FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY – NORTHWEST REGION
REPORT 15-080-9003
ROCKFORD MEMORIAL HOSPITAL

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship & Advocacy Commission opened an investigation after receiving complaints of potential rights violations of a mental health patient at Rockford Memorial Hospital in Rockford. Allegations were that there is a lack of safety on the unit.

Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102(a), Patient Rights under hospital licensing requirements (77 Ill. Admin. 250.260) and the Centers for Medicare/Medicaid Services (CMS) Conditions of Participation for Hospitals (42 C.F.R. 482.13).

According to the website, Rockford Memorial Hospital is a 396-bed-licensed facility that first opened their doors in 1885. The Inpatient Behavioral Medicine Unit provides care and mental health treatment to men and women suffering from severe depression, psychosis, suicidal ideation and other serious mental issues including people with both mental health and substance abuse issues. The unit has 14 adult beds and 10 private rooms. It is staffed by a care team of psychiatrists, nurses, social workers and mental health technicians.

To pursue the matter an HRA team met at the hospital and interviewed the following Inpatient Behavioral Medicine Unit staff: a director of risk management, a physician, a nurse and a mental health technician. In addition, legal representatives for the hospital were also interviewed. Policies were reviewed as were relevant sections of masked records of patients.

COMPLAINT SUMMARY

The complaint alleges that there are concerns regarding the safety, support and security of patients on the behavioral health unit which has led to at least 2 instances of sexual assault for which the patients had to call the police themselves to file a report. The complaint goes on to allege that there was medical neglect that caused further deterioration of a patient. This review focuses on how Rockford Memorial protected patients on the unit. The sexual assault and medical neglect portions of the complaint have been referred by the HRA to the appropriate state enforcement agency.

FINDINGS

The attorney stated that during orientation, the behavioral health unit rules and regulations were discussed with the 3 female patients and 1 male patient involved in this case, but hospital staff are not required to document that patients have been informed.

It was explained by the attorney that on December 4, 2014 a female patient on the unit reported to a mental health technician who in turn reported to a nurse, that a male patient came into her room and touched her on the leg. The male patient was immediately separated from the female patient. On the same morning, another female patient reported to the aforementioned staff that the same male patient exposed himself to her in the shower area of the unit. In addition, a third female patient reported that the male patient touched her on the breast and buttocks. When questioned by the HRA why no documentation regarding this third female patient was provided, the attorney retorted that he would obtain the records and provide them to the HRA.

The physician stated that the nurse verbally communicated the situation to him, but he is unaware if any written reports were filed by the 3 female patients. The attorney replied that the hospital staff did not require the 3 female patients to file written reports, but only verbally communicate their complaints to them. He added that the staff-to-patient ratio on the day of the incident is unknown at this time.

The risk manager explained that the hospital staff monitored the male patient while ensuring the 3 female patients were safe, and they began

securing a 1:1 for the male patient, including meeting with risk management to transfer the male patient to a room on an entirely different floor of the hospital where he continued to receive mental health services until his discharge.

The attorney added that one of the 3 female patients called the police, and all 3 female patients spoke with them. But the police declined to file charges. The attorney then retorted that the police were not called by the staff because "no crime had been committed". The attorney went on to say that the hospital security department was also not called because "the staff did not deem it necessary". When asked whose responsibility it was to call the police, neither the attorney nor any staff would answer. The attorney explained that the male patient as well as the 3 female patients continued to remain separated and receive mental health services until the time of their discharge from the hospital. He added that a report was submitted to the Department of Public Health.

When the HRA team asked what type of training the hospital staff receives regarding these types of circumstances and how often the training is conducted, both the attorney and the nurse stated that they would provide this information at a later date.

Although the attorney stated that the police declined to press charges after speaking with all 3 female patients, the HRA submitted a FOIA (Freedom Of Information Request) to the local police department.

RECORDS

Progress notes dated 12/4/14 by a mental health technician states that "the male peer in question had been spotted on unit cameras entering the patient's room at or around 7:15 a.m. on 12/4/14 at which time staff moved to intervene, but that peer had left patient's room of his own volition before staff arrived".

Progress notes by the nurse dated 12/4/14 with a note time of 8:07 a.m. state that "MHT reports to nurse that patient had gone into another patient's room". "MHT later reported that patient was standing at the shower door when another patient was going into the shower and exposed his genitals. When he was seen he walked away. Later he went to the same patient's room and asked if he could come in". "Patient

continues to attempt to go into other patient's room. Patient is in the halls. Staff in the hall monitoring patient continuously after breakfast".

The attorney's letter to the HRA dated 8/20/15 and the attorney's letter to the Department of Public Health dated 1/26/15 both stated that a third female patient alleged that the same male patient touched her on her buttock and breast on 12/4/14. No time of day was provided on the letters and there was no documentation by staff of this third female's allegations.

Nurse progress notes dated 12/4/14 with a note time of 9:00 a.m. denote that "Patient up in hallway. Described mood as lonely and upset. Patient reports that another patient had wandered into her room and touched her leg, she said that she will kick his ass. She reports that he will not have a chance and says that she had self defense classes and will not hesitate to protect herself. Patient informed that staff are monitoring the hallway continuously. Informed patient of what staff is doing for patient safety".

Progress notes by the nurse dated 12/4/14 with a note time of 12:30 p.m. depict the following: "Patient informs this writer that she would like to call the police to press charges against another patient. She says that she should not have to be here with a sexual predator and will not be able to sleep with him right down the hall. Redirected patient to the present time, saying that it is not bedtime yet. Informed patient that she could talk to our nurse manager or our director about pressing charges. Notified nurse manager in her office. Called and left message for the director. Patient states that she called the police and they said they would send somebody to see her. Told director that police were on their way and a few minutes later, an officer arrived. Director and nurse manager greeted her outside the unit".

The discharge summary (from the behavioral unit) for the male patient has the date, time and author masked. It was most likely written by the physician. It states that "Those 3 female patients filed a report to staff member and the patient was *immediately isolated* from those female patients". The summary goes on to state "It was felt that the patient's presence in the unit will be therapeutically harmful for the other female patients in the unit. On the other hand, the patient needs

help for his schizoaffective disorder. Risk management team was consulted and the meeting was conducted with the hospital and it was decided that we will provide psychiatric care to this patient, which he requires, but will transfer him to a different part of the hospital so the other female patients will be isolated from this individual, and will continue providing psychiatric care to this individual in a different part of the hospital".

Sitter Order #24415680 dated 12/4/14 by the physician and nurse show that the order was placed at 2:21 p.m. and acknowledged at 2:39 p.m. This is noted and compared to the starting point of the sexual incidents time which was between 7:15 a.m. and 8:07 a.m., resulting in a 6 to 7 hour period before a 1:1 was provided to the male patient.

Masked prescription records for the 3 female patients denote that on 12/4/14 (with a prescription start date of 12/4/14) one female patient was administered the medication Citalopram (Celexa) which is used for depression. Another female patient was administered Clonazepam (Klonopin) for the treatment of panic disorders on 12/4/14 with a prescripton start date of 12/2/14. In addition, for bi-polar depression, Latuda (Lurasidone) was ordered and given to the 3rd female patient on the aforementioned date with a prescription start date of 12/4/14.

Progress notes regarding the male patient dated 12/4/14 written by the nurse with a note time of *6:15 p.m.* states "Plan of care conference. Due to reports by 3 female patients reporting alleged incidences of inappropriate touch and exposure of genitalia disrupting the milieu and treatment of those patients with a potential for continued risk of same, patient *is being* transferred to A3 where he will be treated for his presenting symptoms of suicidal ideation, altered thought process, lack of insight and poor judgement". "*Plan is for him to be on 1:1* with security guard within the room at all times".

Per the discharge summary that is dated 12/4/14 written by the physician, "the male patient was discharged from the Behavioral Medicine Unit on 12/4/14 at 8:23 p.m. to a medical floor, acute care hospital". (Unit A3)

But, per the Observation Flowsheet dated 12/4/14 the male patient was discharged to unit A3 on the medical floor at 8:15 p.m. We can also deduce from this document that the unit was adequately staffed on 12/4/14. In addition, the Nursing Staffing Grid indicates that the staff-to-patient ratio for the day shift is 1 nurse and 2 mental health technicians per 6-8 residents. For the night shift there is 1 nurse and 1 mental health technician per 0-11 residents.

Progress notes by the mental health technician dated the following day of 12/5/14 stated that the female patient "tells this author that at some point after yesterday's incident, she had entered (apparently alone and unwitnessed by staff) into the offending peer's room and struck him three times with a hardcover bible in retribution for his earlier actions".

Social worker progress notes regarding the male patient dated 12/9/14 depict that the physician "was planning to transfer the patient for further treatment back to E2 (Behavioral Medicine Unit). The physician requested that the patient be involuntary status". The petition and first certificate were completed. The physician discharge summary states that the male patient was discharged on 12/12/14 to a local outpatient mental health facility. The 3 female patients were discharged by 12/8/14.

In response to the FOIA request, the local police department provided a comprehensive and explicit report to the HRA. It is noted in the report that after the initial interview of the physician by the police officer, the physician later contacted the officer again and explained to him that after further assessing the male patient, the physician believes that the male patient " knew what he was doing at the time of these incidents" and "the physician believes that the actions were a result of criminal behavior rather than his illness". The police officer concluded that "no arrest would be made at this time but this report would be forwarded to the State Attorney's Office for review".

The HRA submitted a FOIA request to the DPH (Department of Public Health) on 1/8/15 requesting all reports of abuse regarding Rockford Memorial Hospital for the period of 1/1/14 through the present. The DPH responded by email on 1/22/15 stating that they were "unable to identify any records responsive to the FOIA request. However, the Department's Office of Health Care Regulation opened up

a complaint investigation based on the information received from the HRA that was provided with the FOIA request" and that "the investigation would take approximately one month to complete". On March 13, 2015 the DPH responded by email with a copy of their report stating that the investigation they conducted on 1/22/15 resulted in no findings of violations.

The attorney presented a letter dated 12/15/14 that he had written on behalf of Rockford Memorial Hospital to the DPH titled "Sexual Assault Report", with a brief explanation of the events that occurred on 12/4/14. Within this letter is the following statement: "A detailed report will be provided within 30 days of this event following completion of the Root Cause Analysis and Investigation." On 1/26/14 the attorney wrote another letter (explaining in great detail what happened with each female patient and the male patient) to the DPH titled "Follow up on submitted to DPH on December 14, 2014". In addition, the attorney provided to the HRA a copy of the same report and same complaint number of no findings that the DPH had previously provided to the HRA dated 1/22/15 along with a copy of the letter from CMS (Centers For Medicare & Medicaid Services) confirming the "no findings" result of the "1/22/15 substantial allegation survey".

CONCLUSION

The Prevention And Response To Sexual Acting Out On The Behavioral Medicine Unit Policy states that "Patients will be informed during the orientation, of unit rules regarding sexual behavior. Patients will be educated and encouraged to immediately report sexual harassment or assault to staff, and educated on the potential consequences of engaging in sexual assault or harassment or participating in consensual sex".

The policy goes on to state that "The purpose of the policy is to ensure a safe environment for patients and staff by establishing procedures for preventing and responding to sexual assault, harassment, or acting out committed on the Behavioral Medicine Unit of Rockford Memorial Hospital".

"Protective interventions will be immediately implemented for the safety of the patients and staff. The alleged victim and perpetrator must be promptly separated. The alleged perpetrator must also be separated from other patients and potential victims".

"The manager of the unit shall promptly notify Risk Management and the Security Department of any incident related to sexual assault or harassment and ensure completion of a Riskmaster Report. Risk Management shall complete the following:

1. Appropriate assessment and interviewing of the alleged victim(s);
2. Advising the alleged victim(s) that the alleged assault must be reported to the police;
3. Notifying police of the alleged assault;
4. Notifying state or other agencies, as appropriate.

The Security Department Policy depicts that "The following is a non-exhaustive list of situations or activities which should be reported to Security by all RHS employees":

3. Disruptive, disturbed or difficult individuals.

6. Any call to outside law enforcement authority regarding RHS business should be directed through security.

11. Any other incident or behavior which, in the judgement of the observing RHS employee, has the potential to cause harm to RHS patients, visitors or employees.

The Security Department Policy states that "It is the policy of Rockford Health System to vest with the Security Department the responsibility and authority necessary to maintain order, protect patients, visitors, and staff from harm and to safeguard system and personal property. All RHS employees are expected to actively assist the Security Department in fulfilling its responsibilities by reporting any suspicious people or activities to the Security Department".

The Security Of Patients And Staff On The Behavioral Medicine Unit Policy denotes that the "Security Department personnel will work closely with the Behavioral Medicine Staff to maintain a reasonable presence on the Behavioral Medicine Unit so as to be aware of

potentially violent patients and to be prepared to intervene immediately in the event a patient is in immediate risk of imposing harm on himself or herself or others resulting in the possible need for restraints for safety".

The policy continues in that "Security personnel shall round on the Behavioral Medicine Unit each shift. Rounds shall consist of: A face-to-face communication between the security staff and the Behavioral Medicine Unit staff regarding the number of patients and number of staff on the unit, and identification of any patients who may display violent behavior as evidenced by threats made by the patient, past or current behavior, or the need for restraints in the past.

The Observation And Monitoring Of Patients Who May Require Additional Supervision Policy states that "It is the RN's responsibility to continuously evaluate the patient's plan of care, modifying as necessary to keep the patient safe. Assessment and intervention of the patient's physical condition and safety is performed on an ongoing basis. The RN is to maintain safety for patients who may require additional supervision and provide guidelines for type of visual observation required. Sitters are deployed by the Nursing Office".

According to the Prevention And Response to Sexual Acting Out On The Behavioral Medicine Unit Policy, "staff members are required to be familiar with the requirements of this policy and knowledgeable in how to recognize and respond to observed or reported incidents of sexual behavior, assault or harassment". Twice, the HRA requested more specifics regarding the staff training and frequency of the training, but the attorney was not forthcoming in providing this information. Neither did any staff from the Behavioral Medicine Unit provide the information.

According to the Mental Health Code (ILCS 5/2-102) regarding care and services; psychotropic medication; religion:

§ 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.

And in Section 5/3-211. Resident as perpetrator of abuse:

§ 3-211. *Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a recipient of services indicates, based upon credible evidence, that another recipient of services in a mental health or developmental disability facility is the perpetrator of the abuse, the condition of the recipient suspected of being the perpetrator shall be immediately evaluated to determine the most suitable therapy and placement, considering the safety of that recipient as well as the safety of other recipients of services and employees of the facility.*

Per the hospital regulations that govern patients' rights (77 Ill. Admin. 250.260):

b) Patient Morale
1) Emotional and Attitudinal Support
Hospitals shall have a written plan for the provision of those components of total patient care that relate to the spiritual, emotional and attitudinal health of the patient, patients' families and hospital personnel.

Under Section 250.990 **990 Unusual Incidents**

a) A procedure shall be established to investigate any unusual incidents which occur at any time on a patient care unit. (Refer to Subpart B Section 250.210 (g)).

*b) The procedure shall include the making and disposition of incident reports. Notation of incidents having a direct medical effect on a specific patient shall be entered in the medical record of that patient. (Refe*r to Subpart R, Section 250.2140 (c)(5).)

c) Each report shall be analyzed and summarized, and corrective action shall be taken if necessary. Summarized reports shall be available to the Department of Public Health and shall be confidential in accordance with Section 9 of the Licensing Act.

And per Section 250.1520 Reports:

f) Any incident or occurrence in a hospital that could be considered a catastrophe or creates an immediate jeopardy and/or dangerous threat and that requires the transfer of patients to other parts of the facility or other facilities, including but not limited to fire, flood, or power failure, shall be reported to the Department within two working days after its occurrence.

According to the Code of Federal Regulations that governs the Conditions of Participation for Hospitals, Patient's Rights (42 C.F.R. 482.13):

(a) Standard: Notice of rights--

(2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.

A hospital must protect and promote each patient's rights.

(c) Standard: Privacy and safety.

(1) The patient has the right to personal privacy.

(2) The patient has the right to receive care in a safe setting.

(3) The patient has the right to be free from all forms of abuse or harassment.

And under Section 482.21 Condition of participation: Quality assessment and performance improvement program.

(e) Standard: Executive responsibilities. *The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following:*

(1) *That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.*

(2) *That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated.*

(3) *That clear expectations for safety are established.*

(4) *That adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients.*

(5) *That the determination of the number of distinct improvement projects is conducted annually.*

Complaint: There is a lack of safety on the unit. Reportedly, on 12/4/14 at approximately 7:15 a.m. the male patient entered a female patient's room and touched her on the leg. The same morning the male patient exposed himself to a female patient near the shower area and later went to her room and asked if he could come in. At an unspecified time during that same day, the male patient touched a third female patient on the breast and buttocks. The attorney stated that the staff neither called the police nor the hospital security as they felt it was not necessary. The nurse progress notes dated 12/4/14 and the Observation Flow Sheet dated 12/4/14 depict that it took approximately 10 hours for the male patient to be transferred out of the mental health unit to the medical floor unit A3. Per the Sitter Order dated 12/4/14 a 1:1 was ordered at 2:21 p.m. and acknowledged by the nurse at 2:39 p.m., but the Observation Flow Sheet 1:1 coding does not show up until 6:15 p.m. deducing that it took approximately 10 hours to provide the 1:1. The following conflicting information is noted on this flow sheet: The male patient was checked every 15 minutes (as routine) on 12/4/14 beginning at 12:15 a.m. and continuing through 8:15 p.m. which brings to question safety on the unit as he was yet able to engage in sexual harassment with the 3 female patients. During the time of the reports by the 3 female patients (a range between 7:00 a.m. and 8:30 a.m. for the very first report) of the harassment, the flowsheet was coded as the male patient being "awake" and "calm", or "ambulated" and "calm" for the majority of the time including several hours later with the only negatives being "pacing" at 7:45 a.m. but then "eating" at 8:00 a.m. and "calm" at 8:15 a.m., "calm" at 8:30 a.m., "sleep" at 9:00 a.m., "calm" at 9:15 a.m. and "restless" at 9:30 a.m., and then coded as "sleep" for the next 9 hours. All of this was even before the 1:1 codes started appearing, which according to this sheet started at 6:15 p.m. The Prevention And Response To Sexual Acting Out Policy states that protective interventions shall be immediately implemented, and the victim and perpetrator will be promptly separated from each other as well as from potential victims. After the first incident there were 2 other female patients that became the potential victims that this policy speaks of, due to a lack of safety on the unit. The policy goes on to state that the Risk

Management Department will advise the victims that the incident must be reported to the police, and it shall be Risk Management's responsibility to notify the police in this type of incident. Per the attorney, the hospital staff did not contact the police as they did not judge it necessary. The Security Policy states that it will work closely with the behavioral medicine staff to maintain a reasonable presence on the unit, assuring that patients and staff on the are kept safe from patients who may display violent or threatening behaviors. A rounding log shall also be maintained on the unit for each shift, documenting the communication between security and the behavioral medicine staff. In addition, any call to outside law enforcement agencies must be directed through security. The hospital staff did not contact the Security Department as this was not considered obligatory for the staff. Medications for anxiety and depression had to be administered to the female patients the day of the incident as well as the following day. Two of the medications were newly started on the day of the incident and one was started two days prior. One of the female patients contacted the police department. All parties were interviewed and an exhaustive report was written by the officer. Although no arrest was made, the report depicts that the physician assessed the behavior by the male patient as criminal and not the result of a mental disability. According to the Code of Federal Regulations that governs the Conditions of Participation for Hospitals, patients have the right to personal privacy and to receive care in a safe setting. Patients also have the right to be free from all forms of abuse or harassment. It is therefore concluded, based on insufficient evidence that the facility followed protective policies in place, that there is a lack of safety on the Behavioral Medicine Unit. The complaint is substantiated.

RECOMMENDATIONS

1. Ensure that any individuals that are difficult and have the potential to cause harm are reported to the Security Department.

2. Follow the Prevention and Response To Sexual Acting Out Policy by implementing protective interventions immediately and promptly separating the perpetrator and victim from each other as well as other potential victims.
3. Ensure that the Risk Management Department advises the victims that the incident must be reported to the police. Per hospital policy it is also Risk Management's responsibility to notify the police via the direction of the Security Department. Ensure that the report is actually filed with the police.
4. Take steps to produce and assure patients of their right to personal privacy, to receive care in a safe environment and be protected from sexual abuse or harassment. (42 C.F.R. 482.13) (ILCS 5/2-102a)

SUGGESTIONS

1. Require staff to document in progress notes all instances of sexual abuse and harassment that patients verbally report to them.

2. Ensure reporting to DPH per the Prevention & Response To Sexual Acting Out On The Behavioral Medicine Unit Policy.

RESPONSE

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

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February 18, 2016

Erin Wade, Ph.D., Chair
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Re: Response to Report #15-080-9003
Rockford Memorial Hospital

Dear Dr. Wade:

We are in receipt of your November 23, 2015 correspondence, wherein you inform Rockford Memorial Hospital ("RMH") that the Human Rights Authority ("HRA") has completed its investigation of Complaint #15-080-9003 and enclose the HRA's resulting Report and Findings.

RMH's top priority is to protect the rights of its patients while providing high quality care and services. RMH is committed to patient safety, and we welcome any opportunity to improve upon our services to our patients and all others whom we serve. To that end, we have considered your Report and Findings and, although we disagree with the HRA's decision to substantiate the Complaint, we have nevertheless taken steps to further improve our services to our patients in light of your recommendations and suggestions, which we describe in further detail below.

As an initial matter, however, we want to take the opportunity to clarify certain misstatements and misunderstandings in the HRA's Report, which were important to the HRA's decision to substantiate the Complaint against RMH. First, for reasons that are unclear, the Report attempts to downplay the significance of the Illinois Department of Public Health and the Centers for Medicare/Medicaid Services (CMS) investigations, in which both agencies found that RMH was in compliance with, and had not violated, their respective requirements and regulations. As the HRA Report admits, RMH fully and accurately reported the three incidents at issue to IDPH and CMS. RMH submitted an initial report and a detailed follow-up report to IDPH, in which RMH fully disclosed information regarding the three reported allegations. After receiving both of these reports, neither IDPH nor CMS believed further action was warranted or that RMH was somehow not in compliance with all governing laws and regulations. To imply otherwise does not accurately reflect the facts.

IDPH and CMS are state and federal agencies, held to standards prescribed by law, and their investigations and resulting conclusions deserve acknowledgement.

Second, the HRA Report implies that RMH was somehow being untruthful or not forthcoming in stating that no criminal charges were filed against the male patient who was accused of incidents of sexual behavior. Indeed, the Report seems to hold it against RMH that it reported to the HRA that no charges were filed, incorrectly implying that RMH was somehow downplaying the alleged incidents as a result. To the contrary, RMH was simply informing the HRA of the facts, accurately reporting that police investigated the complaints of the female patients, with RMH staff, including the psychiatrist on the unit, fully assisting police in their investigation. Despite the information provided, to RMH's knowledge, no criminal charges were pursued.

The fact that criminal charges were not pursued played no role in RMH's response to the incident reports, as RMH had already taken protective action to ensure the safety of the unit, continuously monitoring and isolating the male patient from other patients while further information was gathered, and subsequently effectuating the male patient's transfer to another unit with 1:1 supervision and security.

Third, the HRA Report misreports the incidents of 12/4/14, confusing the timing that the incidents actually occurred with the timing of the *reporting* of those incidents. Likewise, the Report errs by failing to acknowledge that protective measures were, in fact, taken immediately upon staff learning that the male patient was sexually acting out.

The 12/5/2014 progress note of Scott Tenney, Jr., with a time of 12:32 a.m., explains that staff saw the male patient enter another patient's room around 7:15 a.m. on 12/4/2014 for five to ten seconds, and redirected him from the area and reminded him not to enter other patients' rooms. The female patient whose room he entered spoke with staff but did not allege or report at that time that the male patient had touched her. Only later, at or around 9:00 a.m., *after* the male patient had already been isolated from other patients, did the female patient allege to staff that the male patient had entered her room and touched her leg.

The 12/4/14 progress note of Lisa Miles, RN, with a time of 8:07 a.m., stated that a mental health technician reported to her that the male patient had exposed himself to the female patient at the doors to the showers. Reviewing the Observation Flowsheet, the event appears to have taken place between 7:00 and 8:00 a.m. Upon learning of the incident, staff began continuously monitoring patient and took further measures to isolate the patient and investigate the incidents.

Indeed, the HRA Report fails to mention or give any weight to the fact that staff did, in fact, take protective measures immediately upon learning that the male patient had sexually acted out, as evidenced by the records.

The 12/4/14 progress notes demonstrate that by 8:00 a.m., when the male patient was present in the dayroom for breakfast, staff was continuously monitoring him. Further, as clearly established in the Observation Flowsheet for 12/4/14, by 8:15 a.m., the male patient was isolated in his room, away from the other patients, with monitoring by staff. He only left his room for one bathroom break, a very short period in the dayroom and hallway where he was monitored, and meetings with police and staff. He otherwise remained isolated in his room with monitoring until his discharge to another unit later that same day.

The HRA Report does not acknowledge these immediate protective interventions, instead focusing only on the amount of time it took to transfer the male patient to another unit and enter a 1:1 sitter order. The HRA is correct that it did, in fact, take time to effectuate the male patient's transfer to another unit. Yet, that fact in no way equates to RMH failing to take immediate protective interventions. RMH has a duty to all patients, including the male patient at issue, to ensure that they receive appropriate treatment and services while remaining at the facility. The appropriate members of administration, clinical staff, and nursing staff, had to meet and discuss the male patient's behavior, determine whether he required discharge or further treatment at the facility, and secure his placement and corresponding treatment and supervision on another unit. Such a process takes time. In the meantime, however, as explained above, RMH staff took other more immediate protective measures to secure the unit, protect patient safety, and separate the male patient from other patients. "Immediate protective interventions" is not defined as transfer from the unit or securing a 1:1 sitter. The HRA Report's failure to acknowledge, let alone give any weight, to the actions RMH could, and did, take on an immediate basis is unfortunate and an error in our view.

Notwithstanding these issues and RMH's disagreement with the HRA's substantiated finding, we do agree with the HRA that RMH can implement further action to promote patient safety on the behavioral medicine unit and ensure that staff follow applicable policies regarding the reporting of sexual activity. Following the HRA's initial correspondence regarding the Complaint, RMH performed several staff trainings, one in March 2015 and another in April 2015, regarding milieu management and, specifically, the Prevention and Response to Sexual Acting Out on the Behavioral Medicine Unit Policy. During the trainings, we emphasized the importance of immediately responding to allegations of sexual acting out and of following the procedures set forth in the policy for doing so. We plan to offer continued training on our patient safety policies, and as part of our staff training, we will continue to emphasize the importance of documentation, reminding staff to document reported incidents in the patient's medical records, document the timing that incidents are alleged to have occurred, and document all protective measures taken upon learning of such incidents.

As to patient rights, RMH staff continues to ensure that they provide patients with verbal and written notice of their rights on the unit, including their right to privacy and to receive care in a safe environment, and Rights Forms remain posted throughout the unit.

Additionally, to further ensure that patients are aware of their rights, RMH has created large posters, listing patient rights in a much larger format, to be framed and displayed in the day units of the facility.

RMH prides itself on providing a safe environment for all of its patients, as evident from the actions taken by RMH when the incidents at issue occurred as well as its continual efforts to promote patient rights and safety through training and staff support. We are disappointed that the HRA relied on incorrect assumptions and information in finding that there was a lack of safety on the unit, while blatantly ignoring the actual facts that demonstrated that RMH took immediate action to protect the safety of its patients during the events of December 4, 2014. RMH staff immediately began monitoring the male patient accused of improper sexual behavior and isolated him from the alleged victims and other patients for the remainder of his stay on the unit, all the while arranging for his transfer to another unit pursuant to an appropriate treatment plan and security support. Further, RMH fully supported and cooperated with the criminal investigation of the male patient and provided ongoing support and attention to the alleged victims on the unit. The HRA's attempt to discredit the investigations of IDPH and CMS, which both found RMH in compliance with all applicable laws and regulations, is improper. As evident by the agencies' investigations and the records themselves, RMH staff complied with the law in taking prompt action to protect patient safety on the unit.

Should you have any questions or wish to discuss our Response in more detail, please feel free to contact me.

Very truly yours,

Joseph T. Monahan

JTM:klb
Enclosures