FOR IMMEDIATE RELEASE

East Central Regional Human Rights Authority
The Pavilion Foundation
Report of Findings
Case # 21-060-9007

The East Central Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission voted to pursue an investigation of The Pavilion Foundation after receiving the following complaints of possible rights violations:

Complaints:

1. **Inadequate admission process.**
2. **Inadequate Treatment; including the individual and the parent not allowed to be involved in treatment planning and not providing prescribed medicine.**
3. **Inadequate access to records.**
4. **Lack of access to property.**

If the allegations are substantiated, they would violate protections under The Mental Health and Disabilities Code (405 ILCS 5/3-503, 405 ILCS 5/2-200, 405 ILCS 5/2-104, and 405 ILCS 5/2-102) and The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4).

Complaint Summary: The complaint alleges the individual, who is a minor, was admitted into The Pavilion. Allegedly, upon admission, the individual and the minor's guardian were not explained the admission process including the bill of rights. The complaint alleges the guardian was not allowed to speak with the physician treating the minor or be involved in any treatment planning. Allegedly, the minor child was not given prescribed medication but given new medication without her guardian's knowledge. The complaint alleges the guardian asked for the minor's records; however, the guardian was denied access to the records. The complaint alleges the minor was not allowed to have her teddy bear with her while at the facility even though the guardian and minor were advised that the minor could keep the teddy bear while on the unit.

Investigation:

The HRA proceeded with the investigation after having received proper consent. To pursue the matter, the HRA interviewed the program representatives virtually. Relevant practices, policies and sections of the consumer's record were reviewed.

Interviews:

On April 13th, 2021 at 10am the HRA met virtually with The Pavilion Foundation staff via a WebEx video call. The meeting began with introductions, a review of HRA procedures, and a review of the allegations being addressed in this investigation.

Staff provided some general information about The Pavilion. The Pavilion is an acute psychiatric hospital and part of the Universal Health Systems (UHS). There is an inpatient youth psychiatric unit for ages 3 years to 17 years old. There is an adult psychiatric unit as well. Both the youth and adult units each have 30 beds. The Pavilion also offers a residential treatment for up to one year. Most patients in the residential treatment are wards of DCFS (Department of Children and Family Services). The Pavilion also offers a behavioral school as well as substance abuse programs for adults.

The Pavilion has approximately 240 employees. The youth psychiatric unit has about 39 employees consisting of nurses and mental health technicians. There are three shifts on the youth psychiatric unit; first shift is 7-3:30pm, second shift is 3-11:30pm and overnight shift is 11pm-7:30am. The staff to patient ratio during first and second shift is 1 to 4. However, on overnight shift, the ratio is 1 to 10. Staff stated that there are typically 1-2 nurses per shift. Staff attend a one-week orientation where they tour the facility and review policy and procedures. Staff also have an online training through a training company. Staff also attend a 3-day crisis intervention training. During orientation, staff are trained on abuse and neglect. Staff also spend 4 days working with a shift lead to observe and shadow.

Staff disclosed that the individual arrived at the facility via an ambulance from another hospital. The individual was admitted late on 1/10/21 and released 1/15/21. Due to COVID-19, the facility currently has a visitor restriction, so the individual's parents were not allowed into the facility. The individual was referred to the facility from the transferring hospital and upon arrival to the facility, the intake specialist spoke with the referring agency and the individual's guardian to gather information. Staff stated the intake specialist spoke with the individual's guardian via phone and obtained verbal consent for voluntary admission. The intake specialist reviewed all paperwork with the guardian and obtained verbal confirmation that the guardian understood. Staff stated all the forms that were reviewed with the guardian were marked with a "VC" for verbal consent. Staff stated after a verbal consent the forms are supposed to be sent to the guardian who gave the verbal consent. Staff were not sure if the individual's guardian was sent the forms or not.

Staff disclosed the individual's guardian filed a complaint on 1/13/21 with the hospital patient advocate that is similar to this report. The patient advocate investigated the complaints and corrective counsel was provided to staff. Furthermore, the patient advocate had the individual's case manager call the guardian to review the paperwork again to verify that the guardian understood and obtained verbal consent again.

Staff stated patients are examined by the nurse within 8 hours of admission to develop a treatment plan. The individual's guardian was contacted for the assessment to assist the nurse in gathering medical information. After reviewing information with the guardian, the individual

was also admitted for insomnia. The guardian also provided verbal consent to have the individual administered melatonin to assist with the insomnia. After the nurse's assessment the individual was examined by both a medical physician and psychiatrist. Staff stated the policy requires that patients must be seen by the physician and psychiatrist within 24 hours and a treatment plan must be formulated within 72 hours. Staff stated the individual's treatment plan was developed within 24 hours of her admission. Staff stated the individual and guardian agreed to the treatment plan and had no objections. The individual signed the treatment plan. Staff stated the guardian provided verbal consent to the treatment plan. The name of the person who provided verbal consent as documented on the treatment plan is not the guardian's name. Staff were not sure why the guardian's name was not listed and was not sure who provided verbal consent. Staff stated if the guardian or individual had objected to the treatment plan, modifications would have been made to meet the guardian's requests and the individual's needs.

Staff stated the individual was on Prozac upon admission. The psychiatrist noticed that the individual had recently had a change from 20 mg to 10 mg. The individual thought she was not progressing on the Prozac and even thought that Prozac might have caused her suicidal ideations. Staff stated that 10 mg is the lowest dosage for Prozac, so the psychiatrist thought it was best to have the individual stop Prozac and take Cymbalta. The guardian at first did not give consent for Cymbalta for unknown concerns. Staff stated the guardian spoke with the individual's primary care physician (PCP). The guardian then gave consent for the individual to be given Cymbalta after speaking with the PCP. Staff stated the individual was not given the Cymbalta until after the guardian gave consent.

Staff stated the guardian never made a request to speak to the individual's treating physician, so the physician did not speak with the guardian. Usually if there is a specific request, the physician will call families. Otherwise, the physician may recruit the assistance of nursing to communicate messages he is unable to communicate himself. In the family treatment contract reviewed at admission with the guardian, it notes that the case manager is the main contact during the individual's treatment. Additionally, the family may contact the unit to get updates, review the child's treatment and speak with nurses for medication questions or clarification.

Staff stated the release of records policy does not allow for the records to be released while the patient is in the hospital as the records are considered "open". The Pavilion has 30 days after discharge to "close" a record. Once the record is "closed", the records can be released as long as a release of records form is completed and signed. Staff explained that verbal consent for the release of records can be given if there are two witnesses for the verbal consent. Staff stated the individual's records were closed and mailed to the guardian on 2/12/21. Additionally, discharge documents were sent to the individual's primary care physician for follow up.

Upon admission, a patient's property is inventoried and documented on a property form. Patients are given access to 3 outfits to keep in their room. All clothes are washed prior to going onto the unit. Any items not allowed on the unit are either sent home with family or stored. Patients are provided a tote for storing their belongings. The tote is stored in a storage unit until discharge. Staff stated they were not aware of any complaints about the individual not being allowed to have her teddy bear. Staff stated stuffed animals are a prohibited item due to possible health and safety issues. Staff explained that The Pavilion's website, as well as the youth handbook, list

stuffed animals as prohibited items. Staff explained that the individual and guardian would have been notified during admission that the stuffed animal is prohibited. Staff stated that an exception may be granted to allow a stuffed animal on the unit if it was clinically justified. However, the stuffed animal would need to be washed and checked prior to being allowed on the unit. Staff stated the individual signed the property inventory form at admission and discharge and had agreed to have the teddy bear put in storage.

Policy Review:

The HRA reviewed The Pavilion's policy titled "Admissions Process" which states under the assessment process "...Upon arrival in the lobby, persons in the building requesting services are given written material (Acknowledgment of Understanding of Initial Assessment) to assist them to understand the assessment process. They will also receive a copy of the HIPAA privacy statement...Unless eminent safety concerns preclude doing so, the following documents will be reviewed with the patient and their informed consent/signature obtained: Application for Admission, Consent for Admission, Patient Rights, Acknowledgement of receipt of HIPAA notice, Advance Directives, Insurance Documents..." Furthermore, the policy states under Patient Rights that "Patients being admitted on a voluntary basis are to be given a copy of the 'Rights for Voluntary Admittee' at admission. Their signature on the Application for Voluntary Admission documents their consent to be admitted on a voluntary basis. Consent is to be obtained by the RN on the unit if assessment department staff are not present at the time of admission."

The HRA received a copy of The Pavilion's policy titled "Patient Bill of Rights" which states under procedure "Upon admission, all patients will be provided the Patient Bill of Rights by the Intake specialist. An additional Patient Bill of Rights for child/adolescent treatment services will also be provided to ensure that all child/adolescent patients understand these rights...The Patient Bill of Rights having been signed or documented that the patient, guardian, or substitute decision maker has provided consent will be placed in the patient record. All patients 12 years and older, patient guardians, or substitute decision makers will be given the opportunity to review, sign and obtain a copy of this document upon request."

The HRA reviewed the policy titled "Allowed Patient Possession and Possession Checklist" which states "All patient belongings brought onto the unit at the time of admission must be examined and evaluated by staff for safety and appropriateness, as described below...The assessment department will secure patient belongings, place them in a tub, close the lid, and put a sticky with the patient name on top. That bin will then be delivered to the unit upon admission. Staff will take the patient bin and place all patient belongings behind the counter in the nurses' Station until these items have been examined and evaluated. Staff will inform the patient and family that any items brought onto the unit following admission must also be checked in and that the patient and/or family are obligated to tell staff of any personal belongings that are subsequently sent home. Complete the possession checklist. Staff will inform patients that staff may inspect personal belongings at the time of discharge to reconcile the Procession Checklist with items being taken home, although it is each patients' responsibility to keep track of personal belongings while hospitalized...Staff will document all items that remain in the facility on the possession checklist. After patient belongings have been examined, determined to be appropriate

for patient possession on the unit, and entered on the Possession Checklist, patient property not locked up will be given directly to the patient to whom it belongs or placed in that patient's room."

The HRA reviewed the "Use and Disclosure for Treatment, Payment and Health Care Operations" policy which states "As described in the Notice of Privacy Practice, an individual may request in writing access to their PHI (Protected Health Information) in the medical and/or billing records...A facility will respond to an individual's request for access to the PHI within thirty (30) days after receipt of the request for the PHI if is maintained on-site and within sixty (60) days after receipt of the request for PHI if it is maintained off-site...If a Facility denies access to the PHI the Facility must provide a timely, written denial to the individual, in plain language that contains: The basis for the denial; If applicable, a statement of the individual's review rights, including a description of how the individual may exercise the review rights; and a description of how the individual may complain to the Facility pursuant to the Facility complaint procedures or to the Secretary of HHS (U.S Department of Health and Human Services). This description must include the name, or title, and telephone number of the contact person or office."

The HRA reviewed the Pavilion's policy titled "Release of Medical Information" which states "Release to Patients: Upon receipt of written authorization, a patient who is 12 years and older is entitled to inspect his/her records and receive copies of them after discharge. Inpatients desiring to view their own records may do so only with the permissions of their attending physician in the presence of a health care professional and after signing a written authorization. Non-hospitalized patient may view their own records upon written authorization as scheduled by the Medical Record Department. (Note: patients should never be allowed to view their records unattended)."

The Pavilion provided the HRA a copy of the "Youth Unit Handbook". Under admission in the handbook states "Admission to the Youth Unit is facilitated through consent of parent/guardian on behalf of the child upon the order of a psychiatrist. Upon admission, staff will check in all items, take vital signs (blood pressure, temperature, height and weight), and show you the unit and your bedroom. There are restrictions as to what you may have in your room. There will be several assessments that you will complete within the first 24 hours which include a physical examination, a complete medical history, and psychiatric, nursing, school, case management and recreational therapy. The patient will receive an individualized treatment plan to be implemented by the multi-disciplinary team, patient, and the patient's family. The treatment plans guide the treatment goals for each patient's stay." Under treatment team members the handbook states "It is presumed that the patient and family (when applicable) are actively involved in the development of goals and objectives in treatment that is driven by the identified strengths, problems and needs of the patient and family." In a section of the handbook that lists items that are not permitted, it states "There are some items that are not allowed and will need to be locked away or taken home. We cannot list every item. Please know that the unit staff will determine if additional items are safe to keep even though they may not be on this list." Stuffed animals are listed as a prohibited item.

The HRA reviewed the Pavilion's "Family Treatment Contact" which states "Within the first 24 hours after admission (excluding weekends and holidays), your child will be assigned a case

manager (counselor), who will be your main contact person during your child's treatment and who will be in charge of coordinating aftercare services upon your child's discharge from the facility."

Records:

The HRA reviewed a document titled "Mental Health Technician Check in Process for Admission: Patient Possession Checklist for Admission" which listed "1x blk adidas pants, 1x pink t-shirt, 1x blk sports bra, 1x socks and 1x blue sweatshirt" as items that are returned to the patient. For items that are stored in closet it listed "1x teddy bear, 1x camo crocs, 3x earrings." There were no items listed that required storage in the med room. The form was signed by the individual for both admission and discharge. The HRA was provided another document titled "Mental Health Technician Check in Process for Admission Patient Possession Checklist for Admission" which listed "pants x2, shirt x3, socks x2, underwear x3 and bra x2" as items returned to the patient. For items stored in the closet the form listed "shorts, backpack, glasses and glasses case." For items required storage in med room it listed "contacts, contact solution, contact case and birth control." The individual did not sign this form for their admission or discharge.

The HRA reviewed The Pavilion's "Patient Bill or Rights" which states "...You have the right to actively participate in the development of your treatment plan, which will be implemented by the clinical staff and reviewed periodically. You have the right to receive information necessary to give informed consent prior to the start of any treatment or services to be provided....you (or your guardian on your behalf) have the right to refuse treatment and/or medication to the extent permitted by law and to be informed of the consequences of refusing treatment...you have the right to be informed by the prescribing physician of the benefits and/or risks of the drug(s) being prescribed in terms you are able to understand. In the event that you are unable to understand, your family or guardian shall be informed. You have the right to review your treatment record, upon written request...You are entitled to receive, possess, and use personal property unless it is determined that certain items are harmful to you or others. When you are discharged, all lawful property must be returned to you." Furthermore, the form states "You have the right to request discharge by requesting and signing a Request for Discharge form, available from your case manager. In the case of a minor, the request may be made by their parent/legal guardian..." The form indicated the individual's guardian gave verbal consent and the individual signed the form stating "I/We received a copy of my rights explained to me in a language that I understand."

The HRA reviewed The Pavilion's "Youth Unit Guidelines" which was signed by the individual. The guideline goes over dress code, smoking, personal prohibited items, expectations, snacks, visiting hours, telephone, mail, partial hospitalization, and parental participations.

The HRA reviewed "Consent for Treatment Services" which states, "Under most circumstances, I understand that staff cannot share information about my treatment with anyone outside of the treatment team, unless I consent to the release of information." The form was signed by the individual and the form indicated the individual's guardian gave verbal consent.

The Pavilion provided the HRA a copy of the "Application by an adult for admission" for the individual. The form indicated the individual's guardian gave verbal consent to have the individual admitted for treatment.

A review of "Child/Adolescent Treatment Services: Your Rights as A Patient" was conducted by the HRA. The form states "You have the right to know what treatment decision are being made. You have the right to refuse treatment as long as doing so does not put you or other patients in danger. Your treatment here is confidential. We are not allowed to share information with anyone other than your family without the permission of your parents or guardian." This form was signed by the individual.

The HRA reviewed psychiatric evaluation dated 1/11/2021 which states "currently, she had been taking Prozac 10mg a day until the dosage was increased after Christmas to 20 mg daily and now it has been reduced again to 10 mg daily...She is alert and oriented to person, place and time. Her cognitive functioning is fair. Her memory is intact...She did have good cognitive skills and intelligence as assessed by general use of language and knowledge in our conversation. She had immediate, recent and remote memory intact..."

Another psychiatric progress note dated 1/12/21 was reviewed by the HRA which states "She is still anxious. She in particular talked about her anxiety and we did talk about the benefits she received from the medication. She did take the trazodone at bedtime, which did help her sleep. She stated she went to sleep well on this. She had not gotten the Cymbalta until the time I talked to her in early afternoon. Her mother could not be reached to get consent earlier, and we checked, and the nurse will give her dose this afternoon. She is relieved to know this will be started. Currently, she will continue on trazodone 50mg at bedtime as needed for trouble sleeping. She also will continue the melatonin that she was taking at home. She also has now started her Cymbalta 30mg daily. We did stop Prozac yesterday."

A psychiatric progress note dated 1/13/21 states "She has been tolerating the starting dosage of the Cymbalta fairly well. Her mother has been calling the unit quite often. I did learn it when I talked to the case manager and the treatment team today. She has had various complaints about various matters and a lot of it does not really make sense to me, but the case manager and nurse manager on the unit is going to follow up on this. Given her tolerance of the Cymbalta, and its current starting dosage, we will increase it now at 60 mg daily, with guardian approval. She wants to do this as she is committed to controlling both her depression, have it lessen and resolve, and also lessen her anxiety."

A psychiatric progress note dated 1/14/21 states "She has been tolerating the higher dosage of the Cymbalta 60 mg daily well. She did have a family session yesterday, went well. She has had some issues with her parents, with talking about this and this is a benefit."

The HRA reviewed the individual treatment plan for the individual dated 1/11/21 which was signed by the individual. Under "parent/guardian signature" it stated "VC" for verbal consent, but the name of the individual is not the individual's guardians but another person with the same last name as the individual. The treatment plan's short-term goals stated the individual "will

demonstrate an increased ability to effectively manage her depression by reporting no suicidal ideation for two consecutive dates prior to discharge."

The HRA reviewed the "medication administration record" for the individual dated 1/10/21-1/15/21. The record states the individual took "melatonin tablet, ethinyl estradiol-norethindrone with iron, trazodone tablet (Desyrel), and Duloxetine (Cymbalta)." Additionally, the record indicated that Duloxetine (Cymbalta) was not given to the individual until the guardian consented.

The HRA reviewed the discharge summary which states "...of note too is that she had complained at time of her admission this antidepressant Prozac when it went up to 20 mg daily had caused her to feel dizzy and caused her heart to pound or race. She also reported depression for 6-9 months before her admission." Under interventions used it states "Milieu treatment was implemented including intensive individual, group, and activity therapy. Family therapy was performed and also school assessment occurred during hospitalization. Also, psychiatric medication regimen assessment was performed during hospitalization." Under hospital course it states "...She also was concerned about increasing the dosage of her antidepressant because she still thought it might have caused her to have thoughts of suicide. This is why felt was not to continue with this medication and even though resistance to taking it, though it was unclear if this indeed have been the reason she had become suicidal and said she has been in the natural worsening of her depressive syndrome. Therefore, a trial of Cymbalta was initiated and started to treat her depression and anxiety. The latter was chosen and also in part because of its benefit in treating the anxiety that she did complain about. The patient also did complain of trouble sleeping and trazodone was used successfully on an as needed basis to treat this when given at bedtime. She tolerated medication well and the dosage was increased, she was then subsequently to be successfully discharged from the hospital program."

Conclusions

Complaint 1. Inadequate admission process

The Mental Health and Developmental Disabilities Code (405 ILCS 5/3-503) states "(a) Any minor may be admitted to a mental health facility for inpatient treatment upon application to the facility director, if the facility director finds that the minor has a mental illness or emotional disturbance of such severity that hospitalization is necessary and that the minor is likely to benefit from inpatient treatment. Except in cases of admission under Section 3-504, prior to admission, a psychiatrist, clinical social worker, clinical professional counselor, or clinical psychologist who has personally examined the minor shall state in writing that the minor meets the standard for admission. The statement shall set forth in detail the reasons for that conclusion and shall indicate what alternatives to hospitalization have been explored. (b) The application may be executed by a parent or guardian or, in the absence of a parent or guardian, by a person in loco parentis. Application may be made for a minor who is a youth in care as defined in Section 4d of the Children and Family Services Act by the Department of Children and Family Services or by the Department of Corrections."

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-200) states "(a) Upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient, as well as the recipient's guardian or substitute decision maker, and every recipient who is 12 years of age or older and the parent or guardian of a minor or person under guardianship shall be informed orally and in writing of the rights guaranteed by this Chapter which are relevant to the nature of the recipient's services program. Every facility shall also post conspicuously in public areas a summary of the rights which are relevant to the services delivered by that facility as well as contact information for the Guardianship and Advocacy Commission and the agency designated by the Governor under Section 1 of the Protection and Advocacy for Persons with Developmental Disabilities Act.[1] (b) A recipient who is 12 years of age or older and the parent or guardian of a minor or person under guardianship at any time may designate, and upon commencement of services shall be informed of the right to designate, a person or agency to receive notice under Section 2-201 or to direct that no information about the recipient be disclosed to any person or agency."

The Patient Bill of Rights form indicated the individual's guardian gave verbal consent and the individual signed the form stating "I/We received a copy of my rights explained to me in a language that I understand." Since the guardian was not present at the time of admission, she was provided a copy of the Patient Bill of Rights upon discharge, but staff verbally went over the Patient Bill of Rights with the guardian via telephone twice. Furthermore, the guardian gave verbal consent for admission of the individual as the individual was transported to the facility via ambulance from another hospital and the guardian was not present. Staff stated they called the guardian a second time and went over all the admission forms and verified that the guardian understood all the forms when the guardian filed a complaint.

Based on the findings above as documented in the individual's record the East Central Human Rights Authority concludes that there was no evidence proving the recipient's rights were violated and, therefore, the complaint is **unsubstantiated.**

Complaint 2. Inadequate Treatment: including the individual and parent not allowed to be involved in treatment planning and not providing prescribed medicine.

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) 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 recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. 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 HRA reviewed the individual treatment plan which was signed by the individual. Under "parent/guardian signature" it stated "VC" for verbal consent, but the name of the individual is not the guardians or parents of the individual. It is an unknown person with the same last name

as the individual listed on the treatment plan. Staff were not sure why the guardian was not listed as giving verbal consent and could not provide details on who gave verbal consent. The individual was concerned about her medication upon arrival because she believed it may have caused her thoughts of suicide. The guardian was contacted for consent prior to Cymbalta being given to the individual which was documented in the psychiatric note and the individual was not given Cymbalta until the guardian gave verbal consent. It is documented in a psychiatric note that the guardian called often with various concerns. However, the actual concerns were never documented, and it was also not documented whether the concerns were addressed.

Based on the unknown signature and the lack of documentation on whether the guardian's concerns were addressed, the East Central Human Rights Authority finds that the complaint of inadequate treatment planning is **substantiated.** The Human Rights Authority makes the following **recommendations**:

1. The Pavilion verify that the guardian is involved in the treatment plan per The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102). Train staff on 405 ILCS 5/2-102 regarding involvement in treatment planning and provide the HRA with evidence of the training.

The HRA **strongly suggests** that when obtaining verbal consent that the Pavilion properly verify and document who is giving the verbal consent.

Complaint 3: Inadequate access to records

The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4) states "(a) The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof: (1) the parent or guardian of a recipient who is under 12 years of age; (2) the recipient if he is 12 years of age or older; (3) the parent or guardian of a recipient who is at least 12 but under 18 years, if the recipient is informed and does not object or if the therapist does not find that there are compelling reasons for denying the access. The parent or guardian who is denied access by either the recipient or the therapist may petition a court for access to the record. Nothing in this paragraph is intended to prohibit the parent or guardian of a recipient who is at least 12 but under 18 years from requesting and receiving the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed, including medication, if any... (b) Assistance in interpreting the record may be provided without charge and shall be provided if the person inspecting the record is under 18 years of age. However, access may in no way be denied or limited if the person inspecting the record refuses the assistance."

The guardian requested the individual's records upon discharge and the records were mailed to the guardian. However, the staff stated that records cannot be release until after discharge when the record is considered "closed" which is contrary to the Confidentiality Act which states that a parent/guardian or recipient that is 12 or older is entitled to inspect a copy "Upon Request" (740 ILCS 110/4).

Furthermore, the facility's policy does not allow a patient to inspect or receive their records "... may do so only with the permissions of their attending physician in the presence of a health care

professional and after signing a written authorization. Non-hospitalized patient may view their own records upon written authorization as scheduled by the Medical Record Department. (Note: patients should never be allowed to view their records unattended)" which does not align with the above-mentioned section of the Act regarding receiving records "Upon Request". The Act does not state that permission from the attending physician is needed; it reads the patient can review "Upon Request" regardless of permissions by staff. The Act also states that assistance in interpreting the record "...shall be provided if the person inspecting the record is under 18 years of age. However, access may in no way be denied or limited if the person inspecting the record refuses the assistance."

Based on the findings above the East Central Human Rights Authority concludes that practices violate patient rights and, therefore, the complaint is **substantiated.** The Human Rights Authority makes the following **recommendations**:

1. The Pavilion update their Release of Medical Information policy to align with The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4) regarding permission and access.
2. The Pavilion train staff on the updated Release of Medical Information policy and provide the HRA with copies of the policy.
3. The Pavilion cease in the practice of not allowing patient's access to their records until discharge and assure staff training on this specific policy update.

The HRA respectfully requests that The Pavilion provide the HRA with evidence of the updated policy and staff being training on the policy as recommended.

Complaint 4: Lack of access to property

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-104) states "Every recipient who resides in a mental health or developmental disabilities facility shall be permitted to receive, possess and use personal property and shall be provided with a reasonable amount of storage space therefor, except in the circumstances and under the conditions provided in this Section. (a) Possession and use of certain classes of property may be restricted by the facility director when necessary to protect the recipient or others from harm, provided that notice of such restriction shall be given to all recipients upon admission.(b) The professional responsible for overseeing the implementation of a recipient's services plan may, with the approval of the facility director, restrict the right to property when necessary to protect such recipient or others from harm."

The individual arrived with a teddy bear in her procession which is verified by the "patient possession checklist for admission". The individual's teddy bear was kept in the storage unit according to the patient possession checklist for admission and not given to the individual. Staff stated that stuffed animals are not allowed on the unit due to health and safety reasons. The youth handbook states that stuffed animals are not allowed on the unit. Staff stated the individual and guardian were notified at admission of all prohibited items. Staff stated it is also listed on the facilities website that stuffed animals are prohibited. However, staff stated that an exception may be granted to allow a stuffed animal on the unit if it was clinically justified.

Based on the findings above as documented in the individual's record the East Central Human Rights Authority concludes that the consumer's rights were violated and, therefore, the complaint is **unsubstantiated.**

The HRA **strongly suggests** that the Pavilion ensure that a clinical review is conducted if there is a request by a patient or guardian to keep a banned personal item on the unit.

RESPONSE

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

HRA CASE NO. 21-060-9007
SERVICE PROVIDER: Pavilion

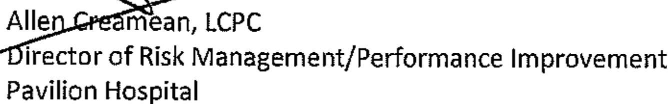
On behalf of the Pavilion, I would like to thank you for the opportunity to provide a written response to the complaint outlined in your correspondence dated May 21st, 2021. Following the completion of a thorough investigation of the complaints and review of the Guardianship and Advocacy investigative findings, we as a facility have identified some opportunities for improvement related to updating facility policies and training opportunities.

In response to the recommendations, the following actions will be taken:

- The Director of Clinical Services and Director of PI/Risk provided education to the clinical services team on the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) regarding involvement in treatment planning on 6/3/2021 (Attachment A).
- The Medical Record Manager and Director of Performance Improvement/Risk Management revised the Release of Medical Information Policy (HIM-22; Attachment B) to align with the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4) regarding permission and access.
- HIPAA training on patient access to records was provided to all employees starting in April 2021, and is provided to all newly hired employees prior to beginning employment.

Please note that we take all complaints and concerns seriously and that we strive to improve the services we provide to our patients. We ask that our response is included as part of the public record. Please feel free to contact me at 217-373-1758 for any additional questions or need for additional information.

Sincerely,



Allen Creamean, LCPC
Director of Risk Management/Performance Improvement
Pavilion Hospital