously diagnosed OCD, ADHD, anxiety disorder, sensory integration disorder, auditory processing disorder, and sleep disorder."

In the key symptoms section, the following was checked: severe anxiety/panic/ruminations, command hallucinations, hopelessness, severe insomnia, agitated aggression, and rapid mood shifts. In the comments section it stated: "the patient continues to experience anxiety and has a history of hearing a voice telling him to hit others or to hurt himself. The patient denies these voices at this time. The patient experiences periods of depression, trouble sleeping, and swings.

In the section on suicide inquiry, suicidal ideation was checked with the following comment "The patient has stated in the past he wishes he were dead."

Under protective factors/patient's strengths, under the section of internal, it was checked that he had no effective coping strategies, no effective anger management skills, no religious beliefs, no frustration tolerance, and no absence of psychosis. In the comments section it stated that "The patient has the psychiatrist, but now a counselor. The patient is enrolled in school. The patient's parents are supportive. The patient's living environment is stable." Under external protective factors that, yes, the patient has ongoing mental health support responsibilities, positive supportive relationships, and a stable living environment.

Under the support systems section it listed two mothers as his parents, who would be involved in treatment.

Under the section regarding homicide/aggression and violence risk factors it listed violence or threats towards others as his previous history of violence. In the comments section it stated "in the past the patient frequently hit peers, the family dog, his parents, and has broken his mother's nose. The mother says aggressive behaviors have decreased."

In the next section, which addresses self injurious behavior it states: "... The patient progress notes on the day of admission document discussion with parent about the *Ready System*. There is also discussion about the patient being fidgety, kicking his peers and unable to return to school."

Under the section concerning patient/family needs and goals for treatment, it stated to keep the patient safe, manage his medication and to help with hallucinations.

The HRA reviewed the *Master Treatment Plan Goal Sheet*. It listed as the target problem behavior(s)/needs as psychosis as evidenced by aggression, hearing voices, and impulsive behaviors. The long-term goal for the patient was to demonstrate an increased ability to manage symptoms and behaviors of psychosis. His short-term objectives were to demonstrate increased ability to manage symptoms and behaviors of psychosis by learning at least 2 new coping skills, to report less than three hallucinations per day for three days prior to discharge, and to participate in creating a discharge plan. The document listed 12 interventions or methods of achieving objectives and various persons responsible for interventions. These included the psychiatrist, licensed clinical social workers (LCSW), an activity therapist, an educational specialist, a case coordinator and registered nurses (RN). The estimated target date for achieving objectives was 5/29/12. Under the section titled intervention completed, canceled or modified it was written "full discharge."

The patient progress notes document the course of treatment from 5/15/12 to 5/29/12. Per the record, the patient received group and individualized therapy, and met with the psychiatrist on a regular basis. A family meeting was held on 5/21/12 and the patient's family completed daily home visit reports documenting the child's behavior. Most patient progress notes during this time document the patient being hyper, fidgety, restless, unfocused, disinterested and lacking direct eye contact. Daily safety assessments were completed by staff on behalf of the patient. There was further documentation of patient having hallucinations during this time. The psychiatrist notes document increasing Seroquel on 5/18/12, 5/21/12, and 5/22/12. On 5/23/12 psychiatry notes document that the patient's behavior improved and he denied having hallucinations.

Documentation of notes on 5/30/12: Psychiatry notes document that "The patient states he is doing all right. He states that his mother is using *The Ready System* at home. He was admitted to the hospital because of hitting, but has not been hitting. There have been no complaints regarding medication. The patient has good eye contact, is bright and pleasant. He is tall for his age. He has no tics or dyskinesias, but quite restless...." The psychiatrist documented that she was asking the nurse to contact the patient's mother to see whether or not he's ever been

on a stimulant. She also documented to continue with the current medication, Seroquel, per the mother's request.

Case-manager documentation states that "The case-manager had spoken with the patient's mother to discuss progress and/or issues about inpatient treatment. The patient's mother sounded agitated over the phone and used curse words throughout the conversation. The patient's mother reported that she was informed that the psychiatrist wants to begin patient on a stimulant medication. The patient's mother did not approve. The patient's mother reportedly stated 'That the Pavilion needs to get it's ___ together so I can stop doing your job for you.' The case manager offered the patient's mother the option to meet with the director of social services to discuss her concerns. The patient's mother agreed, on 6/5/12 at 10:00. The case-manager encouraged the patient's mother to discuss medication concerns with the RN and explained that case management does not make decisions regarding medication. The case-manager encouraged the patient's mother to call with any further questions or concerns."

Patient progress notes state that: "a staff member informed the psychiatrist that the patient had been on Concerta, Ritalin and Focalin. At the hospital that had just recently discharged the patient to the Pavilion for partial hospitalization, a physician had told the mother to never put the patient back on stimulants because it is not going to help him. The patient's mother wants to sit down and talk to the physician."

Program progress notes regarding the patient's treatment document the patient's statement about his treatment for the day. "'I am missing my goal for today.' The patient's affect was blunted, direct eye contact. The patient arrived late for partial hospitalization. The patient stated he had overslept. The patient needed lots of redirection to stay in his seat. The patient has been hyper, fidgety, and climbing on top of the table. The patient struggled to stay focused and interact with his peers. The patient shows little interest in his treatment. There were no aggressive behaviors and no set up. The prognosis was to continue to assess the patient's plan."

Clinical case-manager notes state"... The patient became distracted with the swivel chair. The patient required multiple attempts to redirect. The patient complied when the case manager told the patient of possibly returning to the regular classroom. The patient was shown the chart of feelings and pointed to the angry face. The patient said he was mad because he could no longer stand and cheer. Patient was told that the rule was set for his safety. The patient was then led in a game of toss with the squish ball and enjoyed the activity. The patient pointed to the happy face in the chart, colored the happy, sad and angry face. The patient was returned to group. He was neatly dressed and made good eye contact. The patient affect was blunted, but smiled at her mentally and congruently. The patient was hyperactive and distractive…. The patient demonstrated awareness of various emotional states. The patient also understood the relationship between his behavior and the consequences during individualized time. The patient was hyperactive and required much redirection during the morning, but seemed more invested in his treatment plan. The patient scored four on the 5/24/12 home report. The patient continues to require prompting for appropriate peer interactions. The patient will continue with treatment, including group meetings. The patient will continue to work on reducing aggressive behaviors. The patient will continue to work on at-home behaviors and progress will be monitored by reports from his mother."

The patient notes from social services state that "the case-manager spoke with the patient's mother to discuss progress at home. His mother stated that the patient has not been aggressive at home. His mother stated that the patient has been having hallucinations and the mother asked him who was he was talking to and the patient reported that he was talking to 'number 10.' His mother stated that the hallucinations were being normalized for him. The mother stated things were okay."

A safety assessment documented that the patient does not feel stressed or anxious. "He does not feel the desire to die or harm himself. He does not feel the desire to kill or harm another person at any time."

Documentation on 5/31/12: In the psychiatrist notes regarding the team discussion it states: "The patient's mother did not approve of the stimulant as she reports that he has become aggressive or otherwise deteriorated on this type of medication. She has been rather abrasive herself in interactions with staff. The patient appears to be doing well and is probably ready for discharge."

"The case manager met with the patient to discuss discharge plans for today. The patient presented with the rhythmic effect in a positive mood. The case manager addressed patient's access to weapons, medications, and other potentially lethal items. The case manager assisted the patient in completing a crisis safety plan. The patient was able to identify triggers and stressors and support systems to be used in a crisis. The patient identified coloring, playing with a friend, and watching cartoons as coping skills to use when feeling stressed. The plan is to discharge the patient today."

The social worker's notes document that "The patient was discharged from partial hospitalization. Discharge instructions were reviewed with the patient's other mother. This included follow-up and medications for discharge instructions. No new prescriptions are needed at this time."

Therapist's notes document "'The patient's goal is to follow directions.' The patient was interested, unfocused, direct eye contact, open posture and needed the same redirection. The patient attended all programming, had an interested effect, but was unfocused, hyper and fidgety. The patient had some participation in groups, but required redirection of the disruptive behaviors like side talking, not being able to sit still while in his chair and generally moving about constantly. The patient's peers and staff interactions primarily positive, but the patient often needed multiple directives to correct negative behavior. The prognosis for the patient was further assessment would be needed and continue with the plan."

On the document titled "master treatment plan," it stated under the problem/long-term list, aggression and hallucinations; the target date was 5/29/12 and the date of resolution was 5/31/12. The diagnoses under Axis 1 are mood disorder, NOS, autism and ADHD. The diagnosis under Axis II is developmental delay. Axis III are constipation and rule out a mature puberty. For the treatment plan updates on 5/22/12, it stated "the patient is continuing to struggle at times

with hallucinations and some programs. Treatment plan to be reassessed on 5/29/12" On 5/31/12 it stated "the patient has not been aggressive at home for mom and full discharge."

A crisis safety plan was completed with the child and the child's parent. A discharge and continuing care plan was completed and signed by the other parent. It documented on 5/31/12, the day of discharge, "that educational materials, the importance of attending all scheduled aftercare appointments and continuing any prescribed medications were discussed with the parent...."

There were discharge cover letters sent to the patient's therapist and psychiatrist.

The HRA reviewed the portion of the ***Pavilion Advocacy Log*** from 5/31/11 regarding this patient. It documented: "The Patient's mother was very upset that her son was being discharged today. The patient's mother states that he was suicidal yesterday and that he was still unstable and hallucinating. The patient's mother was belligerent on the phone and states she will be contacting an attorney to file a formal grievance with DCFS, the state and Joint Commission.

This worker reviewed patient's chart and nothing was mentioned about patient being suicidal yesterday. The patient's safety assessments are all fine and patient's mother reported the day prior to discharge that patient was doing fine and his hallucinations were no longer a problem and had been normalized for him. Notes indicate the patient was doing well and ready for discharge. No follow up letter sent. Per phone call the patient's "mother refused to speak to the patient advocate and stated we would hear from her lawyer."

Policy Reviews

The HRA reviewed the Pavilion discharge policy dated 11/22/11, for processes and procedures which explain that "Discharge planning begins shortly after admission, with the completion of the Preliminary Discharge Plan and Criteria to be Met sections of the Master Treatment Plan, as well as items in the Seamless Assessment. The discharge process spans the entire course of treatment and is reassessed periodically based upon patient need. The nurse or her/his designee should ensure the proper discharge procedure. A Physician's Order is required for any type of discharge."

In section IV of procedures regarding a regular medical discharge - regardless of the type of admission, states: "any patient may be discharged at the discretion of the attending physician…."

It explained that at discharge there is a discharge checklist that is unit specific. There is a "Recovery/Safety Plan that is developed by the patient and case-manager to assist in recognizing relapse warning signs and identifying ways to maintain safety. The plan also serves as a tool if a crisis ensues. The case-manager and patient develop the recovery/safety plan during hospitalization. The nurse or case-manager reviews it again with the patient and family at discharge."

"The case-manager will develop the Discharge and Continuing Care Plan for each patient to determine that patient discharge needs are being appropriately met. The nurse will complete

medications prescribed at discharge section. The nurse will review all sections of the Discharge and Continuing Care Plan with the patient and family at discharge. "

It also covered that discharged patients would be given a Post Hospital Discharge Survey. It explained that the survey form will be given to the patient at the time of discharge or prior to discharge. "Staff will explain the importance of completing the survey. The survey may be completed prior to leaving the Pavilion and placed in the survey folder at the nurses' station. Patient and/or family are to complete a post-hospital discharge survey after each level of care admission (e.g., inpatient stay, partial hospital stay)…."

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

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

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

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

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

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

The HRA reviewed *The Ready System Parent Manual* 12/8/11for parents, which had been provided to the child's parents at admission. In the manual on page 6 it describes the Ready System as "a behavioral management system designed to improve the behavior of young children with the goal that noncompliant or physically out-of-control children will learn to be more cooperative and to behave more responsibly, even when they are having intense negative feelings."

It explained that this is achieved by "the use of three methods to achieve more compliant, cooperative behavior. All three of the following methods are most effective when used together

and in equal proportions. Used together, they provide powerful opportunities to interrupt negative behaviors, to increase compliance, and to improve the quality of a child's relationship with caretakers. Behavioral management methods include: Steps, Tokens, and Positive Parenting Skills." In general, the manual was a good guide for providing parents with the tools they need to help their children and to work cooperatively with Pavilion staff in providing treatment.

SUMMARY

1. **A child with disabilities was denied service and was discharged while experiencing suicidal ideation and hallucinations.**
2. **There is an inadequate grievance process at the facility.**
3. **The parent of that child was denied access to the child's record or a copy of the child's rights.**

Per the record, the notice was given to the child's parent on the actual day of discharge. When the child's mother attempted to object by phone it does not appear that the parent was informed that she had to make her objection in writing. The estimated discharge date was 5/29/12, which is a couple days earlier than the child's actual discharge, was documented on the master treatment plan and was signed by the parent and child on 5/16/12. However it does not appear that the patient's parents had any idea that the child would be discharged on 5/31/12. Per the Pavilions Patient's Bill of Rights, a patient has the right to be informed if it is necessary for them to be discharged and to be prepared for the discharge.

Per the Mental Health and Developmental Disabilities Code in section **5/2-102** regarding the rights of recipients for **Care and services;** (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…." Per the child's treatment plan his short-term objectives were to demonstrate increased ability to manage the symptoms and behaviors of psychosis by learning at least 2 new coping skills, to report less than three hallucinations per day for three days prior to discharge, and participate in creating a discharge plan.

The record on 5/30/12 and 5/31/12 documents there was no evidence of the child experiencing suicidal ideation. It does appear that from the records that the child, while at home, still experienced hallucinations. The record documents that the patient was still unfocused, hyper and fidgety. Per the Code, the child receiving services has the right to receive them in the least restrictive environment per his individual service plan completed with the assistance of his substitute decision makers, which in this case would have been his parents.

Per the psychiatrist's notes on 5/31/12, the patient's mother did not approve the stimulant because of the patient's history of aggression and his mother had been abrasive in interactions with staff. It also documents that the patient appears to be doing well and is probably ready for discharge. There is no evidence the child was discharged as a retaliatory act because of the parent's reaction or refusal concerning stimulants as a treatment option for her son. There is evidence that the child's condition had improved in the record and it appears to be a general consensus by most of those providing care that the child was not a danger to himself or others.

Based on the evidence, the first complaint, **a child with disabilities was denied service and was discharged while experiencing suicidal ideation and hallucinations is unsubstantiated as a rights violation.**

The HRA takes this opportunity to make the following suggestions:

1. There is evidence on the master treatment plan that was signed on 5/16/12 that the estimated date of discharge was 5/29/12. However during the following two weeks of treatment there appears to be no evidence in the record that the child's upcoming discharge was discussed with the parent. Considering the severity of this child's disabilities, it is probable that his parents would have had to obtain a new support system to provide care to replace what the partial hospitalization would have provided for the child. It seems reasonable to give parents some advance notice or at least make them aware that discharge could be at any point in time so that patients and caregivers could prepare for the transition. The Pavilion's Patient Bill of Rights states that a patient has the right to have continuity of care at discharge.

Regarding the complaint, **there is an inadequate grievance process at the facility,** the Code of Federal Regulations regarding participation in Medicare/Medicaid for hospitals, state in section 42 CFR 482.13: "A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.

The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care…. At a minimum:

(i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.
(ii) The grievance process must specify time frames for review of the grievance and the provision of a response.
(iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion."

In this case the hospital had policies that would allow for prompt resolution of the grievances. The patient's rights to file a grievance was explained to patient's mother verbally and in writing. The grievance process followed specific time frames for review of the grievance and there was the provision of response. Per the record the staff did call the patient's mother and reviewed the record to investigate the complaint. When the patient's mother would not communicate and had informed the hospital that she was going to hire an attorney, the Pavilion did not provide a written notice of its decision, who to contact at the hospital, and the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the

date of completion. The complaint that **there is an inadequate grievance process at the facility is substantiated.**

The HRA makes the following recommendation:

1. **Follow the 42 Code of Federal regulations 482.13 regarding resolution of the grievances. Provide the patient with a 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.**

Regarding the third complaint, **the parent of a child with disabilities was denied access to the child's record or a copy of the child's rights**, there was documentation signed by the parent that she received a copy of the child's rights and that the rights were explained to her pursuant to the Code section 5/2-200 which states "Upon commencement of services… the parent or guardian of a minor or person under guardianship shall be informed orally and in writing of the rights guaranteed by this Chapter which are relevant to the nature of the recipient's services program. Every facility shall also post conspicuously in public areas a summary of the rights which are relevant to the services delivered by that facility…." If the parent had received copies of her son's records, the copy of the rights she had signed would have been included with her child's records.

The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4) states, "The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof: (1) the parent or guardian of a recipient who is under 12 years of age…." The HRA found no evidence that the parent was denied a copy of her child's record. Per the provider, they had completed copying the child's records and had them readily available for the parent to pick up after the weekend. Per the complaint the records were not made available to the parent. However the HRA cannot substantiate a complaint based on one person's word against another. Based on this evidence, the third complaint, **that the parent of a child with a disability was denied access to the child's record or a copy of the child's rights is unsubstantiated.** The HRA suggests contacting the parent to confirm whether or not she would still like a copy of her child's record.

The HRA would like to thank the Pavilion staff for their full cooperation with this investigation. The HRA commends the Pavilion for making accessible to parents and using programs like *The Ready System*.

RESPONSE

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

The Pavilion

BEHAVIORAL HEALTH SYSTEM

November 15, 2012

Cathy Wolf, HRA Coordinator
Guardianship & Advocacy Commission
2125 South First Street
Champaign, IL 61820

Re: HRA Case No. 13-060-9001

Dear Ms. Wolf,

The purpose of this letter is to respond to the findings regarding the grievance process at our Facility. The recommendation was made to follow the 42 Code of Federal regulations 482.12 to provide the patient with a written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process and the date of completion.

The Pavilion acknowledges that it did not follow this process in Case # 13-060-9001 and agrees to follow the established grievance process going forward.

If you have any questions or need additional information, please feel free to contact me at 373-1701. Thank you.

Sincerely,

Joseph Sheehy, CEO
The Pavilion Foundation

JS/jp

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809 West Church Street, PO Box 380, Champaign, IL 61824-0380 (217) 373-1700 (800) 373-1700 Fax (217) 373-1737