FOR IMMEDIATE RELEASE

Springfield Human Rights Authority
McFarland Mental Health Center
Report of Findings
Case 18-050-9013

The Springfield Human Rights Authority, a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning McFarland Mental Health Center:

1. **Failure to heat the patient's dinner.**
2. **An involuntary injection was given without adequate reason. Hour of sleep medication was given at dinner.**
3. **Physician staff are rude and confrontational to guardian.**
4. **Failure to contact guardian regarding a unit transfer and treatment planning**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Complaint Statement

The complaint states that a patient was over-drowsy during a phone conversation with his guardian and the guardian learned that he was getting his sleeping medications at dinner; a nurse said they could give the medication 3-4 hours within the prescribed time. The patient had been moved to another unit and has been regressing since. The guardian spoke to the director of nursing, who addressed some of her concerns, but not all of them. He has not returned all of the calls to the guardian. The guardian's input has not been invited nor considered in these issues. The guardian brought the resident carry-out food that had become cold. She asked staff if it could be warmed up and a staff said they could not do that. Another staff said they could. Later, a caseworker called to schedule a meeting with several treatment team members to discuss the guardian's concerns or "entertain you in finding placement." Staff held the meeting within 24 hours, not waiting to hear back from the guardian who had no idea of what transpired. On 2/23/18 around 5:30 p.m. the guardian was on the phone with the patient when he started yelling "Stop! Don't hit me! Don't!" and then someone was near the phone saying, "Get off your fat a**!" The guardian called a nurse to report. The nurse denied anything happened or was said. Staff did nothing to look into what happened, nor was the incident reported. At 9:00 p.m. the same night a physician called the guardian and said her brother was physically aggressive and threw coffee on someone; he wanted to know all of the patient's drug allergies. She said she would have to look for them and the physician yelled at her to get out of bed and find it. The patient ended up getting an injection for which she received written notification, but she is not sure the reasons are accurate.

Since the case opening, there have been more issues that have arisen. Again, the patient was not allowed to have food heated up that was brought from home. It was observed that a nurse yelled at a resident and his guardian. Then the nurse allegedly yelled at another patient and made him/her cry. The individual has issues with cellulitis and was not adequately treated. He is not wearing his diabetic socks.

To investigate the allegations, the HRA team met with and interviewed McFarland Mental Health Center staff, examined resident records, with consent, and examined pertinent policies.

Interviews

At the interview the HRA asked what types of services are provided. Staff explained that they serve two populations. Some patients are court committed through the civil court, others are there through the criminal court system having been found not guilty by reason of insanity (NGRI). The current census shows there are 142 patients that are provided care. The geographic area served is Illinois, mainly in 52 counties. There are 240 staff that provide services.

The HRA asked about the patient concerning the report. Staff explained that this patient has Schizoaffective disorder. He has been a voluntary patient that came to facility on a petition and certificate from a local hospital. He has been at McFarland for approximately 6 years. His symptoms are favorable to move to a less restrictive environment. He was aggressive at his admission, but now his behaviors are very mild. He does have some long standing false beliefs and delusions. The guardian is unhappy with care at McFarland. She lives close to him here and she wants him to stay in a 30-mile radius. He has not been accepted to receive care by any nursing home within that radius.

The HRA asked how treatment is determined. The psychiatrist, medical physician, social work and care staff have daily morning meetings to discuss the patient's medical and psychiatric needs. A typical patient sees a psychiatrist and the medical physician once a week, unless that patient is a forensic admission.

The HRA shared concerns that the individual may be chronically getting his sleeping medications at 5 pm (dinnertime) instead 9 pm. HRA staff suggested to have him take these medications at the appropriate time like when he is dressed for bed and questioned the danger of falling if medication was taken to early. Staff stated there was no documentation that this has happened, but the patient does not sleep at normal times. Staff stated he receives his medications accurately, but this patient does not go to bed at the regular time. Staff stated that he has been able to use his right to refuse. His sleeping medication allows a 4 hour-window of when it is given, but there has been no reason not to give it near his bed time. He is not a difficult patient and he has been fairly compliant with medication. The HRA was advised this patient is not typically groggy. The physician did not agree with concern of falls if he has been taking sleeping medication during the four-hour window. Per the staff, the patient claims that his guardian told him not to take his medications. We followed up with unit staff separately and were told that they give his medications at 8 p.m.

Staff further stated that they wish he would put on his pajamas and go to bed at a regular time for his sake. On admission the patient was treated with antibiotics for the cellulitis. In the medical physician's opinion, he has chronic stasis dermatitis. This condition requires resting the calf muscles and elevation to alleviate symptoms. His gait prevents the movement for venous return and he cannot be convinced to keep his feet up. He is on Furosemide and has a variety of topical treatments to keep the skin in the best condition possible. This is very difficult to treat with his degree of psychiatric disability. He does not keep his feet elevated. He has had an after-hours physician visit on his feet per the guardian's request, and he was not diagnosed with cellulitis. He has fluid that pools in his feet and legs from venous insufficiency. The HRA asked about the diabetic socks, and per his physician, he does not need them. It would be beneficial if he had compression stockings and would elevate his feet. Staff were not sure what happened to his diabetic socks. The patient does have incontinence and possibly the socks were misplaced when he was cleaned up. They do make sure he has clean clothes. Staff redirect him to sit down and elevate his feet. He does not sleep much but paces quite a bit.

The HRA brought up the issue about the nighttime phone call from the physician. They have an afterhours medical officer of the day (MOD) that can be a little abrupt as per staff. The HRA asked if drug allergy information is on his care plan or in the chart. Staff explained that there is information on the electronic file system, but not these details. He wanted to know what reactions the allergies cause and the guardian refused to get up and help the physician. It was 9:00 p.m., but this does not excuse the physician if he was abrupt according to staff.

The HRA brought up concerns about forced medication. There is documentation of aggression, pouring coffee on peers and attacking another peer. The patient's choice of emergency medication was used. The medical officer on duty did contact the guardian on the date of the complaint to investigate the adverse reactions of emergency medications.

The HRA asked whether the guardian participates in his care plan or was given ample notice to participate in his care plan. Staff explained that she is notified every 4 weeks and at the admission she was invited to participate. She is normally invited by mail. The guardian historically has not attended. However, there was one instance when there was a glitch in the system. They attempted call the guardian who could have participated by phone, but once again she chose not to participate. Regarding the unit transfer the HRA asked why the patient moved from one unit to another and if the guardian was alerted or consulted. They said it was for administrative reasons; there was a patient swap as another patient needed to be on an all-male unit. "In this case, it was a lateral transfer (civil unit, same restrictions) within the same facility; therefore, we would not consult the guardian prior to transfer. Typically, we would notify them following the lateral transfer, as a courtesy."

On the subject of warming food brought into the facility, the staff explained that is something they do not do for infection control and issues of food safety. A microwave in the visitation area is a safety issue for example. The staff do welcome the food for the patients, but there are not enough staff available to heat outside food for all patients. If they did, it would require additional staff for just that purpose. Patients heating food on their own in the visitation room would likely be hazardous. This patient does not have capacity to do this task for himself. If the patient was in a less restrictive environment such as a nursing home, he would probably have this privilege.

Allegedly, a specific nurse yelled at this individual and his guardian and also at another individual who cried. The nurse denies this has ever happened. There is a conflict between the guardian and this nurse's mother. The nurse explained that this guardian has made so many false allegations that it is at the point of harassment. It is the practice when staff deal with this guardian to always have another staff available to be a witness. There have been numerous false allegations. Allegedly per staff, the guardian always has a reason to not cooperate with staff and only wants to speak to staff independently. Staff have been advised to not deal with the guardian by themselves. She is reportedly rude to all staff according to the staff interviewed. Staff have no issue with the individual; they are frustrated in dealing with the guardian. This individual has requested to move to a nursing home, but his guardian has not allowed him to do so.

After the interview the HRA met the patient in person and found him a friendly, elderly gentleman.

Record Review:

On 12/28/17 social work notes document: "The social worker met with the patient on unit in the television area and dining room one to one, to discuss placement problems identified and the inability for the social worker to pursue any other placement due to guardian declining to sign all request of information (ROI) within a one-hour distance of Springfield, Illinois and declining to consider any facilities over an hour drive from Springfield. Social worker has exhausted all facilities within this criteria at this time…."

Nurse progress notes document on 1/7/18: "Throughout the week the patient has remained mobile in the milieu. The patient continues to converse amongst peers and will be seen out on the milieu reclining in a chair watching television or interacting with others. Documentation notes the patient has an average of five or more hours of sleep a night."

Nurse incident notes on 1/9/18 at 9:28 am document: "The patient was transferred to Jefferson Hall this morning. He walked over with a staff and a nurse along with his belongings and medications. As the staff was leaving, the nurse reported the patient called after the staff while seated in their milieu…."

Nurse progress notes document on 1/21/18: "He is up and about on the unit. He remains alert and responsive. He remains compliant with medications. He is fairly cooperative with care and is usually cooperative with staff when he is incontinent. He continues to voice inappropriate sexual comments to staff. He continues to require frequent prompts to sit and elevate his feet to prevent swelling. He continues to have issues with insomnia and frequently stays up all night, standing at the desk…."

The social work notes on 2/21/18 document that the guardian called and was concerned that the patient's food that was brought in by the family could not be warmed up. The social worker explained that "we have never been able to warm up food for the patients during a visit." The guardian explained that some staff said it could be done.

Social work notes on 2/21/18 at 3:50 pm document that the patient's guardian called to "discuss some concerns. When the guardian came to visit on 2/19/18 and asked the staff about warming up food for the patient, she was told it was not possible. The social worker explained to the guardian it was her understanding that staff have never been able to warm up food for patients during a visit. The guardian expressed her concern over this and states that she had called and spoke with someone on a different hall and a shift coordinator told her the food could be warmed up. She went on to discuss other concerns, she questions if the transition to Jefferson Hall is causing other problems, she spoke about the patient being assaulted and then the fall. The social worker talked with the guardian about each incident individually. Explained the reason for the fall was unknown, however the incident note talks (explains) in depth about everything nursing staff did to assist and evaluate the patient after the fall. It was explained that the patient in this report has hit other people, that all units at McFarland have potential to have aggressive patients. The guardian requested a copy of the incident note. The social worker also provided an overall picture of how the patient had been doing on Jefferson hall. It was explained to the guardian that many of the staff that have worked with the patient over the years on various units still have the opportunity to work with him on Jefferson as well.

After the phone call the social worker talked to the director of nursing, he suggested they call the guardian as a team. The guardian had left multiple messages for him. The social worker called guardian back, she did not answer; the social worker left guardian a voicemail and asked guardian to call back with a time she would be available to talk with the team together. By Tuesday 2/22/18 in the late in the afternoon, staff had not heard back from the guardian. Another voicemail was left by the social worker, the clinical nurse manager and the clinical director present."

On 2/23/18 at 5:27 p.m. an incident report documents "(Peer aggression, angry guardian) the patient had a call transferred to unit phone and was speaking to his sister/guardian when another patient, walked up and attempted to take the phone from him. He began screaming that the call was for him. Staff intervened and was able to remove the peer from the area. The patient hung up not too long after that, the guardian called the station phone to state that she had witnessed the event that took place with the patient. She stated that she asked the patient if he was hit and he said yes. This writer as well as another staff member assured her that they both were present during the event and can attest that he was not hit. The person just attempted to take the phone and they were escorted away by another staff member. She then stated that her and her friend heard someone say 'get off your fat a**,' while the incident was going on. This writer as well as the RN informed her that no such statement was heard in this environment as both were present…."

On 2/23/18 3:00 caseworker notes document that "the patient was transferred to Jefferson Hall on 1/9/18. This patient had several incidents of sexually inappropriate behaviors and comments since transfer: 1/21/18, 1/27/18, 2/3/18. The patient spit on staff on 2/18, hit a peer on 2/14/18, several incidents of incontinence, at times refusing to allow staff to assist him in clean up. This patient has fallen twice, once on 2/19 and once on 2/20. This patient continues to need much assistance from staff to assist with daily living activities, he is eating fair, he only sleeps a few hours per night. The patient is often up at the desk talking with staff, he mumbles and is very difficult to understand most of the time. The patient had a visit with his sister and legal guardian.

His guardian has expressed concerns with his care. The social worker has tried to schedule a call with the team and the guardian together to address her concerns with no success."

The HRA reviewed the incident report on 2/23/18 at 8:55 it stated "The security was contacted and an unscheduled medication was given. The patient has been increasingly agitated this evening. He presented to the medication window and began cursing this writer and using racial slurs while attempting to strike her. He then spat on writer and proceeded to curse other nursing staff. He went over to the dining area where a group of peers were playing cards, and poured coffee on a peer, grabbed another peer by the hands and wrists in an attempt to injure her, spat at another staff member and struck at her as well. MOD notified. When the MOD arrived to assess patient's condition, he began to threaten the MOD. New order received for Lorazepam 2 mg IM and Diphenhydramine 50 mg IM. Security called for standby. Medications given as ordered without the need for a physical hold at 2125."

Staff notations on 2/23/18 document that the patient did receive a PRN shot for "aggression and pouring coffee on peers, attacking another peer, threatened physician and placing himself and others in immediate danger." His preference was utilized; his guardian was contacted.

The physician's note documented that he had called the guardian: "the patient became aggressive with other patients. He threw coffee on other patients. I went to see him and he became aggressive to me. I called guardian to ask about his allergies. She was in bed and not willing to get up and see her notes. Just said I told McFarland everything…."

The notice regarding restricted rights (MHDD-4) was completed on 2/23/18 at 2125 (9:25 p.m.) documenting administered emergency medication. "The individual was administered emergency medication. The reasons for the identified restrictions are: Increased agitation and aggression. spitting on staff, striking at staff. He had poured coffee on a peer, he attacked another peer, he threatened the physician, he placed himself and others in immediate danger." The individual's preference was utilized. Part 3 of the rights restriction documented that the patient wished no one else would be contacted, but as always, the guardian was contacted. The physician's note on the form stated: "(the patient) needed to be injected for aggression to others." It was checked that the above medication was needed to protect the patient from causing serious and imminent physical harm to himself or others. It was signed and dated by the physician.

The HRA reviewed the medicine administration record; it documented that the resident was allergic to phenothiazines, olanzapine, quetiapine, haloperidol, opiates, and butyrophen, haloper, and 2-clozapine). It was documented by the physician that medication could be given within a four-hour scheduled time. The MAR was pre-printed and basically had just a spot to acknowledge that the "9PM" meds were administered. No special entries were made for anything other than PRN medications.

Policy Review

The HRA reviewed the McFarland Health Center Procedural Guide Component: Treatment Services Series#: TS620 Title Visitors on Civil Units 5/19/16 Policy:

"McFarland Mental Health Center shall encourage patient visits to promote recovery and will establish visitor policies in a manner that maintains the safety and security of the Adult Non-Forensic Program."

In the procedure section: M. "Food items, home cooked meals, or fast food items may be brought in for the individual, but must be eaten during the visit. Commercially prepared food may be brought in the original unopened package for consumption at the visit. Non-perishable food items brought for individuals to be consumed at a later date must be in their original, unopened package to avoid contamination and potential health problems. All items must fit into the individual's storage bin. No open drinks will be allowed. Drinks must be decaffeinated and in unopened, sealed containers. If a visit occurs during the typical mealtime, the individual will be offered a choice of consuming the tray during the visit or waiting until after the visit (within the 120-minute time frame. Refer to Procedure Guide DI140). The individual will be offered his or her tray during or after the visit, even if additional food is consumed during the visit." It did not say anything about warming food provided by visitors.

The HRA reviewed the McFarland Health Center Procedural Guide Component: Individual Human Rights Series #: HR126, Title: Individual rights and restrictions of such rights, References: Mental Health Code, Art. I, Sec. 2-103 MD460 Use of Restraints & Seclusion (Containment) in Mental Health Facilities, 11/15/16 Section V. which states that: "Individuals have a qualified right to be free of seclusion/restraint."

Under section VI. Refusal of Services it states:

A. "A patient, guardian, or substitute decision maker, if any, must be informed of the patient's right to refuse services, including medication.

B. Services, including medication, may be given to prevent the patient from causing serious and imminent physical harm to the patient or others. Emergency forced medication/involuntary treatment may be given following an examination by a physician or a nurse in consultation with a physician. The order for medication must be written, signed and dated by a physician."

Under section VIII. B and C. Restriction of Rights it states "If indications necessitate restrictions of any of these rights, the following procedures must be followed:

B. A Notice Regarding Restricted Rights of Individuals (MHDD-4) is given to the individual who identifies the date, time, nature, rationale and duration of the restriction.

C. The original MHDD-4 is placed in the medical record, with copies to the individual's guardian, if applicable, and any individual(s) designated by the patient."

Per staff there was not a policy specific to guardian notification, except for the Mental Health Code.

Mandates

The Code (405 ILCS 5/2-102 (a)) states: "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. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan.

Section 5/2-103 states: "Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation.
(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…."

According to Section 5/2-107 regarding the refusal of services/informing of risks, (a) "An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services.

(b) Psychotropic medication or electroconvulsive therapy may be administered under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record."

Section 5/2-201 (a) requires: "Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to:
(1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian;
(2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice;
(3) the facility director;

(4) the Guardianship and Advocacy Commission, or the agency designated under "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, 1985,1 if either is so designated; and
(5) the recipient's substitute decision maker, if any.
The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefor in the recipient's record."

Conclusion

Complaint 1. Failure to heat patient's dinner. The facility does not heat food brought in for the patients. Per the interview with staff, if they did, it would require additional staff for just that purpose. The patients heating food on their own in the visitation room would likely be hazardous due to the facility being a state-run hospital for seriously mentally ill patients, and is a much better argument than having to hire staff to warm food. The facility did fail to heat the patient's dinner, but it is not a mandated patient right to have outside food reheated up for patient, and there are hot meals that are available at the facility. **The complaint is unsubstantiated as a rights violation.**

Complaints 2. An involuntary injection was given without adequate reason. Hour of sleep medication was given at dinner. Both parties have witnesses and both parties have a different account of what happened during the call on the evening the patient received the injection. The HRA is unable to determine what exactly happened during the call. Regarding the emergency injection it was documented that the patient did not want anyone notified. The patient's choice of emergency medication was used. It was well documented by nursing staff and the physician that the patient received the emergency injection because he was a physical danger to himself and others. He had poured coffee on a peer, attacked a peer and was aggressive with staff and the physician. A rights restriction was issued and the guardian was also notified according to the record.

Regarding the sleeping medication, the MAR was pre-printed and basically had just a spot to acknowledge that the "9pm" meds were administered. No special entries were made for anything other than PRN medications. After meeting with the patient, it was clear that the patient did not have capacity to advocate for himself if he is being offered his 9pm medications at 5pm even if the physician did allow for a 4-hour window to give medications. However, the HRA followed up with unit staff who verified that the patient received his sleeping medication at 8:00 pm without hesitancy.

Based on the documentation that an involuntary injection was given because the patient was a physical danger to himself and others, and verification that the patient is receiving sleeping medication per the physician's order, the complaints are both **unsubstantiated.**

Complaint 3. Physician staff are rude and confrontational to guardian. The medical officer on duty did try to contact the guardian on the date of the incident to investigate the adverse

reactions to some of the emergent medications that could be used. His notes document that "She was in bed and not willing to get up and see her notes. Just said I told McFarland everything…." Staff admitted the physician can be abrupt which could probably be interpreted as being rude and confrontational to some. However, there is no evidence that he was rude or verbally abusive to the patient, and he was advocating for his safety and rights of the individual.

Per the record the guardian was contacted, the individual's preference was administered, and a rights restriction notice was completed when the emergency medication was given. The Code does not specifically address a physician being rude, confrontational or abrupt to a guardian, but a guardian does direct the care of the patient and should be respected. **Complaint 3. Physician staff are rude and confrontational to guardian may have been true, but it is not substantiated as a rights violation.**

Complaint 4. Failure to contact guardian in unit transfer and treatment planning. When the HRA asked about guardian participation in the patient's care plan or if the guardian been given ample notice to participate, staff explained that she was invited every 4 weeks and at the admission to participate by mail and this guardian historically has not attended. There was a glitch in the system when they failed to contact the guardian one time by mail; they attempted call the guardian who could have participated by phone, but once again she chose not to participate. Per follow-up with staff after the initial interview, the HRA was informed that the guardian would not have been consulted about the administrative move of the patient to a different hall.

When the HRA reviewed the record, the nursing notes documented on 1/7/18: "Throughout the week the patient has remained mobile in the milieu. The patient continues to converse amongst peers and will be seen out on the milieu reclining in a chair watching television or interacting with others. Documentation notes show the patient has an average of five or more hours of sleep a night." When the patient was transferred to the different unit, the notes document on 1/21/18: "He continues to require frequent prompts to sit and elevate his feet to prevent swelling. He continues to have issues with insomnia and frequently stays up all night, standing at the desk…." The facility staff notations show this patient's behavior changed after the administrative transfer from being able to rest and stay off his feet some of the time verses staying up all night and standing at the nursing desk. Per the interview with staff and the record, this patient really needed to rest his feet and legs. After the transfer this patient slept less and was on his feet pacing more per the evidence in the record. The guardian did inquire about whether the move was affecting the patient's health, but the guardian was not included in the decision-making process. The Code in section 5/2-102 (a) states "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 HRA recognizes that staff have invited the guardian to treatment planning and there was an accidental "glitch" when she was not invited, but staff did invite her by phone. Since this was an administrative placement in a different hall of the facility, staff stated the guardian would not have been consulted. The HRA appreciates that this is not a placement outside of the facility, but based on the evidence the record shows this move may have negatively affected the patient's well-being and the guardian was not provided an opportunity to speak to the individual's transfer

of care, thus, **Complaint 4. Failure to contact guardian in unit transfer and treatment planning is substantiated as a rights violation. The HRA makes the following recommendation: Follow the Mental Health Code in section 5/5-102. The guardian at a minimum should have been informed to help prepare the patient for the move. Consulting the guardian before the move would have been consistent with Code requirements. If the patient is still having trouble readjusting consider revisiting the issue with the guardian's input.**

The HRA acknowledges the cooperation of McFarland Mental Health Center during its investigation.

RESPONSE

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

Bruce Rauner, *Governor*

Illinois Department of Human Services

James T. Dimas, *Secretary*

McFarland Mental Health Center
901 Southwind Drive • Springfield, IL 62703

August 20, 2018

Tara Dunning, HRA Chair, Human Rights Authority
Illinois Guardianship and Advocacy Commission
521 Stratton Building
401 S. Spring Street
Springfield, IL 62706

RE: Case #18-050-9013

Dear Ms. Dunning,

This letter is in response to your Report of Findings for case # 18-050-9013 dated August 6, 2018 which included a substantiated rights violation for failure to contact a patient's guardian when the patient was transferred to another unit within the facility.

Although current practice dictates the guardian be notified at the time of a transfer, it did not occur in a timely manner during this instance. Therefore, policy was reviewed and is being updated to indicate that the social worker is to notify the guardian at the time of transfer. The policy changes will go through our Policy Implementation & Compliance Committee at the next meeting which is scheduled for Tuesday, September 11, 2018. Once the changes are approved by the committee, education will be provided to all staff regarding the requirement.

Another complaint which was not substantiated was in regard to medication being provided to the patient outside the prescribed times. During your investigation, information was provided to you stating that a patient can be provided with medication up to four hours outside the prescribed time. McFarland policy only allows for a one-hour window either side of the prescribed time. This issue will be addressed through nursing education.

Thank you for the opportunity to address systems issues that allow our hospital to improve performance and patient safety.

Sincerely,

Dana Wilkerson, LCSW
Interim Hospital Administrator