FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case #14-090-9020 & 14-090-9021
North Central Behavioral Health

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at North Central Behavioral Health. Because case number 14-090-9020 and 14-090-9021 involve the same recipient and the same facility, the complaints were combined into one report. The complaints alleged:

14-090-9020

1. **Inhumane treatment, including the following: the staff yelling and intimidating residents; the staff falsifying resident statements; the staff neglecting to keep residents safe while at facility; inappropriate staff involvement in resident's finances and the staff not allowing residents to make decisions involving finances; the staff manipulating residents into signing documents; the residents made to clean up after other residents; a lack of privacy from the staff; the staff misrepresenting resident documentation; and the staff misrepresenting services allowed to residents.**
2. **Inadequate grievance process.**
3. **Inadequate admission process, including not providing the resident with adequate explanation of the facility.**
4. **Inadequate treatment, including the following: the staff not allowing a resident to talk with a medical provider and supplying medical providers with inadequate information; the staff removing PRN (as needed) medication without a physician's knowledge and not providing PRN when needed; the staff providing wrong medication on three instances; the staff providing medication that a resident was allergic to and then not allowing a resident a physician examination when reporting medication side effects; and not allowing a resident to leave facility to attend to personal issues and find housing.**
5. **Communication violation, including a resident not being allowed to contact his/her physician and a resident not being allowed to leave the facility to visit their family.**
6. **Inadequate facility staffing.**

14-090-9021

1. **Confidentiality violation.**
2. **Retaliation against clients for voicing a grievance against the facility.**

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (MHDD Code) (405 ILCS 5), Rules for Community Integrated Living Arrangements (CILA) (59 Il Admin Code 115), the Mental Health and Developmental Disabilities Confidentiality Act (740 ILC 110/3), and Rules for the Administration of Medication in Community Settings (59 Il Admin Code 116).

The program's catchment area includes LaSalle, Bureau, Putnam, Marshall, Stark, Fulton and McDonough counties. The CILA involved in the complaint is in Princeville, IL. It is an 8 bed CILA for adults with mental illness and has 4 staff. Other services provided by North Central Behavioral Health include outpatient care, case management, psychosocial rehabilitation, and psychiatry.

To investigate the allegations, HRA team members interviewed North Central Behavioral Health staff members and reviewed documentation that is pertinent to the investigation.

COMPLAINT STATEMENT

Regarding case 14-090-9020, the complaint states that a resident did not know what documents she was signing during admission to the CILA and was not provided an explanation to help her understand the facility. The resident allegedly did not know the CILA was a mental health group home and thought that she was only paying rent. Allegedly the resident was not wearing her glasses prior to signing admission paperwork and was administered an injection in the arm before signing into the facility. The allegations also state that residents are made to clean up after other residents who are not able to clean up for themselves. Another complaint is that staff provided a grievance form to residents and then took the forms away. Residents also reportedly did not know that they had the right to file a grievance. Another complaint alleges that anything said in private around the dinner table at the CILA is entered into the residents' records. Another allegation states that staff yelled at the resident for not saying "please," "thank you," and "pardon me." Also, the staff reportedly try to censor residents while speaking to medical providers and told providers that this specific resident was delusional. Staff also told the resident not to "overwhelm your doctor" and "I don't have time to take you" when the resident made a request to see the physician as per the complaint. Allegedly the staff made mistakes with the resident's medication on 3 occasions. The resident broke out and had a runny nose from the medication (Haldol) and staff would not give her allergy medication. The allergy medication was removed from the resident's prescription list without the physician's knowledge (as well as Tylenol and Advil). Residents were also reportedly reprimanded for not working as a team and staff became upset at a specific resident because she contacted her physician. The resident was told that she could not contact the physician any longer. Allegedly it took a resident a month of allergic reactions for staff to call the physician. The resident kept telling staff that she was having an allergic reaction and they would only say that it was the physician's prescription. The physician finally discontinued the medication. Another complaint states that a resident hurt herself in a broken chair and staff did not warn residents about the chairs. It was said that the chairs needed thrown out but have not been. Residents are allegedly afraid of staff, who tell them

to “shut up” and that they “are getting on their nerves.” They also accuse residents of spreading stories. The complaints state that staff yelled at a resident to return to the house when smoking outdoors. Two other staff members also told a resident to “shut up” while she was waiting at the bathroom door as per the complaint. The complaint also states that a resident was attacked by another resident. The female resident was reportedly cornered by a male resident who said that he liked her and when she did not reciprocate he sprayed her in the face with room spray. Staff were told about the incident but would not report it; they only said that they would talk to the assailant’s case manager.

Allegedly the facility is short staffed and staff call in sick often and are overloaded. Allegedly the basement has black mold that makes residents sick. Staff tried to clean the mold but the cleaning crew hired never came to do the work and were never called about the absence. A resident discussed the mold with an administrator who assured her the issue was being resolved but nothing was done. The complaints allege that a case manager discovered that a resident had a large social security settlement and forced the resident go to an expensive eye clinic rather than a more affordable one. Then the resident was told by the same case manager that she could not leave the facility because she did not have enough money. A staff member allegedly said that a resident was not paying bills and told the resident that she must pay her bills when she already was. A staff member was reportedly overly involved in the resident’s money.

The complaint also alleges that the resident was not allowed to leave the facility to take care of personal issues or find housing without staff supervision. The resident had an appointment that they would not let her attend and staff would not let her take a bus to visit her family. Additionally staff lied and said that residents cannot receive services without going to group although people in the LaSalle location were receiving services. Residents were also only meeting with a psychiatrist but receiving services in other locations (Ottawa and Princeton). Allegedly a nurse practitioner made the resident sign a document and would not inform her what she signed. It turned out to be a form saying that she would not drink. Additionally, a staff member reportedly asked the resident a bunch of questions and then said that the resident must be delusional and that she had no resources which was untrue.

Regarding case number 14-090-9021, the complaint alleges that someone from the staff provided the resident with a tentative budget when being discharged from the facility. The resident never signed any releases allowing disclosure of her records, but the tentative budget was given to her family physician without the resident’s permission.

The complaint also states that whenever someone presents a complaint to a specific staff member, she enters onto their electronic record that they are delusional and threatens to have them committed.

INTERVIEW WITH STAFF (7.1.2014)

Staff stated that the resident was discharged from a state operated mental health facility and had no home. The resident was left at the North Central Behavioral Health Ottawa office with no resources or transportation and limited medications in the middle of winter. Staff explained that the resident had no social security benefits or public aid and staff completed an

intake to open emergency services and to find the resident a place to live. Staff said that the intake assessment may be where the delusional complaint stems from because it did state that the resident had delusions as a part of the diagnostic which was attached to the treatment plan completed as part of the resident's assessment. The resident had a diagnosis of Schizophrenia with Paranoia. The resident was assigned a case manager on the day of admission who initiated services to a shelter and began to set up physician's appointments as well as regain her disability services. Staff said that the resident was still symptomatic on the day of admission. The resident was attending psychosocial rehabilitation groups at the North Central Behavioral Health offices in Ottawa. The resident was at a homeless shelter for 14 days and then was accepted for short term placement at the North Central Behavioral Health group home.

The resident received a psychiatric evaluation from the Advanced Practice Nurse (APN) on 1/21 who continued the medication from the state operated facility. The medication was a Haldol injection. The resident received an advisory form with the side effects of the Haldol which warned to avoid alcohol. The resident was in the CILA from 1/28 until 5/1. The resident gave notice to leave on 4/1 and found another private residence.

According to the staff the resident thought that she had accomplished all of her goals and staff were not aware of any complaints while she was staying at the house. Staff said that they had no knowledge of an incident where the resident was attacked by a housemate. The case manager who was named directly in the complaint does not work at the home, so she would not have been there. When the resident was discharged, the staff felt as though she was in a stable condition. She had some persistent symptoms because of the diagnosis but they believed she was aware of her situation, understood the facility and the documents upon admission and that she comprehended the services the facility provided.

If individuals are identified to live in the CILA, they are explained their rights and then they are given expectations regarding the house, such as no drugs or drinking. The residents are all orientated to the home, medication is reviewed, and medication sheets are created. The individuals sign all the documents needed for admission and medical appointments are made for them as needed. Also, the facility name is on all the documents and it is indicated that the facility is a CILA on the client rights statement and the plan of care. The grievance process is in the client's rights statement along with agencies to contact if there is a grievance. The goal on the treatment plan is temporary placement until subsidized housing is found. The resident would have had a tuberculosis test at the health department before moving into the home and she also may have had a Haldol injection. The facility does not give injections, so the Haldol would have been administered at the hospital and the tuberculosis would have been administered at the health department. Because no injections are given at the agency, when an injection is needed the residents are taken to the hospital with the prescription for the injection. The hospital fills the prescription by administering the injection. Staff saw no side effects from the Haldol while at the facility. The APN completed an assessment of the medication and nothing was noted. The staff were unaware of any allergies or reactions. The resident's primary care physician asked about allergies or reactions during the physical and nothing was noted. The resident is still receiving Haldol and the prescription was never changed or discontinued. The APN prescribes and monitors psychiatric medication under the supervision of the North Central Behavioral

Health physician. North Central employs a psychiatric physician who is the medical director of the facility.

The resident had multiple over-the-counter pain medications and muscle relaxers but her primary care physician discontinued those medications. Staff explained that the patient was present during the physical when the medications were discontinued. The pain medications and muscle relaxers were the only medications that were discontinued. The resident was only using two psychiatric medications, Haldol being one, and those medications were prescribed while the resident was at the state operated facility. The facility staff explained that they track all medication errors at the CILA and none where reported.

The resident's chart indicates that the resident made multiple phone calls to her primary care physician (PCP). One day the resident called her PCP 7 times with multiple issues and the PCP called back to pinpoint what the major issue was. Staff said that the resident had a cell phone but that the residents can also use the home phone whenever they want. There was continuous communication between the PCP's nurse and the CILA nurse. The facility does not restrict phone or mail rights so the resident never received a rights restriction. Staff may have conversed with the resident about the number of calls to the physician after the physician's office requested to know why the resident was calling so often. If staff did speak with her, it was more of a behavioral intervention than anything else. While at the facility, the resident had said that she had a sore back and at the time her back bothered her she wanted pain medications and muscle relaxers but there was no mention of an itchy or sore throat. The resident was never told that she could not contact the physician. The resident had medication that she could take as needed (PRN) such as Ibuprofen, Benadryl, Tylenol, and Advil. The house rules state that the PRN must be secured in a locked cabinet and when a patient requested some medication, it would be given.

Staff would take the patient to appointments with the PRN but they would not be present during the appointment. They would have discussed the medications. The resident saw the APN 3 times since she was admitted in January and was taken to urgent care on one occasion because of her back. The resident also saw her PCP one time. Staff said that she had no ongoing health issues outside of asthma and she complained of having a bad back. She was never denied a request to see a doctor and was denied.

The staff whom we interviewed said that there were no complaints about the staff that they were aware of. During the interview, one staff member stated that she had a previous role with the facility where she oversaw residential homes and never had complaints about staff yelling, being disrespectful or abusive. Staff explained that the house staff probably work on social skills but she does not think there is an emphasis on social skills. Staff would not tell residents to work as a team, because it is not part of the program. The CILA is a home and they treat it as such. There is an expectation that residents clean after themselves. There is one day of the week in which the residents choose to do a chore in the house, such as clearing the table or putting dishes in the dishwasher. They do that because they try to operate the facility as though it was a house. Someone sets the table and then someone else cleans up, etc. They could see how that could be interpreted as cleaning up after someone but that is not the case.

Staff explained that it is a CILA, so there are common areas where there is no privacy. The resident did have her own bedroom and there was a front porch area where residents can go. The residents can take the phone with them to the private areas. Staff are required to document anything out of the ordinary. Staff said that this usually does not include dinner conversations but if something was observed, they would document. If a resident fell or had an altercation, then that would be documented. Staff said that they did not see any dinner conversation in the shift notes. The shift notes consist of two notes per person, per shift.

There is one staff member per shift. If there is a situation in which someone else needs to be present, such as if someone's behavior was escalating or someone was acting suicidal, they would call a staff member from the community to help. There are other community workers and a coverage policy for the CILA staff. If CILA staff need to call in, they contact the supervisor a few hours in advance. Staff may split a shift in that situation because staff cannot work two shifts in a row. They do not have staff who call in sick often. They had a staff member who was on leave for medical reasons and then, over the winter, some could not come to work because of the weather. Staff assured that shifts are always covered and they document coverage. Staff said that residents can leave anytime that they want if they have an independent program, and if they are not suicidal or overly symptomatic. Typically, the residents do not travel too far because they live in a very small town. Other than a train station, there is no public transportation in the town, so they do have to walk if they go anywhere. The resident involved in this complaint was on an independent program and went for walks. The residents sign-in and sign-out and they are asked to do that for safety reasons. Individuals can leave with their family whenever they want to and the resident could go and look for housing. In this case, because of the transportation situation, if the resident was looking in another city staff would have had to assist her. Staff said that the notes indicate that the staff were assisting the resident who did not have family that lived in the same town as the CILA. She had no visitors at the house, and never left with family.

Staff explained that the patient did not ask to travel on the bus. The resident did find housing and was receiving assistance from the North Central Behavioral Health staff. The resident currently is still receiving supportive services through North Central and part of the services include assistance with transportation as well as with basic living skills. The agency policy is that clients cannot receive "medication only services". They cannot only see a psychiatrist or only receive medication. As far as services received, everything is individualized. The resident involved in this complaint received individual services from residential staff and a case manager and never expressed that she did not want these services. While at the house, if a resident does not want to attend group, then they do not have to. Also, if they do not like a particular group, then they do not have to go. CILA residents go to group sometimes 4 or 5 days a week in two separate locations. There are community support groups and some attend an intensive therapy group. They will also use remote services from the house if residents do not want to travel to the locations.

They stated that if a female resident was cornered, they believe someone would have told staff about it and staff would have reported it. Staff are trained to deal with these sort of situations. The case manager is not located at the house, so she would not have been present to witness the situation. They do have co-ed arrangements in the home. Staff said that in the past,

situations or incidents such as this have been reported by residents or staff so it is not something to which they are unaccustomed.

Regarding the complaint that staff told someone to return to the house, staff explained that if there was severe weather they could request someone to come back into the house. They would explain that it is too cold and to come back in. Also if it was late at night, they might ask someone to come back inside. The doors of the house are locked at a specific time. Staff said there was an issue with mold on the basement walls and people were brought in to clean and disinfect the area. They then brought in a sealer to paint over the patch. The house is a two story Victorian and the mold was caused by some water and humidity but it was taken care of. No resident was sick because of the mold; in fact, it was the first year that no one had the flu in the group home. It only took them a day to clean the mold and it was only one section of one wall. It was cleaned while residents were gone to group. Staff said that the resident mentioned the black mold to them and they said that it had been corrected. Staff told the resident that it was being addressed while she was staying at the house. Staff said that the process of resolving the issue took a couple of months and that was due to the need to ventilate the basement but it was winter.

In regard to the complaint about the eyeglasses, the eye clinic that they went to was the resident's choice. When she was being assisted with glasses, staff told her that she could receive free glasses through public aid and she said she wanted the best and purchased $400 glasses. The resident controlled her own money and paid her own bills, but she did not have many. The resident only had copays for a pharmacy and then paid the facility rent for the home. She was actually a month ahead on the payments for rent. She paid directly and it was not through Medicare. The rent at the facility is 30 percent of the resident's income and covers utilities. Her case manager did assist her with budgeting and reviewed multiple scenarios about budgets but never told her what to do with her money.

Staff said that the resident spoke regularly with nursing staff and never said that she was hurt in a broken chair. The resident never received medical help because of a broken chair and there were no notes regarding broken chairs in the record. The grievance procedure within the client rights are reviewed when clients are admitted and they are covered again when admitted to the group home. They have a weekly house meeting where they can discuss issues and the minutes to that meeting are forwarded to a supervisor. If residents had something they wanted changed, they would bring it up at that meeting. The residents have brought up different situations at those meetings, for example they wanted a new television and wanted a new Christmas tree and presented this at the meeting.

Staff receive a 40-hour intensive training that is outlined by the Illinois Department of Human Services Rule 115. The training includes safety, medications, behavior modification, interpersonal skills, and first aid to name a few items covered. When there is a new hire, the new employee completes a 3-week training. They also have job shadowing and training before new employees are left alone with the residents.

The HRA spoke with other staff members involved in the resident's care while at North Central Behavioral Health. One of the individuals who was named directly in the complaint

(regarding the resident attack, eyeglasses, and involvement in the patient's bills) worked with the patient primarily with housing. She also helped her regain her entitlements and benefits as well as cost factors surrounding living arrangements. Also, this individual had no contact with the eye clinic named in the complaint. The resident also never voiced a complaint to this staff member regarding a specific individual. The resident was aggressive with others and her personality changed often, making her hard to read. Staff said that the resident was an advocate for herself calling renters and realtors.

Staff said that the resident felt out of place. She understood the concept of treatment but did not believe that she needed treatment. She believed that she was a homeless person who needed a home. It was all explained to her upon admission and she was accepting. She made comments that others were sick but she just needed someplace to live. The resident used derogatory words towards the other residents and was offensive towards them. These staff members also said that there was never any abuse reported and that in knowing the individuals who live at the facility, they would not commit the act described. They thought maybe that the complaint was a misunderstanding. Staff also explained that the resident would become upset because others would use the words "please" and "thank you" when talking and she acted as though they should not use the term. Staff would stress to the residents that they did not have to request things in that manner. The insults were the only things that would have been documented in the house notes.

The HRA discussed case 14-090-9021 with the staff who stated that they had no contact with any physician to discuss anything about the resident. The resident wanted to revoke the release to the PCP and the case manager updated the release. This occurred shortly before the resident left the facility. After the release was revoked, the staff no longer had any contact with the PCP. The individual named in the complaint never had any involvement with medication. The facility has a policy for authorization to disclose that follows the Mental Health and Developmental Disabilities Confidentiality Act and the Health Insurance Portability and Accountability Act (HIPAA). Residents are explained consents and disclosure at their intake and they receive a form as a part of their new client packet. Staff said that they did not develop any budget for the resident. When talking housing budgets, they discussed what was financially available but never developed a budget, so there was nothing like that to even provide to the PCP. The facility did provide information to the PCP about medications that were being prescribed, physical issues that she was having and other general information that a physician may need with the resident's written consent. The resident terminated her own placement from the house but she is still receiving treatment and her record still belongs to her. The staff track disclosures to outside entities and they never released documents from the resident's chart to outside entities.

Regarding the retaliation claim, the staff member who allegedly threatened to have the resident committed is the one who completed her intake to open services and that was her only interaction with the resident. The resident never brought a complaint to the staff member or spoke to her after the admission. The facility does not commit residents. It is within their authority to petition for commitment but the resident never presented the need. The commitment would occur at the hospital and not occur at the facility. The staff work towards keeping people out of that situation. The facility does have a complaint process and the client can present a

complaint to any staff member. The complaint can be accepted in written form or verbally. In this case, the staff member would have added the complaint a progress note and documented it in the resident's file. They could also put them into an unusual occurrence report. The staff most often receive complaints over the telephone. The clients can also contact them if they do not feel like they have received resolution but staff try to work through the issue with them until they are satisfied. If they are not satisfied, then they can present the complaint to others in leadership.

The facility has a retaliation policy in their code of conduct. All hires agree to not retaliate against the clients. They have two non-retaliation policies in their procedures. Retaliation is part of the grievance process and it is reviewed upon admission with the clients. Staff do not believe the term delusional was used to describe the resident but thinks that it was used to lead to a diagnosis.

FINDINGS (Including record review, mandates, and conclusion)

According to a screen shot provided to the HRA of a client data live program, the admission date of the client to the agency was 1/9/2014 and according to the client information sheet, the client was admitted into the CILA on 1/27/2014. An assignment form states the client's discharge date is 5/1/2014.

The HRA reviewed records and policies pertinent to the complaints in this investigation. The HRA began with 14-090-9020 and then proceeded to the 14-090-9021 complaints:

14-090-9020

Complaint #1 - Inhumane treatment, including the staff yelling and intimidating residents, the staff falsifying resident statements, the staff neglecting to keep residents safe while at facility, inappropriate staff involvement in resident's finances and the staff not allowing residents to make decisions involving finances, the staff manipulating residents into signing documents, the residents made to clean up after other residents, a lack of privacy from the staff, the staff misrepresenting resident documentation, and the staff misrepresenting services allowed to residents.

The HRA began by reviewing the resident's treatment plan. A plan dated 2/8/2014 through 8/7/2014, signed by the resident, states that "[Resident] will report to being able to prepare one meal with only staff verbal direction per week, she will be able to complete three of four steps related to household cleaning each week on Saturday, she will be able to report to staff having money left at the end of the week and not needing additional funds beyond what is budgeted." According to an outside provider appointment document, the resident was given a no lifting order by a physician. The order was for nothing more than 5 pounds. An individual progress note, dated 2/25/2014 reads "Client stated 'I have to clean at the house, and I don't know why, I want a no lifting order, so I don't have to lift heavy things. I'll ask the doctor about it today.'" The same document reads "Client requested her no lifting order for the doctor today, and the doctor asked her why she would need this. Client replied 'they expect me to do chores at that home, and I don't want to be lifting anything.' [PCP] replied that the goal of living in a group home is to work together, and that client should probably try to meet the goal of taking

care of the home. The Doctor did write client a NO LIFTING order for anything beyond 5 lbs. Client again stated 'I just don't see why I have to do chores there.'" The HRA reviewed progress notes confirming that the resident "… had the upstairs bathroom as her chore and finished most of it" on 3/5/2014 and prepared dinner for herself and peers two other occasions and cleaned the kitchen after cooking on one occasion.

The patient's diagnostic review form, dated 1/10/2014 states that the resident has minimal support and is on a fixed income with financial problems. This is part of the resident's care plan which was signed by the patient. A progress note dated 2/5/2014 reads "Writer met with [resident] for individual community support budgeting and shopping. The purpose of this service is to support client by teaching and practicing skills that will increase client's understanding of money management with meeting personal needs such as creating a shopping list to insure weekly needs are met, creating a budget for shopping, making good choices regarding spending." The note states that this service is written into the resident's care plan.

Regarding the complaints that a staff member asked questions and then stated the resident was delusional and had no resources, the resident's treatment plan, dated 2/8/2014 through 8/7/2014 states "Paranoia, sadness, anxiety, disorganized thinking, and delusions are interfering in [resident's] life and are identified as being in need of change." The resident's plan of care dated 2/8/2014 also reads "[Resident] has a previous diagnosis of schizophrenia and history of symptoms of delusions, paranoia, disorganized thinking." The resident's treatment plan dated 1/10/2014 reads "[Resident] will learn to identify her patterns of symptoms and her risk factors through group and individual treatment. She currently does not identify any of her thoughts as delusional and will learn in group and point out one thought in the next 6 months that is delusional and causing her to limit her functioning." In the initial admission assessment dated 1/10/2014, which was electronically signed by the individual named in the complaint, it states that the resident "… has had a previous diagnosis of schizophrenia and a history of symptoms of delusions, paranoia, disorganized thinking." In a Level of Care form, dated 1/24/2014, it reads "Client still presenting with some delusions and distorted things."

In an individual progress note, it reads that the "client attended intake appointment. She has agreed to attend CIS, PSR, CSG [acronyms for services provided by the facility] services at the agency and community based services. See Intake."

Regarding the complaint that the resident had no choice in eye clinic attended, another progress note, dated 2/6/2014 reads that the resident had medical appointments made for her, including one at the more expensive eye clinic. An individual progress note reads "Writer provided community support to [resident] at [more expensive eye clinic] in ordering new glasses. Writer assisted with registration, providing them with her scrip, choosing frames and completing ordering process. [Resident] demanding, agitated, kept repeating 'I am paying cash, I want the best.'"

The HRA reviewed documents regarding the complaint that the resident was afraid of staff who were verbally abusive towards the resident and others, and the HRA reviewed an individual progress note which read "[Resident] actively participated in this individual support service but was defiant at times. Client was supported to her doctor's appt. and during the drive

made many negative comments about staff at NCBHS that she does not want to live in the group home, and client made rather rude comments about other clients. Writer asked that [resident] not discuss other clients." Another, informational progress note (dated 2/23/2014) reads that the client "woke up and ate breakfast on her own. Sat in kitchen belching loudly. Was asked to control belching and she became angry with the writer."

The CILA training policy states that each new employee must complete the initial forty hour training expectations before they can work alone with a consumer. The training includes concepts of treatment, abuse and neglect, elder abuse and rights. The Orientation of New Employees policy indicates that the employees are oriented in the philosophy of the facility, including the mission, vision and goals, as well as ethics, policies and process. The policy also states that employees are trained in the "Human Rights and Ethics Committee functions and members, including Client rights and responsibilities, Abuse Reporting, OIG reporting." The summary of rights reads "You are entitled to adequate and humane care and services" and "You have the right to be free from abuse and neglect. Any incidents of abuse or neglect should be reported to the Illinois Department of Public Health, the Illinois Department of Mental Health or the Illinois Department of State Police for investigation."

The HRA reviewed the facility medication monitoring guidelines which reads "Medications will be prescribed only to individuals open and engaged in services." Other than this policy, the facility did not provide a specific policy regarding services that residents/clients must receive for medications but staff did clarify in an email that psychiatry is not available as a standalone service. Staff also clarified that clinicians and the individuals discuss recommended services and develop a treatment plan based on these recommendations which is agreed upon and signed by the individual. This resident also signed her treatment plan.

The other statement that the HRA reviewed regarding a chair was a progress note dated 2/22/2014 which read that the resident took her medications, had some back pain and took pain medication for the pain, then finished her cleaning skills. The note then read "She said she was not able to sit in the chair that she needed for her back but let it go."

Regarding the complaint that a nurse forced the resident to sign a document without informing her it was about prohibited drinking, the HRA reviewed a medication self-administration client consent for Haldol and Benadryl which reads that the resident should "Avoid use of alcohol." This form was signed by the nurse named in the complaint. Additionally the HRA was provided a list of resident rules that also prohibits drinking, smoking or using drugs in the house.

The HRA reviewed a purchase order and contractor's invoice for cleaning mold in the basement of the house named in this complaint. In addition to that task, the contractor was to prime the spot where the mold was eliminated and add a finishing coat of industrial epoxy. The invoice had no date but the purchase order (which was North Central's document) was dated 3/4/2014 and had a signature date of 3/11/2014. The HRA reviewed a clarification email sent from staff to the HRA on 8/12/2014 stating that an incident report had not been completed but that the mold was reported on January 14th. According to the email sent, the facility cleaning service was contacted, but referred the issue to another vendor because they could not resolve the

mold issue. The second vender viewed the problem on 1/29/2013. The vendor reported that they could resolve the issue but it would take some time and that the process would best be started in the spring because the basement could be ventilated. The issue was finally finished in March. The HRA requested a facility safety policy but only received a policy regarding security at the facility.

The Rule 115 reads that "6) The agency shall ensure that: A) Living arrangements shall be safe and clean within common areas and within apartments over which the agency has control" (59 Il Admin Code 115.300). Also, "6) Compliance with life safety standards and requirements. All program facilities shall be in compliance with applicable State licensure requirements and local ordinances with regard to fire, building, zoning, sanitation, health, and safety requirements" (59 Il Admin Code 115.320). The Rule also reads "5) Every individual receiving CILA services has the right to be free from abuse and neglect" (59 IL ADC 115.250). The Mental Health and Developmental Disabilities Code states that "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan" (405 ILCS 5/2-102) and that "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect" (405 ILCS 5/2-112).

The MHDD Code also reads "A recipient of services may perform labor to which he consents for a service provider, if the professional responsible for overseeing the implementation of the services plan for such recipient determines that such labor would be consistent with such plan. A recipient who performs labor which is of any consequential economic benefit to a service provider shall receive wages which are commensurate with the value of the work performed, in accordance with applicable federal and state laws and regulations. A recipient may be required to perform tasks of a personal housekeeping nature without compensation" (405 ILCS 5/2-106).

Complaint #1 - Conclusion

The HRA saw no evidence that privacy was violated, that statements were falsified, that there was a broken chair at the facility, or that staff were verbally abusive to residents. The HRA saw no evidence that the resident was attacked by another resident. Additionally, the HRA saw no evidence that a staff made residents clean up after other residents, manipulated residents into signing documents, or misrepresented resident documentation. The HRA did not see evidence that the resident was told that they could not receive services without attending group, or that the resident questioned services, but rather saw evidence that the resident agreed to the services in her treatment plan. The HRA did see evidence that staff was involved with the resident's finances but it appeared to be used as education for budgeting.

The HRA found that the allegations listed in this complaint were **unsubstantiated** but offers the following **suggestions:**

- The HRA understands that the contractor stated that the facility should wait until the Spring to clean the mold, so the house could be aired out, but the HRA still felt as though this was a long time and suggests that in the future, the facility staff work on correcting issues like this in a shorter time span.

- The HRA suggest that the agency construct a facility safety policy.
- Review the assignment of chores with the resident as part of treatment planning. Consider bringing this practice before the internal human rights committee for review and discussion.

Complaint #2 - Inadequate grievance process.

The facility grievance policy documents steps to addressing complaints and reads that complaints will first attempt to be resolved between the resident and the staff member, and this does not occur, the resident is provided the staff's supervisor's contact information and the contact information for the Illinois Guardianship and Advocacy Commission and the Illinois Department of Human Services' Office of the Inspector General. From there, the resident is to provide the grievance in writing to the supervisor who will respond within 5 days and if that does not resolve the issue, the facility President will review and provide a written response to the grievance.

The HRA reviewed the facility "Client Rights and Responsibilities" policy/procedure which states that the facility will post the rights and responsibilities in all offices and additionally, upon admission or re-admission, clients will receive written confirmation of their rights and responsibilities. The policy/procedures special instructions state that a copy and explanation of the rights will be provided at the onset of treatment and the client will sign documents related to the client rights and a receipt verification of the rights and responsibilities document which will be filed with the record. The policy/procedure states that "If the client/consumer feels that his/her rights have been violated, he/she shall report the situation to his/her primary staff person. The staff member will discuss the situation with the client/consumer and advise the client/consumer of steps which are available to be taken toward the resolution of the situation. Additionally, the policy/procedure states the client has the right to contact the Illinois Guardianship and Advocacy Commission (IGAC), Office of Inspector General (OIG), among other agencies.

The HRA reviewed the rights document that is provided by the facility and was signed by the resident which states that the resident has the right to express any grievances and appeal "adverse decisions" to the authorized agency representative.

Rule 115 reads "c) Individuals or guardians shall be permitted to present grievances and to appeal adverse decisions of the agency and other service providers up to and including the authorized agency representative. The agency representative's decision on the grievance shall be subject to review in accordance with the Administrative Review Law [735 ILCS 5/Art. III]. For all individuals enrolled in the Medicaid DD Waiver, their rights to present grievances and to appeal adverse decisions of the agency are detailed in 59 Ill. Adm. Code 120" (59 Il Admin Code 115.250). The Mental Health and Developmental Disabilities Code (MHDD Code) reads "Every facility shall also post conspicuously in public areas a summary of the rights which are relevant to the services delivered by that facility" (405 ILCS 5/2-200).

Complaint #2 - Conclusion

The HRA reviewed no evidence indicating that staff provided and then took away complaint forms or that residents do not know that they have the right to present grievances, therefore the complaint is found **unsubstantiated** but the HRA offers the following **suggestion:**

- The contact information for the IGAC in the Client Rights and Responsibilities policy does not have the correct contact information or the statewide intake number. Also, in the patient rights document that is signed, the Rockford IGAC office is listed but, for that particular facility, the contact for the Peoria office should be provided. Also, the statewide intake number is not provided on that document as well. The HRA suggests that the facility update their records with the correct contact information and also assure that they are providing the clients with the contact information for the IGAC office that falls within their region.
- Assure that the resident's rights and responsibilities are being posted in a conspicuous public area per the MHDD Code (405 ILCS 5/2-200).

Complaint #3 - Inadequate admission process, including providing the resident with adequate explanation of the facility.

The HRA reviewed a policy dealing with initial client paperwork which states that under Rule 115 the client must complete a client rights form, agreement to participate, and house expectations. The special instructions of the policy state "It is the responsibility of the Community Support Team to meet with the client and review each form before signatures are received." The instructions also state "The CILA Q is responsible for explaining and receiving appropriate signatures on all forms." The instructions also state that the "Individual or guardian must give consent to participate in CILA program. This is noted by signature on Human Rights Assessment."

The HRA reviewed the "Human Rights" document which includes a confirmation that reads "Consumer consents and agrees to placement with the CILA or supervised residential program." This question was answered as, "yes," and was signed and dated by the resident. Another statement reads "Consumer has been provided with a statement of Rights and has had the service he/she will receive explained." This is also signed and dated by the resident. The resident also signed a consent for services document which reads that the resident is receiving services from North Central Behavioral Health and doing so on a voluntary basis. The form also indicated that the consent was explained to the resident.

The HRA did see that in the residential admission physical examination documentation, the resident received a tuberculosis test on 1/30/2014.

After reviewing a copy of this report and approving the draft at the September meeting, the HRA received further information from North Central Behavioral Health. The HRA received a document titled the "NCBHS Internal Resource Guide" which contains eligibility criteria for the facility. The criteria reads that the individual must be "1. 18 years old or greater 2. Have Medicaid as the payor source 3. Have a diagnosis of SPMI 4. LOCUS score of 24-27 5. GAF 45 or less 6. Priority populations given considerations for placement first and waiting list." Additionally, the facility provided a policy/procedure titled "Appeal Process For Denial 24

Hours Placement (Transitional Residential)." In that document, it reads "CILA has a no decline option, therefor, policy is not applicable to any 24 Hour CILA requests." Also, in the facility's "Summary of Rights" it reads "You have the right to receive all services regardless of your sex, race, ethnic background, handicap, religion, national origin, age or financial standing."

Additionally, the facility created an admission policy (dated 10/14/2014) which reads "All individuals referred for placement in the agency's 24 hour supervised Mental Health CILA will meet the requirements set forth in Rule 115." This policy includes the criteria information listed above and a statement which reads "NCBHS does not discriminate in the admission and provision of service, and has a no decline option."

Rule 115 reads "A) Agencies shall not discriminate in the admission to and provision of needed services to individuals on the basis of race, color, sex, religion, national origin, ancestry, or disability. B) Admission policies and procedures shall be set forth in writing and be available for review." (59 Il Admin Code 115.320). The HRA also reviewed the Illinois Department of Human Services CILA Tool Non-Deemed which has a guideline for this regulation which reads "Does the facility have written admission policies that contain the required non-discrimination statements?" The Rule also reads "a) An individual receiving services in a CILA shall be at least 18 years of age, have a mental disability and be in need of an array of services and a supervised living arrangement. If an agency does not have the capacity to accommodate the individual's particular type or level of disability, this does not render the individual ineligible for CILA services. b) The individual or guardian shall give informed consent to participate in a CILA, which shall be documented in the individual's record. c) The individual or guardian shall agree to participate in the development and implementation of the individual integrated services plan, which shall be indicated by the individual's or guardian's signature on the plan or a note describing why there is no such signature" (59 Il Admin Code 115.210).

Complaint #3 - Conclusion

The HRA found no evidence that the resident did not understand what she was signing upon entering the CILA or that the facility was not explained to her. The HRA also found no evidence that the resident received a shot in the arm prior to signing admission documentation; the HRA found evidence that consent for services and services received were explained to the resident, so, even if the resident had visual needs and did not have eyeglasses, an explanation of services were verbalized. Additionally, the facility appears to have the necessary admission policies/procedures required by Rule 115 (59 Il Admin Code 115.210) and the CILA Tool. Also the facility took their policies and combined them into one Admission Policy which includes eligibility criteria and a nondiscrimination statement. Because of this, the HRA finds the complaint **unsubstantiated.**

Complaint #4 - Inadequate treatment, including the following: the staff not allowing a resident to talk with medical provider and supplying medical providers with inadequate information; the staff removing PRN medication without a physician's knowledge and not providing PRN when needed; the staff providing wrong medication on three instances; the staff providing medication that a resident was allergic to and then not allowing a resident a

physician examination when reporting medication side effects; and not allowing a resident to leave facility to attend to personal issues and find housing.

The resident's psychiatric evaluation, dated 1/21/2014, indicates that the resident took Benadryl for her stiff muscles while on Haldol but stopped taking Benadryl because it caused problems with her memory. She said that she still had some for emergencies. The initial psychiatric visit sheet, dated 1/21/2014 indicates that the resident was taking Haldol, Benadryl, Meloxicam, and Fluticasone/Salmeterol Inhaler but she no longer takes the Meloxicam. The advanced practice nurse wrote in the initial psychiatric visit document to "Continue current medications of Haldol Decanoate 100mg/ml – Inject 0.5ml IM every weeks with next due on 1/24/14, and continue Benadryl 50 mg PO QHS."

Regarding the complaint that staff censor residents while speaking with physicians, the HRA reviewed a note, dated 2/13/2014, where the patient was taken to an urgent care center that read "Writer provided community support as ordered on the plan of care to [resident] at [urgent care] and saw [physician]. Writer provided support with registration, providing insurance copies and current medication sheets. Writer aided in communicating needs and problems with Dr and assisted Dr in explaining recommended treatment and medications … [Resident] very poor report of symptoms, confused, giving different answers when asked the same question. [Resident] complaining of back pain all week, refused to go to Dr earlier …. New symptom every time question was asked. Very hard to keep [resident] focused."

An outside provider appointment note reads "Client discussed her pain issues with the doctor this day, client, doctor, and writer reviewed client needs for refills of medications … d/cing [discontinuing] some medications due to too much pain medication being taken by client, and Dr. wanting to prescribe only Meloxicam and Tylenol at this time for clients pain … Clients med to D/C per the Dr. [name] are as follows; Regular Aspirin, Diphenhydramine, Tramadol, Advair, and Ibuprofen." On 2/25/2014 there was another instance documented on the resident's progress note where a staff member provided the resident with service while at a physician's appointment and reviewed the resident's medical issues with the physician. Part of the note reads "[Resident] actively participated in this individual support service but was defiant at times … Client went on to state that she would 'tell' the doctor that he needed to give her her Back and Body, that she knows what pain meds are right for her, and that NCBHS staff keep telling her she needs an order to take this med along with her Meloxicam. Client states she is 'very upset' about this. At this time writer did remind [resident], No Order, No Med … [resident] discussed many different ailments today, some from 20 years ago others recent, client reporting multiple issues with pain to her doctor and discussed her pain for the first hour of the appt. Client then began telling the doctor how unhappy she was not receiving her back and body med, and her Ibuprofen, to which the doctor told her that she would no longer be able to take these meds with her Meloxicam. The doctor explained to [resident] that she will be able to take Tylenol with her Meloxicam and [resident] was unhappy to hear this … [PCP] recommended that [resident] see [physician] for her psychiatric needs, as client was symptomatic and struggling to stay on any one topic, client would discuss her jail time, a man she asked for bread and then was taken to jail for asking him, and borrowing money from people whom she couldn't recall, client was observed to be anxious and unable to stay focused on any one topic jumping from her pain issues, to suing people, to anger with living at the CILA home, to telling the doctor she knows

what pain meds she needs and he does not." In reviewing the registered nurse (RN) progress note from the same day, the client was to not have Ibuprofen, any type of Back and Body meds, regular aspirin, Tramadol, Diphenhydramine (which is an allergy medication) and Advair. The client was to only be on low dose Aspirin, multi-vitamin, ProAir (asthma), Doc-q-lace, Cyclobenzaprin, and Meloxicam. The client could also have Tylenol PRN.

The HRA reviewed a standing order for medications where Meloxicam was discontinued on 3/26/2014 per the resident's PCP and Ibuprofen was prescribed also dated 3/26/2014. Bendryl and Tylenol were also prescribed as PRN on 3/25/14. According to the medication log, Tylenol was given in February but at no other time. The HRA also viewed PRN medication records dated from 3/25/2014 until 4/29/2914 and Benadryl was on the administration records as well as Ibuprofen. The HRA also reviewed a Medication Self-Administration Client Consent which states the client's medications are Haldol and Benadryl.

The HRA was provided a physician's order where Haldol injections were prescribed for every four weeks starting on 1/21/2014 and ending 4/20/2014. Benadryl was prescribed 1/21/2014 and ending 3/27/2014 and it was explained to the HRA in a clarification email that the Benadryl was not a PRN medication. The HRA reviewed another order with a start date of 5/6/2014 for Haldol. The Benadryl was not part of that order but the resident was out of the house by that time. The HRA also saw progress notes in which it is documented that staff assisted the resident in receiving the Haldol injections on 2/20/2014, 3/20/2014 and 4/17/2014 at a separate location.

The Medication Errors policy reads "North Central Behavioral Health Systems establishes several internal processes to reduce the likelihood of a medication error occurring. A medication error is identified as a failure in the treatment process that leads to or has the potential to lead to harm to the patient or individual receiving treatment." In the special instructions section of the policy, it reads "NCBHS works to assure that the right patient, right drug, right dosage, right time and right route are in place." The policy also provides instructions on how to avoid medication errors, for example nurses read back and verify verbal orders with the physician and pharmacist and psychiatric services staff have a process to check and double check orders. The HRA reviewed another policy for Medication Sheets/Medication Passes at the residential homes, and the policy states that all consumers must have a medication sheet listing current medications and the times to be taken.

The Department of Human Services Rule 115 states that "a) A physician shall be responsible for the medical services provided to individuals and the management of individuals' medications" (59 IL ADC 115.240). Rule 115 also reads "A) A licensed physician (MD or DO) shall assume medical and legal responsibility for medical services offered in any program, including prescription of medications. B) All services shall be provided by appropriately trained employees, operating under the supervision of qualified clinical professionals" (59 IL ADC 115.320). The Mental Health and Developmental Disabilities Code reads "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. 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). Rule 116 reads "All medications, including patent or proprietary medications (e.g., cathartics, headache remedies, or vitamins, but not limited to those) shall be given only upon the written order of a physician, advanced practice nurse, or physician assistant…. All orders shall be given as prescribed by the physician and at the designated time…." (59 Ill. Admin. Code 116.70).

Complaint #4 - Conclusion

The HRA found no evidence that staff censored the resident while speaking with a physician, said to the physician that she was delusional or that they did not have to take the resident to an appointment. The HRA saw no evidence that the staff made mistakes with the resident's medication or that there was an allergic reaction to the Haldol and the patient was not allowed allergy medication for the reaction. There was no evidence that Tylenol and Advil were removed from the patient's prescription list without the physician's knowledge. Because the HRA found no evidence in the findings, the complaint is found **unsubstantiated** but the HRA offers the following **suggestions:**

- The medication self-administration client consent sheet indicates that the client is able to give themselves Haldol but the facility stated that the Haldol was provided via IM shot at a hospital. The HRA suggests that the facility use a different form if medication is not actually a self-administration.
- The facility indicated that PRNs were accounted for separately in March and that Benadryl was not considered a PRN. Benadry still appeared on the PRN form in March, so the HRA suggests that the facility discuss this with staff so that they are completely aware that Benadryl is not a PRN.

Complaint #5 - Communication violation, including a resident not being allowed to contact his/her physician and a resident not being allowed to leave facility to visit their family.

The HRA determined the section of complaint #4 which states the facility did not allow the resident to leave facility to attend personal issues and find housing is answered in this complaint.

The HRA began by reviewing the resident's record. An individual progress note dated 3/14/2014 reads "Emails reviewed, updated med sheets, and spoke with [PCP] nurse [nurse's name]. [Resident] has been calling [PCP] office excessively on a daily basis with reports of pain and her meds not working." A Nursing Voicemail Assessment dated 4.8.2014 reads "Hi this is [Nurse] from [PCP] office in Spring Valley. I'm calling about [Resident]. I just kind of wanted to talk to you to see about what's been going on with her cause she's called us today about multiple, multiple things so if you could call us back at [phone number]." That same assessment reads "Chart reviewed returned call to [Nurse] at [PCP] office, she reports that client is calling several times a day saying her back hurts, she has a cold with N, V, & D, and that her vagina hurts, [PCP] wanted to know what her DX (diagnosis) is, advised of DX, and next Drs apt, [Nurse] stated she also called [staff] for a report as well."

As documented in complaint #4, the resident did attend a physician's appointment with assistance from the staff.

In reviewing the resident's shift notes, she received a phone call on 2/3/2014. Another note reads from 2/7/2014 states that "Writer and [resident] met at [house] to complete annual rental agreement, discuss housing and transportation options, and arrange for [resident] to obtain a free TV for her use." The document states that the resident was provided forms for different apartments and staff discussed the details of rental sites with the resident and determined they would complete forms at the next service date. In the resident's progress notes, it stated that she received a few phone calls on 4/3/2014 and another note on 4/11/2014 reads that the resident needed help with a cell phone during the shift. On 4/20/2013 it was stated that the resident called family.

The note also states "Writer explained the basic workings for BPART [Bureau and Putnam Area Rural Transit] for transportation and provided [resident] with contact number to gain more information/schedule rides." Another part of the note states that the resident "… will know how to contact BPART for transportation needs." The HRA reviewed the BPART website which reads that "BPART is a demand response, curb-to-curb transportation service for Bureau and Putnam counties."

In the resident's independent program checklist it reads "[Resident] will be able to leave the house independently, for two-three hours each day to go to local restaurants, stores or establishments." The resident rights form reads that "You have the right to communicate with other people in private, without obstruction or censorship by agency staff. These rights include mail, telephone calls and visitors."

The HRA reviewed a policy dealing with independence and safety in 24-hour facilities, which reads "It is the policy of North Central Behavioral Health Systems, Inc. to provide and assure that residents in our 24-hour facilities are safe and allowed to exercise some degree of independence." The policy states that the residents are expected to remain in the home between 12am and 6am unless there are other arrangements and that no consumer is to leave the facility unsupervised "if they are symptomatic or do not have an independent program." The policy states that residents are expected to inform staff when they are leaving the facility and when they plan to return. The HRA reviewed a sign-in sheet which indicated that the resident did leave the facility on a number of occasions, mostly to take a walk. The HRA also reviewed the Resident Rules which indicate that there are visiting hours between 6pm and 10pm in the evenings and in one home, residents can have overnight guests. The rules also state that residents are not allowed to leave facilities or grounds without staff until they have been assessed for independent programs, which should happen within two weeks of placement.

The HRA was not provided a communication policy for the facility. There was a sheet titled "Resident Rules" that was provided to the HRA and labeled as the "Visitation Policy." The Resident Rules did have some rules regarding visitation and a statement regarding the residents being responsible for the payment of long distance calls or calls made on agency phones. Additionally there is a CILA rights document which states "You have the right to communicate

with other people in private, without obstruction or censorship by agency staff. These rights include mail, telephone calls and visitors."

The Rule 115 reads that "a) Employees shall inform individuals entering a CILA program of the following: 1) The rights of individuals shall be protected in accordance with Chapter II of the Code except that the use of seclusion will not be permitted …" (59 Il Admin Code 115.250)

The Mental Health and Developmental Disabilities Code reads "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 … (b) Reasonable times and places for the use of telephones and for visits may be established in writing by the facility director. (c) Unimpeded, private and uncensored communication by mail, telephone, and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission" (405 ILCS 5/2-103). The Code also states "The Secretary of Human Services and the facility director of each service provider shall adopt in writing such policies and procedures as are necessary to implement this Chapter. Such policies and procedures may amplify or expand, but shall not restrict or limit, the rights guaranteed to recipients by this Chapter" (405 ILCS 5/2-202).

Complaint #5 - Conclusion

The HRA saw no evidence that residents were not allowed to contact their physicians, that a resident was not allowed to leave the facility, that a resident was not allowed to go to an appointment or that a resident was not allowed to take a bus to visit family. Although there were no findings with these allegations, there is no documented communication policy which is a violation of 405 ILCS 5/2-202. Because of the lack of policy, the HRA finds this complaint **substantiated** and makes the **recommendation that the facility create a communication policy to comply with the Code. The HRA requests evidence of the policy and staff training on the policy.**

Complaint #6 - Inadequate facility staffing.

The HRA reviewed a residential call-in and coverage policy which states that "All residential staff will need to call the Extended Care Manager or designee and the location of his/her shift of two (2) hours prior to the beginning of the shift if they are going to be off. The exception, being the 6:00 am – 2:00pm shift, who will need to call one (1) hour prior to the beginning of the shift." The policy has additional special instructions dealing with coverage, one of which states "Prior to each 5th hour of the person's shift, they need to take a 20-minute break, however, since the staff have to remain on-site, they will be paid for this time."

The HRA reviewed a schedule that was effective on May 31st and all shifts were accounted for in the CILA home. The HRA also reviewed email correspondence where administrative staff emailed other staff requesting coverage for days at the CILA home. In a 4 month timespan (February – April 2014) the facility requested coverage for 37 dates. The

facility did not state the reasoning for the requests. All dates appeared to be covered. No staff worked more than 5 consecutive days but one staff member does appear to work from 2pm – 10pm on Thursday and then the 10pm – 6am shift.

Rule 115 states "d) Based on their needs, individuals shall receive supervision and supportive services which may range from continuous to intermittent … The agency shall have a plan and arrangements for providing relief for employees and contractual workers who have responsibility more than eight consecutive hours or five consecutive days for individuals receiving services, and shall have evidence of implementation of the plan and arrangements. Any such plan shall comply with federal and State labor laws and shall provide recognition of the need for respite in foster care model settings" (59 Il Admin Code 115.200).

Complaint #6 - Conclusion

The HRA found no evidence that the facility is short staffed, that staff call in sick regularly or that staff are overworked, and because of this the complaint is found **unsubstantiated.**

14-090-9021

Compliant #1 - Confidentiality violation.

The HRA reviewed the facility confidentiality policy which states that "All employees of North Central Behavioral Health Systems, Inc., independent contractors, students and all other service providers are required to maintain strict adherence to confidentiality as specified in the Confidentiality of Alcohol and Drug Abuse Client Records and the Department of Mental Health and Developmental Disabilities Confidentiality Act and the confidentiality of HIV/AIDS status and testing." The policy provides further instructions on keeping patient information confidential.

The HRA also reviewed the facility's authorization to disclose policy. The policy reads "All information released by North Central Behavioral Health Systems, Inc. is disclosed from records whose confidentiality are protected by the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), the Confidentiality of Alcohol and Drug Abuse Patient Records and the Health Insurance Portability and Accountability Act (HIPAA) and may be released only upon receipt of a written authorization from the client or guardian or a court order … Verbal consent for release of information is not acceptable." The policy includes special instructions relating to disclosure forms.

The record shows that the resident did consent to disclose information to her PCP for the purpose of continued treatment. The HRA reviewed a revocation of the disclosure dated 4/24/2014.

The HRA did see some evidence that the facility dealt with budgets with the resident. The resident's treatment plan read "… she will be able to report to staff having money left at the end of the week and not needing additional funds beyond what is budgeted." A progress note, dated 2.5.2014, reads "Writer met with [resident] for individual community support budgeting

and shopping. The purpose of this service is to support client by teaching and practicing skills that will increase client's understanding of money management with meeting personal needs such as creating a shopping list to insure weekly needs are met, creating a budget for shopping, making good choices regarding spending."

The facility Summary of Rights statement also reads that "All information concerning you is held confidential and released only by your written consent or by court order, as governed by the confidentiality act." Another facility form titled "Confidentiality of Client Records" states there is also another facility form which states "Whenever possible, all contact and inquiries at North Central Behavioral Health Systems, Inc. are held in the strictest of confidence. Usually, information is disclosed only in the presence of the client's written consent. However, in some situations Illinois Law requires the disclosure of client information. It is vital for you to understand these exceptions as you consider counseling services." The form lists 6 instances where the records can be disclosed without consent and they include suspected child abuse, suspected elderly abuse, and a court order, among others.

The Mental Health and Developmental Disabilities Confidentiality Act reads "All records and communications shall be confidential and shall not be disclosed except as provided in this Act" (740 ILC 110/3). Also "Except as provided in Sections 6 through 12.2 of this Act, records and communications may be disclosed to someone other than those persons listed in Section 4 of this Act only with the written consent of those persons who are entitled to inspect and copy a recipient's record pursuant to Section 4 of this Act" (740 ILCS 110/5)

Complaint #1 - Conclusion

The HRA found no evidence that documents were sent to the resident's primary care physician. Therefore, the complaint is found **unsubstantiated** but the HRA offers the following **suggestion:**

- The facility form "Confidentiality of Client Records" indicates that there are 6 situations where the facility may disclose confidential information without consent, but the Mental Health and Developmental Disabilities Confidentiality Act indicates that there are more situations than what is listed. The HRA suggests the facility review the Act and update the form based on the review.

Complaint #2 - Retaliation against clients for voicing a grievance against facility.

The HRA reviewed the facility grievance policy which states that residents are supported in communicating their concerns. The facility summary of rights reads "You have the right to terminate treatment at any time and you shall not be denied, suspended or terminated from services or have services reduced for exercising any of your rights."

The facilities "Organizational Code of Conduct" reads that staff will "Not engage in or tolerate retaliation against another staff member, client, or other party who reports violations or breaches related to State and Federal laws and regulations or agency policies."

Rule 115 reads “d) Individuals shall not be denied, suspended or terminated from services or have services reduced for exercising any of their rights.” (59 Il Admin Code 115.250). The Mental Health and Developmental 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).

Complaint #2 - Conclusion

In reviewing the records, the HRA saw no evidence that there was a grievance brought against the facility by the resident. Because the HRA found no evidence that the patient's visitation rights were restricted while at the facility, the complaint is **unsubstantiated.**

RESPONSE

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

NORTH CENTRAL
BEHAVIORAL HEALTH SYSTEMS

www.ncbhs.org

Health Directions

February 12, 2015

Guardianship and Advocacy Commission
Human Rights Authority
401 Main Street, Suite 620
Peoria, IL 61602
Attn: Ms. Debra Goodwin

Ms. Goodwin:

This letter serves as North Central Behavioral Health Systems' formal response to the findings, outcomes and recommendations of the Human Rights Authority's investigation related to Case #14-090-9020 and 14-090-9021.

We appreciate the opportunity to respond to the report and request that our response be posted with the original complaint and final report on the HRA's website.

This response also serves as a formal appeal and request to review the one substantiated finding related to the complaint of a communication policy violation and reverse this to unsubstantiated with suggestions, based on the HRA's own report that they found no evidence related to the specific complaints by the individual that they were valid.

Enclosed please find the responses to each complaint of substantiated and unsubstantiated that had recommendations or suggestions. The substantiated finding is addressed first, presenting additional information and evidence to request a review of the outcome and change in the findings.

Thank you.

Sincerely,

Donald Miskowiec, Chief Executive Officer
North Central Behavioral Health Systems, Inc.

Enclosure

Administrative Offices: 2960 Chartres Street | P.O. Box 1488 | La Salle, IL 61301 | 815-224-1610 | FAX: 815-223-1634

727 Etna Road
Ottawa, IL 61350
815-434-4727
FAX: 815-434-0271

2960 Chartres Street
La Salle, IL 61301
815-224-1610
FAX: 815-224-1730

17 North Point Drive
Streator IL 61364
815-673-3388
FAX 815-673 1437

Perry Plaza, Suite F
526 S. Bureau Valley Pkwy.
Princeton, IL 61356
815-875-4458
FAX: 815-872-0417

229 Martin Avenue
Canton, IL 61520
309-647-1881
FAX 309-647-1878

301 East Jefferson
Macomb, IL 61455
309-833-2191
FAX: 309-836-2118

#14-090-9020

Complaint # 5 – Communication violation, including a resident not being allowed to contact her physician and a resident not being allowed to leave facility to visit their family.

The HRA saw no evidence that residents were not allowed to contact their physicians, that the resident was not allowed to leave the facility, that a resident was not allowed to go to an appointment or that a resident was not allowed to take a bus to visit family.

Even though the HRA found no evidence of violation or restriction of the individual's rights, the complaint was still substantiated. NCBHS disagrees with this finding. The finding was based on two areas cited within the Mental Health Code, those being:

> (405 ILCS 5/2-103) (from Ch. 91 1/2, par. 2-103)
>
> (c) Unimpeded, private and uncensored communication by mail, telephone, and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission. When communications are restricted, the facility shall advise the recipient that he has the right to require the facility to notify the affected parties of the restriction, and to notify such affected party when the restrictions are no longer in effect. However, all letters addressed by a recipient to the Governor, members of the General Assembly, Attorney General, judges, state's attorneys, Guardianship and Advocacy Commission, or the Agency designated pursuant to "An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named", approved September 20, 1985, officers of the Department, 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 5/2-202) (from Ch. 91 1/2, par. 2-202)
> Sec. 2-202. The Secretary of Human Services and the facility director of each service provider shall adopt in writing such policies and procedures as are necessary to implement this Chapter. Such policies and procedures may amplify or expand, but shall not restrict or limit, the rights guaranteed to recipients by this Chapter.
> (Source: P.A. 89-507, eff. 7-1-97.)

NCBHS contends that the documentation of sec. 405 ILCS 5/2 – 103 related to unimpeded private communication is addressed in our CILA rights forms, the Confidentiality of client rights statement received at intake and that the training the staff receive on client rights and responsibilities, the Mental Health Code and the Confidentiality Act satisfy this section of the code.

Sec 5/2 -202 indicates a provider shall adopt in writing policies and procedures as are necessary to implement. Nothing in this section requires a specific policy on "Communication". While we will add to our client rights and responsibilities policy this section of the code, we contend that because there was no direct violation related to this chapter or the Mental Health Code, or the individual, and evidence supports the agency followed the requirements, that this complaint should be reversed and deemed unsubstantiated with suggestions.

#14-090-9020

Complaint #1 Inhumane Treatment

The HRA found no evidence that privacy was violated, that statements were falsified, that staff were verbally abusive, that a resident was attacked by another resident, no misrepresentation of documentation or that the resident was not aware of receiving services.

The HRA's suggestions related to complaint indicated that work done at the home should be completed in a shorter time span, that the agency should construct a safety plan and that assignment of chores should be incorporated into treatment planning.

We contend that issues related to safety, maintenance and health are addressed in an expedited manner in the agency. Staff perform regular safety and hazard surveillance inspections of all sites and the group home. Issues that are found are communicated immediately to the appropriate department. The length of time related to repair or correct issues is dependent on outside contractors, the extent of work needed and the process required. We appreciate the committee's suggestion that work should take less time, but in order to assure that work is done properly and follows all codes and rules upon completion, we follow the recommendations of professionals responsible for the tasks and their timeframes. Please note, that at no time were any individuals' health or safety at risk and the length of time the process took prevented individuals in our care from being exposed to a hazardous situation.

NCBHS has multiple policies related to safety and care of its facilities. When asked to clarify which safety policy the HRA staff was referring to in the list of documents requested, he stated one that would demonstrate the staff know how to address safety issues between clients. Therefore, he was given the agency security policy.

NCBHS currently has the following policies/plans:

Safety Management Plan

Safety Survey Policy

Facility Review Policy

Hazard Surveillance Plan

Life Safety Deficiency Policy

Physical Environment Management Plan

Each of these policies or plans address areas in rules and regulations in order to ensure our group home and offices are safe, clean and compliant with Life Safety, Rule 115, Rule 132 and the Fire Marshall. In previous CILA, Medicaid, and Joint Commission reviews these plans and policies were found by auditors to be sufficient to meet all requirements. Therefore, it would be redundant to construct another facility safety policy.

#14-090-9020

Complaint #2 Inadequate Grievance Process

The complaint alleged that the individual was not allowed to present a grievance about issues she had with the agency and group home.

HRA found no evidence to support this allegation and the complaint was determined to be unsubstantiated.

NCBHS will update the Client Rights and Responsibilities to correct the contact information and add the Peoria office and statewide intake number, as suggested. Currently, the Rights and Responsibilities are and have been, including prior to the allegation/investigation, posted in the common area of the group home and the lobby of all offices. The HRA representative did not tour the home or go into the clinical lobby of the office, so he would not have been aware these were posted. So, while this was a suggestion by the committee it is already and had been in place prior to this incident.

#14-090-9020

Complaint #4 Inadequate Treatment

The complaint alleged that the individual was given the wrong medications that she was not allowed to talk with her physician and that her prn medications were withheld.

HRA found no evidence to confirm the allegations and found the complaint unsubstantiated.

Regarding the suggestion that the agency use another self administration form for Haldol IM, the agency medication self administration form is required and is used to document whether an individual is able or not able to self administer medications with or without supervision. Nowhere on the form does it designate that the individual was able to self administer Haldol Deconate. The form was used to identify the individual was able to self administer medications taken orally without supervision, as required by Rule 115 and Rule 132. A Haldol injection is not able to be self administered with or without supervision, so the creation of another form to designate this non occurrence would be burdensome to the system and the prescribers within our agency. The agency will during the staffs' annual medication management training, remind them that Benadryl can be both a PRN and a prescribed medication as suggested.

#14-090-9021

Complaint #1 Confidentiality Violation

The complaint alleges that staff gave documents to the individual's primary care physician.

HRA found no evidence to support the complaint and the agency provided HRA documentation of a valid authorization to disclose related to the individual and the physician.

The agency accepts the suggestion and will add to our policy related to Confidentiality of Client Records the areas also allowable under the Act for disclosure without authorization. Those areas being during the course of an investigation, monitoring, auditing by a government agency and in the course of working with a state agency or facility for the provision of facilitating care and treatment at admission or discharge.

Thank you for your time and reconsideration of the areas that were cited as substantiated. If you require further documentation or information in order to fully review these areas please feel free to contact us.