GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

April 6, 2022

Wendy Briggs, Administrator/CEO
Brghtwell Behavioral Health
3512 Coolidge Rd
East Lansing, MI 48933

Dear Ms. Briggs,

Attached you will find the results of the assessment completed by Michigan Department of Health and Human Services Office of Recipient Rights (MDHHS-ORR) LPH Rights Specialists Beverly Sobolewski and Sue Witting from February 23-14, 2022. In accordance with an Interagency Agreement between the Department of Health and Human Services (DHHS) and the Department of Licensing and Regulatory Affairs (LARA), ORR has conducted this onsite assessment as part of the State licensing inspection required of LARA by the Mental Health Code, specifically MCL 330.1134. This assessment focused specifically on the licensee's compliance with Chapters 7 and 7A of the Mental Health Code.

As a result of the assessment your rights system has achieved a score of **260 points out of a total of 374** and has been found to be in **LESS THAN SUBSTANTIAL COMPLIANCE** with the standards established in Chapter 7 of the Michigan Mental Health Code and part 7 of the MDHHS Administrative Rules to promote and protect the rights of recipients.

Please carefully review the findings, comments and required actions contained in this report. There are several standards which will require a written corrective plan of action. This plan should be provided to Beverly Sobolewski Sobolewskib@michigan.gov no later than **May 18, 2022**. This plan must:

- Provide a clear and specific response to each standard for which "required action" is cited in the report.
- Assure implementation of corrective action across the entire behavioral health service delivery system.
- Include documentation and/or other appropriate evidence of implementation of all corrective action taken.

The findings by ORR will be provided to LARA as part of the Interagency Agreement as LARA is the authority with jurisdiction for licensure compliance. ORR will also coordinate a necessary plan of correction and follow up assessment and share these findings too with LARA as required

by the agreement. Failure to provide the required plan of correction or evidence of action taken by the date due could result in licensing action by LARA. LARA is responsible for any enforcement action necessary to assure correction and compliance with the applicable regulations.

Once again, I appreciate the assistance and cooperation offered to MDHHS-ORR during the assessment process. We are available to assist you with any concerns or questions you may have. Specific questions relative to your assessment or the development of your plan of correction should be directed to Beverly Sobolewski, LPH Rights Specialist at 517-242-5832.

Sincerely,

Raymie Postema, Director
MDHHS Office of Recipient Rights

Attachments:
Compliance Standards Worksheet
Policy Guideline Worksheet

cc:
Elizabeth Hertel, Director, MDHHS
Bureau of Community Health Systems State Licensing
Kami Sutton, Rights Advisor, Brightwell Behavioral Health

LPH: **Brightwell Behavioral Health**

ASSESSMENT DATES: **February 23, 24, 2022**

REVIEWERS: **Beverly Sobolewski, Sue Witting**

SECTION	MAXIMUM POSSIBLE SCORE	WEIGHT	MAXIMUM POSSIBLE SCORE (WEIGHTED)	YOUR BASE SCORE	YOUR WEIGHTED SCORE
1. LPH RESPONSIBILITIES	26	3	78	17	51
2. RIGHTS OFFICE OPERATIONS	14	3	42	12	36
3. SEMI-ANNUAL AND ANNUAL REPORTING	4	1	4	4	4
4. EDUCATION AND TRAINING	6	2	12	3	6
5. POLICIES	8	3	24	5	15
6. RIGHTS ADVISORY COMMITTEE	14	1	14	6	6
7. COMPLAINT RESOLUTION - PROCESS	18	3	54	13	39
8. COMPLAINT RESOLUTION – CONTENT	34	3	102	20	60
9. COMPLAINT RESOLUTION - TIMEFRAMES	10	3	30	10	30
10. APPEALS	14	1	14	13	13
TOTAL SCORE	**148**		**374**	**103**	**260**

Full Compliance	Substantial Compliance	Less than Substantial Compliance
336/374 (90%)	299/374 (80%)	<299/374

Beverly Sobolewski

Report Prepared by: Beverly Sobolewski, Community Rights Specialist, MDHHS-ORR — 3/7/2022 Date

Andrew Silver

Report Reviewed by: Andrew Silver, Director, Education, Training and Compliance, MDHHS- — 3/7/2022 Date

CITATION	STANDARD	SECTION 1 - LPH RESPONSIBILITIES	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
MHC 1755(1)	1.1.1	The Agency has established a recipient rights office subordinate only to the Hospital Director.	2	2		
MHC 1100(b)(10) MHC 17102 AR 1267	1.1.2	The Agency has appointed a designee to act in place of the hospital director in the absence of the director.	2	2		
MHC 1755(2)(b)	1.2.1	The process for funding the rights office includes a review of the funding by the recipient rights advisory committee.	2	0	Committee has only met once to date. Funding was not addressed.	Finalize committee membership. Send Advisory Committee meeting minutes that show that funding for the rights office was presented.
MHC 1755(2)(c)	1.3.1	The recipient rights office is protected from pressures that could interfere with the impartial, even-handed, and thorough performance of its duties.	2	2		
MHC 1755(2) (d)	1.3.2	The rights office has had unimpeded access to a) All programs and services operated by, or under contract to, the LPU; b) All staff employed by, or under contract to, LPU; c) All evidence necessary to conduct a thorough investigation or to fulfill its monitoring function.	2	1	ORR has not had access to incident reports except to reports selected on their behalf	Assure that rights receives all incident reports.
MHC 1755(3) (a)	1.3.3	Complainants, rights office staff, and any staff acting on behalf of a recipient will be protected from harassment or retaliation resulting from recipient rights activities.	2	2		
MHC 1755(3) (a) AR 7035(1)	1.3.4	Appropriate disciplinary action was taken if there was evidence of retaliation and harassment.	2	2		
MHC 1755(4) MHC 1757(2) (e)	1.4.1	The hospital director has selected a rights director who has the education, training, and experience to fulfill the responsibilities of the office.	2	2	The hospital is currently interviewing to fill the rights advisor position. The rights advisor resigned immediately prior to the site visit.	
MHC 1755(4) MHC 1778(1)	1.4.2	The LPH has established a process to assure ongoing rights protection in the absence of the rights advisor/officer.	2	0	There has been no alternate advisor to date.	Provide evidence of coverage of rights protection in the absence of the rights advisor.
MHC 1755 (4)	1.4.3	The rights director has no clinical service responsibilities.	2	2		

CITATION	STANDARD	SECTION 1 - LPH RESPONSIBILITIES	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
AR 7199 (2)(g)	1.5.1	The LPH has established a specially constituted body (behavior treatment plan review committee) to review and approve limitations of recipient rights, any intrusive techniques or use of psycho-active drugs for behavior control purposes.	2	0	Although the hospital has a licensed psychologist by contract there is no committee internally and no process in place to utilize the recipient's CMH of record.	Establish committee or use the Behavior Treatment Plan Review Committee (BTPRC) from the CMH of record. Provide evidence of committee or process that clarifies when a BTPRC review is needed and process for review. This process should include contacting CMH BTPRC if using their committee. Recommend adding to Treatment Planning policy.
MHC 1755(2)(f)(ii)	1.5.2	Each contract between a LPH and a service provider requires that all recipients be protected from rights violations while receiving services.	2	0	Required rights language was not found in the contracts reviewed between Brightwell and service providers.	Update all contracts to include rights protection and training language. Send one contract with required language.
MHC 1706	1.5.3	At the time services are initiated, ORR ensured that recipients, parents of minor recipients, and guardians are notified, in an understandable manner, of the rights guaranteed by Chapter 7 and 7A of the Mental Health Code and provided access to summaries of the rights guaranteed by Chapter 7 and 7A both at the time services are initiated and periodically during the time services are provided.	2	2		

		Section 1 Total	26	17	

CITATION	STANDARD	SECTION 2 – RIGHTS OFFICE OPERATIONS	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
MHC 1776 (5)	2.2.1	ORR ensured there is a mechanism to advise recipients or other individuals that there are advocacy organizations available to assist in preparation of a written rights complaint and offered to make the referral.	2	2		
MHC 1776 (5)	2.3.1	As necessary, the office assists recipients or other individuals with the complaint process.	2	2		

CITATION	STANDARD	SECTION 2 - RIGHTS OFFICE OPERATIONS	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
MHC 1755[5][d][I]	2.4.1	ORR maintained a record system for all reports of apparent or suspected rights violations received including a mechanism for logging all complaints.	2	2		
MHC 1755[5][d]	2.4.2	ORR has established a mechanism for secure storage of all investigative documents and evidence.	2	2	The rights advisor shares an office with two other staff, which results in evidence, phone calls and interviews being accessible by all non-rights staff.	Provide evidence of a private space for the rights advisor to conduct interviews, phone calls and write reports. Provide the rights advisor a place for secure storage that can be accessed by only ORR and the Director.
MHC 1755[5][h]	2.5.1	ORR serves as a consultant to the hospital director in rights related matters.	2	2		
MHC 1755[5][i]	2.6.1	Ensure that all reports of apparent or suspected violations of rights within LPH are investigated in accordance with section 1778.	2	1	There is no evidence that complaint forms are utilized for complaints	Assure complaint forms are utilized by ORR. Send copies of 3 completed complaints to B. Sobolewski within 60 days.
MHC 1755 (5)(e)	2.7.1	The units are visited with the frequency necessary for the protection of rights.	2	1	The rights advisor indicated that she visits the units frequently but did not document required observations.	Complete a site visit using the monitoring form quarterly. Add a process to policy. Send the next completed form.

		Section 2 Total	14	12

CITATION	STANDARD	SECTION 3 – SEMI-ANNUAL AND ANNUAL REPORTING	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
MHC 1755[5][j]	3.1.1	By June 30 of each year, the Rights Office provided to MDHHS, a summary of complaint data together with a remedial action taken on substantiated complaints. The report will also be shared with the RRAC	2	2		
MHC 1755[6]	3.2.1	By December 30 of each year, the LPU submitted to MDHHS, an annual report prepared by the recipient rights office on the current status of recipient rights in the hospital and a review of the operations of the rights office for the preceding fiscal year. The hospital director submitted written notice attesting to the accuracy and completeness of the report.	2	2		

CITATION	STANDARD	SECTION 3 - SEMI-ANNUAL AND ANNUAL REPORTING	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
		Section 3 Total	4	4		

CITATION	STANDARD	SECTION 4 – EDUCATION AND TRAINING	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
MHC 1755[2][e]	4.2.1	The staff of the rights office receive training each year in recipient rights protection.	2	2		
MHC 1755[5][f]	4.3.1	All individuals employed by the LPH or its contract agencies received training related to recipient rights protection before or within 30 days after being employed.	2	1	Although there is an indication that training was conducted it was only 60 minutes in length	All staff participate in rights training via ImprovingMIpractices and follow up with the rights advisor to assure full training in rights protection
MHC 1755[2][a]	4.4.1	Education and training in recipient rights policies and procedures are provided to the recipient rights advisory committee.	2	0	Committee has only met once to date. Policies were not addressed.	Once the committee is established provide evidence of policy reviews in advisory committee minutes. Send the next 2 meeting minutes to B. Sobolewski.
		Section 4 Total	6	3		

CITATION	STANDARD	SECTION 5 – POLICIES	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
MHC 1752[1]	5.1.1	The policies and procedures provided a mechanism for prompt reporting, review, investigation, and resolution of apparent or suspected rights violations, and are designed to protect recipients from, and prevent repetition of, violations of rights guaranteed by Chapters 7 and 7A.	2	1	The policy contained language from the pre-1996 MHC. Complaints are identified as being given to ORR from administration.	Update the policy to reflect current practice regarding submission of complaints and investigative and report writing practices.
MHC 1752[1]	5.1.2	Policies and procedures included, at a minimum, all those specifically delineated in MHC 330.1752 (1).	2	2		

CITATION	STANDARD	SECTION 5 – POLICIES	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
MHC 1752 (1) MHC 1704 (1)	5.1.3	Policies and procedures meet the criteria established in the Mental Health Code and Administrative Rules.	2	1	Policies were 74% compliant with the standards identified in law. See attached policy review for identification of specific issues	Ensure language in polices comes from the MMHC and is the most protective of recipients and policies are clear and logical.
MHC 1712 AR7199	5.1.4	The LPH has a policy and procedure that ensures a person centered planning process is used to develop a written IPOS in partnership with the recipient and all the required components of the IPOS are included.	2	1	Policy language is staff-centric with the recipient present	Amend policies to reflect practice. Add methods for including recipients in the entire process.
		Section 5 Total	8	5		

CITATION	STANDARD	SECTION 6 – RECIPIENT RIGHTS ADVISORY COMMITTEE	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
MHC 1758	6.1.1	The hospital will either contract with the local community mental health services program in order to utilize the CMH committee or will appoint a recipient rights advisory committee. At least 1/3 of the membership shall be primary consumers or family members and, of that 1/3, at least 1/2 shall be primary consumers.	2	1	The committee is not yet formed and only met immediately prior to the assessment. There was no committee from 2020 through 2021	Finalize establishment of a RRAC in compliance with 1758 of the MMHC.
MHC 1758 (a)	6.1.2	The RRAC met at least semiannually or as necessary to carry out its responsibilities.	2	0	There was no committee from 2020 through 2021	Recommend once committee is established that you meet at least 4 times a year till you meet policy and office funding requirement.
MHC 1758(b)	6.1.3	The LPH maintains a current list of members' names. This list is available to individuals upon request.	2	2		
MHC 1758(b)	6.1.4	The LPH maintains a current list of categories represented by members. This list is available to individuals upon request.	2	2		
MHC 1758(c)(e)	6.1.5	The RRAC acts to protect the recipient rights office from pressures which could interfere with the impartial, even-handed and thorough performance of its duties and serves in an advisory capacity to the Hospital Director and the rights director.	2	0	There was no committee from 2020 through 2021	

CITATION	STANDARD	SECTION 6 – RECIPIENT RIGHTS ADVISORY COMMITTEE	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
MHC 1758(d)	6.1.6	The RRAC reviewed and provided comments on the annual rights report submitted by the hospital director to the Board and MDHHS-ORR.	2	0	There was no committee from 2020 through 2021	Once Advisory Committee is established ensure that they review your semi-annual and annual reports reflective in committee meeting minutes.
MHC 1758	6.1.10	Minutes of the RRAC meetings are maintained.	2	1	Minutes were present for the one meeting	Submit evidence of meeting minutes after committee is established.
		Section 6 Total	14	6		

CITATION	STANDARD	SECTION 7 – COMPLAINT RESOLUTION - PROCESS	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
Case Reviews:		# Investigations 6 # Interventions 0 # No Right Involved/Out of Jurisdiction 2				
MHC 1776[3]	7.1.1	Each rights complaint was recorded upon receipt by the rights office.	2	2		
MHC 1776[3]	7.1.2	For each rights complaint recorded, an acknowledgement letter and copy of the complaint was sent to the complainant.	2	0	There was no evidence that complaint acknowledgments contained a copy of the complaint. There was no proof that acknowledgement letters were sent.	Ensure that complaints are being responded to in a clear manner and include evidence that a copy of the complaint is attached. Send your next 6 acknowledgement letters with copy of the complaint to+G73 Bev Sobolewski
MHC 1778[1] IM01(7/16/2019)	7.3.1	The rights office immediately initiated investigation of apparent or suspected rights violations involving serious physical harm or the death of a recipient, or other alleged abuse or neglect of a recipient.	2	2		
MHC 1778[1] IM01(7/16/2019)	7.3.2	The rights office-initiated investigation of apparent or suspected rights violations in a timely and efficient manner.	2	2		
MHC 1778[2]	7.4.1	Investigation activities for each rights complaint were accurately recorded by the office. This includes interview notes, documents reviewed, policies, and other sources of evidence pertaining to the investigation being contained in the complaint case file.	2	0	Files did not contain evidence.	Ensure that you are keeping complete investigative files showing all evidence used that is relevant to the allegation.

CITATION	STANDARD	SECTION 7 – COMPLAINT RESOLUTION - PROCESS	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
MHC 1778[5]	7.5.1	Upon completion of the investigation, the office completed a written investigative report (RIF) and submitted it to the Chief Administrative Officer (CAO).	2	2		
MHC 1782[1]	7.6.1	The hospital director [Chief Administrative Officer (CAO)] submitted a written summary report to the complainant, recipient if different, guardian/parent of a minor recipient.	2	1	Summary reports were contained in the file, But there was no evidence of the reports being sent to the appropriate people	Director to complete summary reports and ensure they are provided to all persons with appeal rights. Send the next 3 summary reports
MHC 1782[2]	7.7.1	Information in the summary report did not violate the rights of any employee.	2	2		
MHC 1784[3]	7.10.1	The rights office advised the appellant that there are advocacy organizations available to assist in preparing the written appeal and offered to make the referral. In the absence of assistance from an advocacy organization, the rights office assisted the appellant in meeting the procedural requirements of a written appeal.	2	2		

		Section 7 Total	18	13		

CITATION	STANDARD	SECTION 8 – COMPLAINT RESOLUTION - CONTENT	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
MHC 1776 (4)	8.1.1	Complaints identified as out-of-jurisdiction or no right involved were correctly categorized and responded to. Sufficient rationale was provided to the complainant.	2	1	Of the two cases reviewed, one was miscategorized.	Send next NRI and OJ for review.
MHC 1755 (5)(i) MDHHS Standards	8.1.2	For complaints where the intervention process was utilized, the rights office conducted the intervention in compliance with the standards established by MDHHS and utilizing the preponderance of evidence standard.	2	2		
MHC 1755 (5)(i) MDHHS Standards	8.1.3	The results of the intervention indicated whether a rights violation was substantiated.	2	2		
MHC 7755(5)(i) 1776 MDHHS Standards	8.1.4	The correspondence clearly indicated that process for requesting an investigation if the complainant was not satisfied with the result of the intervention.	2	2		
MHC 1778[4]	8.2.1	Issued status reports contained all required elements and were sent to all required persons.	2	2		
MHC 1778[5][a]	8.3.1	The written investigative report included a statement of alleged rights violation.	2	2		

CITATION	STANDARD	SECTION 8 – COMPLAINT RESOLUTION - CONTENT	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
MHC 1778[5][c]	8.3.2	The written investigative report included citations to relevant provisions of the Mental Health Code, other applicable laws, rules, policies, and guidelines.	2	0	Citations were incorrect in the majority of cases	Assure the new rights advisor attends Basic Skills and Building Blocks as soon as possible.
MHC 1778[5][b]	8.3.3	The written investigative report included a statement of the issues involved.	2	0	Issue Questions were based upon the incorrect citations	Assure the new rights advisor attends Basic Skills and Building Blocks as soon as possible.
MHC 1778[5][d]	8.3.4	The written investigative report included investigative findings that were sufficient to provide a detailed inquiry and systematic examination of the allegation.	2	0	In investigations reviewed there was relevant evidence missing. Findings lacked interviews and reviews of other evidence including documentation.	Assure the new rights advisor attends Basic Skills and Building Blocks as soon as possible.
MHC 1778[5][e]	8.3.5	The written investigative report included a conclusion section which provided an analysis of the findings and a decision as to whether a violation occurred using a preponderance of the evidence.	2	0	Issue questions were responded to with a conclusion, but no supporting evidence.	Assure the new rights advisor attends Basic Skills and Building Blocks as soon as possible.
MHC 1778[5][f]	8.3.6	When appropriate, the written investigative report included recommendations to remediate the violation and attempt to prevent a recurrence.	2	2	The recommendations often included disciplinary action but did not include any recommendations to prevent recurrence.	Assure the new rights advisor attends Basic Skills and Building Blocks as soon as possible.
MHC 1755[3][b] MHC 1780[1]	8.4.1	On substantiated rights violations the hospital director took timely remedial action to remedy the violation and attempt to prevent recurrence.	2	2		
MHC 1722[2] AR 7035(1)	8.4.2	On substantiated rights violations involving abuse or neglect, the hospital director ensured disciplinary action was taken.	2	1	When requested, the director took disciplinary action. For the abuse case that the rights advisor erroneously asked for remedial action, the director did not take disciplinary action	Director must assure that "disciplinary action" is taken in keeping with 330.7035 for all cases of abuse or neglect.
MHC 1780(2)	8.4.3	The remedial/disciplinary action was documented and made part of the rights case file.	2	0	No evidence	

CITATION	STANDARD	SECTION 8 – COMPLAINT RESOLUTION - CONTENT	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
MHC 1782 [1] (a)(b)(c)(d)(e)(f)(g)	8.5.1	Summary reports reflected the information from the allegation, citation, and issues, and recommendation sections of the RIF and provided a summary of the investigative findings of the rights office.	2	1	Summary reports reflected allegations citations and issues correctly. However conclusions from the RIF were altered and key elements were removed.	Director must include information from the RIF verbatim. A summary of the investigative findings is acceptable. Provide the next 3 summary reports to Bev.
MHC 1782(1)(g)	8.5.2	The Summary Report provided detailed information as to the action taken (or action planned to be taken) in order to meet the requirements stated in MHC 1782.	2	2		
MHC 1782[1][h]	8.5.3	As part of the Summary Report the complainant, recipient, if different, guardian or parent of a minor were informed of their right to appeal, the grounds for filing the appeal, and information about where to send the appeal.	2	1	There was no there was no evidence that ORR determined the appropriate appeals committee or advised the director as to where the appeal should be sent.	Director must include appeal information to the recipient's CMH committee or MDHHS committee if there is no CMH involved.
		Section 8 Total	34	20		

CITATION	STANDARD	SECTION 9 – COMPLAINT RESOLUTION - TIMEFRAMES	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
MHC 1776 (3)	9.1.1	For each complaint received, the Rights Office provided, to the complainant within 5 business days, an acknowledgement of receipt and a copy of the complaint.	2	2	Acknowledgement were timely.	
CMHSP 6.4.3.2	9.1.2	For each complaint utilizing the intervention process, responses were provided to the complaint within 30 calendar days.	2	2	Interventions were not utilized	
MHC 1778 (4)	9.1.3	For each investigation, status reports were issued every 30 days, as required.	2	2	Status letters were not required due to the completion of investigations within 30 days	
MHC 1778 (1)	9.1.4	Subject to delays involving pending action by external agencies, the office completed investigations no later than 90 calendar days following receipt.	2	2		
MHC 1782 (1)	9.1.5	A written Summary Report was issued by the hospital director for each Report of Investigative Findings (RIF) within 10 business days after receipt of the RIF.	2	2		

CITATION	STANDARD	SECTION 9 - COMPLAINT RESOLUTON - TIMEFRAMES	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
		Section 9 Total	10	10		

CITATION	STANDARD	SECTION 10 – APPEALS	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
MHC 1774 [3]	10.1.1	*For recipients who are under the authority of a CMHSP,* the governing body of a licensed hospital shall designate the appeals committee of the local community mental health services program to hear an appeal of a decision on a recipient rights matter brought by or on behalf of a recipient of that community mental health *services program.*	2	2		
MHC 1774 [4]	10.1.2	*For recipients who are not under the authority of a CMHSP,* the Governing Body (Board) of Hospital appointed an appeals committee to hear appeals of recipient rights matters **OR** entered into an agreement with MDHHS to use that entities appeals committee.	2	2	There were no appeals	
MHC 1774 (3)	10.1.3	Notices of appeal rights refer recipients to appropriate appeals committee.	2	2		
MHC 1784(5 APL 133; recipient rights appeal process	10.2.1	If an investigation is returned to the LPH by an appeals committee for reinvestigation, the office will complete the reinvestigation within 45 days following the standards established in 330.1778.	2	2		
MHC 1784(5)(b) APL 133; recipient rights appeal process	10.2.2	If an investigation is returned to the LPH by an appeals committee for reinvestigation, upon receipt of the RIF, the director will take appropriate remedial action and will submit a written summary report to the complainant, recipient, if different than the complainant, parent or guardian, and the appeals committee within 10 business days.	2	2		
MHC 1784(5)(c) APL 133; recipient rights appeal process	10.2.3	If a request for additional or different action is sent to the Director, a response will be sent within 30 days as to the action taken or justification as to why it was not taken. The response will be sent to the complainant, recipient, if different than the complainant, parent or guardian, and the appeals committee.	2	1	The policy did not have the correct timeframe.	Correct the policy to reflect 30 days, not 45
MHC 1784(5)(d) APL 133; recipient rights appeal process	10.2.4	If the committee notifies the LPH Board chair of a recommendation to seek an external investigation from MDHHS-ORR, the board will send a letter of request to the director of MDHHS-ORR within 5-business days of receipt of the request from the appeals committee. The director of the LPH making the request will be responsible for the issuance of the summary report, which will identify the grounds and advocacy information.	2	2		

		Section 10 Total	14	13		

POLICY	SCORE	OUT OF	PERCENT
Complaint and appeal process	50	78	64%
Consent to treatment and services	9	18	50%
Abuse and neglect, including detailed categories of type	14	18	78%
Right to be treated with dignity and respect	6	10	60%
Fingerprinting, photographing, audiotaping, and use of 1-	14	32	44%
Confidentiality and disclosure	17	44	39%
Change in type of treatment / services suited to condition	17	22	77%
Change and type of treatment / person centered planning	5	10	50%
Sterilization, contraception, and abortion	0	6	0%
Communication and visits	12	16	75%
Medication procedures	18	18	100%
Use of psychotropic drugs	10	10	100%
Treatment by spiritual means	16	18	89%
Property and funds	16	16	100%
Right to entertainment material, information, and news	11	18	61%
Resident labor	10	10	100%
Least restrictive setting / Freedom of movement	6	8	75%
Use of restraint	37	42	88%
Use of seclusion	23	32	72%
Comprehensive Examinations	2	2	100%
Qualifications and Training for Recipient Rights Staff	14	14	100%

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
		Complaint and appeal process		
		Policy Name/Number: Policy revision date:	Handling of recipient rights complaints and appeals	In general, there are several references to minors or to the parents of minors. If the unit does not treat minors, they should be removed. The policies use the term “this section" When it is referring to "this policy”
		The policy requires the following:		
2	A1	A process to assure that all recipients receive a summary of rights.	5.0 A. (a-d)	
2	A2	A process for explaining recipient rights to all recipients in an understandable manner, including documentation of alternative methods utilized, and the name of the person who provided the explanation. [MHC 1755 (5) (b); AR 7011	1.0 and 5.0 A.	The policy indicated that the next step was to go to the MDHHS-ORR website. Indicate the next steps if the website does not have the language requested. P. 2 5.0 A.b
2	A3	The Rights Office assures that recipients, parents of minors, guardians and others had ready access to complaint forms. [MHC 1776 (1), (5)]	5.0 B.	
2	A4	Each rights complaint is recorded upon receipt by the rights office. [MHC 1776 (3)]	5.0 C.	
1	A5	Rights complaints filed by recipients, or anyone on their behalf, are placed in a secure receptacle accessed only by ORR. [MHC 1776 (1); 1778 (1)]	5.0 A.	The policy indicates that complaints "will be given to the recipient rights adviser as soon as possible but no later than 24 hours after receipt of the complaint". Amend the policy to indicate that all complaints should be placed in the box, no matter who receives the complaint.
	A6	Acknowledgment of receipt/recording of the complaint is sent along with a copy of the complaint to the complainant within 5 business days. [MHC 1776 (3)]	5.0 B./D.	
1	A7	The rights office must notify the complainant within 5 business days after it received/recorded the complaint if it determined that no investigation of the complaint was warranted. [MHC 1776 (3) (4)]	5.0 C./D.	Section 5.0 B.e. indicates a violation that doesn't meet the ORR standards for opening a case will be handled informally. This is incorrect. The standard for not a code protected right is in C. Remove 5.0 B.e.
2	A8	The rights office to assist the recipient or other individual with the complaint process, as necessary. [MHC 776 (5)]	5.0 D.	
2	A9	The rights office to advise the recipient or other individual that there are advocacy organizations available to assist in preparation of a written rights complaint and offered to make the referral. [MHC 1776 (2) (a-c), (5)]	5.0 D.	
1	A10	In the absence of assistance from an advocacy organization, the rights office must assist in preparing a written complaint. [MHC 1776 (2)(a-c); (5)]	5.0 D.	Section 5.0 E includes language regarding mediation which was repealed in March of 2020. Remove the language in the last sentrence.
1	A12	If a rights complaint is received regarding the conduct of the hospital director (CAO), the rights investigation must be conducted by the recipient rights office of another LPH, a CMHSP or by the state office of recipient rights as decided by the board. [MHC 1776 (6)]	5.0 E.	Because you are not a CMH, the policy cannot refer to "another community mental health" complete the investigation . Amend the policy to indicate that the board may ask another LPH or MDHHS-ORR.

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
1	A13	In cases involving alleged abuse, neglect, serious injury, or when a rights violation is apparent or suspected in the death of a recipient during hospitalization or including deaths that occurred within 48 hours after discharge and including all deaths by suicide ~~or unknown cause~~, investigation must be immediately initiated. [MHC 1778 (1)]	5.0 F.	The policy fails to include the words "with an apparent or suspected violation" after the word death in the first sentence. The policy also indicates that illegal discrimination or any other violation chapter 7 will be opened within 24 hours. This is not required per the department. If the intent of the policy is to be more strict than MDHHS-ORR, the requirement of 24 hours can stand; if it is an attempt to reflect the department's requirements it should say "within 10 business days".
0	A14	The rights office must initiate investigation of apparent or suspected rights violations in a timely and efficient manner. [MHC 1778 (1)]	6.0 IX	The policy statement does not reflect the language of the MHC. It states ORR "may" investigate "apparent" violations of "Chapter7". The language needs to reflect the MHC: "A recipient, or another individual on behalf of a recipient, may file a rights complaint with the office alleging a violation of this act or rules promulgated under this act." and "The office shall initiate investigation of apparent or suspected rights violations..."
2	A15	The rights office must issue a written Status Report every 30 calendar days during the investigation to the complainant, respondent, and the responsible mental health hospital (LPH Director) and that the Status Report must contain the following: a) statement of the allegations, b) citations, c) statement of the issues, d) investigative progress to date and, e) expected date of completion. [MHC 1778 (4)]	B.	
2	A16	Investigations must be completed within 90 calendar days, unless awaiting action by external agencies. (CPS, law enforcement, etc.) [MHC 1778 (1)]	B.	
2	A17	The policy requires that the rights office must conduct investigations in a manner that does not violate employee rights. [MHC 1755(3)(b) added 1/11/21"appropriate remedial action is taken in a manner..."	6.0 DD.	
1	A18	Investigation activities for each rights complaint must be accurately recorded by the office. [MHC 1778 2)]	4.0 C./ N. XII	Although the policy clearly indicates that complaints are logged, the policy needs to indicate that dates of status letters, submission of RIFs and summary reports as well as action will also be logged.
2	A19	The rights office must use "preponderance of the evidence" as its standard of proof in determining whether a right was violated. [MHC 1778 (3)]	6.0 Z. (6.0 N)	
2	A20	Upon completion of the investigation, the rights office must submit a written investigative report (RIF) to the respondent [who is also the Director (Chief Administrative Officer)]. [MHC 1778 (5)]	6.0 Y.	Remove extraneous language regarding the responsible mental health agency
1	A21	The RIF must include all the following: a) statement of the allegations, b) citations to relevant provisions of applicable laws, rules, policies, and guidelines, c) statement of the issues involved, d) investigative findings, e) conclusions, and f) recommendations, if any. [MHC 1778 (5)]	6.0 Y.	In addition to the correct reference in 6.0 Y there is an incorrect reference in 6.0 X. Remove X as it contains incorrect information, fully explained in Y.
2	A22	When rights violations are substantiated, the Director (Chief Administrative Officer) must take appropriate remedial action that meets the following requirements: a) corrects or remedies the violation, b) is implemented in a timely manner, c) attempts to prevent a recurrence of the violation. [MHC 1780 (1)]	6.0 DD.	
2	A23	Remedial action taken on substantiated violations is documented and made part of the record maintained by the rights office. [MHC 1780 (2)]	6.0 DD.	

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
1	A24	The Director (Chief Administrative Officer) must submit a written summary report to the complainant, recipient, if different than the complainant, parent of a minor, or guardian, within 10 business days after receiving the RIF from the rights office. [MHC 1782 (1)]	.	This section is merged with the report of investigative findings section. It makes the policy very confusing. Guardian is missing from this section. Amend the policy to insert guardian.
2	A25	The summary report contains all of the following: a) statement of the allegations, b) citations to relevant provisions of applicable laws, rules, policies, and guidelines, c) statement of the issues involved, d) summary of investigative findings, e) conclusions, f) recommendations, if any, g) action taken or plan of action proposed by the respondent, and, h) information describing potential appellants' right to appeal, time frames and grounds for making an appeal, and process for filing an appeal to the appropriate appeals committee. [MHC 1782 (1)]	.	This section is merged with the appeal section. It makes the policy very confusing.
0	A26	The hospital must ensure that appropriate disciplinary action was taken against those who have engaged in abuse or neglect [MHC 1722 (2)] or retaliation and harassment. [(hospital staff, any contract staff) MHC 1755 (3) (a)] [AR 7035 (1)]	6.0 DD.	6.0 DD addresses remedial and or disciplinary action but does not delineate when each is used. Amend the policy to include the language of 1722 (2) and 7035
2	A27	Information in the summary report must be provided within the constraints of the confidentiality/ privileged communications sections (1748, 1750) of the Mental Health Code. [MHC 1782 (2)]	6.0 CC.	
2	A28	Information in the summary report must not violate the rights of any employee (IE. PA 397 of 1978; Bullard-Plawecki Employee Right to Know Act). [MHC 1755 (3) (b), 1782 (2)]	6.0 CC.	Correct spelling of Plawecki
2	A29	If the summary report contains a plan of action the director must send a letter indicating when the action was completed [APL 133; recipient rights appeal process III.d.]	7.0 M. (6.0 BB)	
2	A30	If the letter indicating the plan of action describes an action that differs from the plan, the letter must indicate that an appeal may be made within 45 days on "action". [2018 technical requirement; recipient rights appeal process]	6.0 BB.	
2	A31	Appeals may be filed no later than 45 days after receipt of the summary report. [MHC 1784 (1)]	7.0 A.	
2	A32	The grounds for appeal must be a) the investigative findings of the rights office are not consistent with the facts, law, rules, policies or guidelines, b) the action taken, or plan of action proposed, by the respondent does not provide an adequate remedy, or c) an investigation was not initiated or completed on a timely basis. [MHC 1784 (2)]	7.0 indented A-C.	
2	A33	The rights office must advise the complainant that there are advocacy organizations available to assist in preparing the written appeal and offered to make the referral. [MHC 1784 (3)]	7.0 C.	The language in C is passive. Add, "the appeal notice contains a statement".
2	A34	In the absence of assistance from an advocacy organization, the rights office must assist the complainant in meeting the procedural requirements of a written appeal. [MHC 1784 (3)]	7.0 C.	
1	A35	The governing body of a licensed hospital must designate the appeals committee of the local community mental health services program to hear an appeal of a decision on a recipient rights matter brought by or on behalf of a recipient of that community mental health services program. [MHC 1774 (4)]	.	The policy references the Governing Body of Sparrow Hospital. Correct the hospital name
2	A36	The governing body of a licensed hospital may (b) by agreement with the department, designate the appeals committee appointed by the department to hear appeals of rights complaints brought against the licensed hospital. [MHC 1774 (4) (b)]	7.0 B.	
2	A37	If an investigation is returned to the LPH by an appeals committee for reinvestigation, the office will complete the reinvestigation within 45 days (APL 133; recipient rights appeal process]	7.0 L. (a)	
1	A38	If an investigation is returned to the LPH by an appeals committee for reinvestigation, upon receipt of the RIF, the director will take appropriate remedial action and will submit a written summary report to the complainant, recipient, if different than the complainant, parent or guardian, and the appeals committee within 10 business days. [MHC 1780, 1782 (1), 1784 (5) (b), 2019 contract attachment/technical requirement, APL 133; recipient rights appeal process]	7.0 L. (b)	The policy references Sparrow. Correct the hospital name. Add c for the hospital director's action when the re-investigation remains unsubstantiated (see 7.0 K)
1	A39	If a request for additional or different action is sent to the Director, a response will be sent within 30 days as to the action taken or justification as to why it was not taken. The response will be sent to the complainant, recipient, if different than the complainant, parent or guardian, **ORR and** the appeals committee. [MHC 330.1784(5)(c), 2019 contract attachment/technical requirement, APL 133; recipient rights appeal process]	7.0 M.	7.0 M indicates 45 days. The legal standard is 30 days. Correct the timeframe in the paragraph.

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
0	A40	If the committee notifies the LPH or CMH Board chair of a recommendation to seek an external investigation from MDHHS-ORR, the board will send a letter of request to the director of MDHHS-ORR within 5-business days of receipt of the request from the appeals committee. The director of the CMH or LPH making the request will be responsible for the issuance of the summary report, which will identify the grounds and advocacy information as in A32-A34 of this document and MDHHS-ORR Appeal Committee as the committee for any Appeal. [MHC 330.1784(5)(d), 2019 contract attachment/technical requirement, APL 133; recipient rights appeal process]	7.0 N.	The policy does not contain 7.0 N. Add the language from A40 (APL 133)
		Consent to treatment and services		
		Policy Name/Number: Policy revision date:	Informed consent	
		The policy requires the following:		
0	B1	Consent is defined in accordance with the definition in the Mental Health Code 330.1100a (19).	A.	The definition of consent is not in the policy. Amend the policy to include the language from the MHC. The policy includes DPOA and Representative rather than guardians or Advocates under a Mental Health Advance Directive and is very confusing. Remove language not addressed in the MHC, rules or Advance Directive for mental health.
1	B2	Informed consent is defined in accordance with the definition in the Administrative Rules 330.7003 (1) (a-d)	A.	The definitions in the policy are not those in 7003. This lessens the mandates of informed consent. Amend the policy to encompass the language from the MHC.
2	B3	The individual is presumed to be competent, or application has been made for a guardian. The policy does NOT allow that the recipient be denied the right to make decisions in any other circumstances. The procedures must include specific circumstances and the types of information that must be disclosed and steps that may be taken to protect voluntariness. *This is not required language for your policy but the policies addressing situations requiring informed consent, such as treatment planning or medication should indicate how they adhere to 4 requirements of informed consent [MHC 1702, AR330.7003 (1)]	B.(d.)	p. 2 B appears to contradict this section. Correct the policy to reconcile the two sections
0	B4	A method is identified for evaluating comprehension and for assuring disclosure of relevant information and measures to ensure voluntariness before obtaining consent. The procedures shall include a mechanism for determining whether guardianship proceedings should be considered.	A.(b.) B.	The policy does not contain a process to measure comprehension or whether guardianship proceedings should be initiated. Amend the policy to indicate the process.
0	B5	The policy requires that the individual providing consent shall be made aware of the purpose of the procedure, the risks and benefits, alternative procedures available, and offered an opportunity to ask and receive answers to questions. [AR 7003(1)(b)]	A.(c.)	The word comprehension is absent and disclosure is defined in a way that implies witholding. The policy on Medication does not require explainations that the recipient understands. Amend the policy to reflect the standard in B5
0	B6	Information is presented in a manner the recipient understands and a mechanism for evaluating comprehension is utilized. [AR 7003(1)(c) (2) (4)]	A.(c.)	Explanations are not identified as being adjusted to adapt to the recipient's level of comprehension. The policy appears to imply that consent is not required in varying levels of comprehension. Amend the policy to reflect the standard in B6.
2	B7	The recipient has free power of choice without force, fraud, deceit, duress, constraint, coercion, etc. [AR 7003 (1) (d)]	A.(d.)	

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
2	B8	The recipient/guardian is informed that if they withdraw consent this can be done without prejudice toward the recipient. [AR 7003 (1) (d)]	4.0 VII	There are others identified as being able to give consent. On the psychiatric unit, the recipient or the guardian can give consent. The policy must distinguish from medical policies which would allow a DPOA. Amend the policy to make the difference clear.
2	B9	Informed consent will be reobtained if changes in circumstances substantially change the risks, other consequences or benefits that were previously expected. [AR 7003 (3)]	J.(d.)	
9	18	50%		
		Abuse and neglect, including detailed categories of type and severity		
		Policy Name/Number: Policy revision date:	Abuse and Neglect - Handling of apparent or suspected abuse and neglect	
		The policy requires the following:		
2	C1	Abuse is defined in accordance with the definitions in AR 7001 (a-c), AR 7001 (z). [AR7035 (2) (a).	3.0 A.-C.	
2	C2	Neglect is defined in accordance with the definitions in AR 7001 (i-k). [AR7035 (2) (a).	3.0 J.-L.	
2	C3	Procedures are established for the mandatory reporting of abuse or neglect to a) the rights office, b) administration, c) other agencies as required by law. [MHC 1723]	p5 III	Add direct reporting to ORR to the policy.
2	C4	Investigations of abuse/neglect allegations are conducted by the Rights Office. [MHC 1778 (1)]		
0	C5	If an allegation is found to be substantiated, the hospital will take firm and fair disciplinary action and remedial action as appropriate. [MHC 1722 (2)]		Add disciplinary action language to the policy.
1	C6	There is clear delineation as to who is required to report abuse. [MHC 1723(1); P.A. 238 of 1978; P.A. 519 of 1982; and MHC 1722 (2)]	III reporting structure section 3 below E.	Amend the policy to identify who are mandatory reporters to ORR.
2	C7	Reporting is required of criminal abuse including vulnerable adult abuse and child abuse to local law enforcement. [MHC 1723]	1.0 Section 3	
1	C8	There is delineation as to who will prepare written reports to law enforcement agencies regarding criminal abuse. [MHC 1723 (2)]	1.0	The policy states that "Administration will assist in/assure" - The policy needs to identify who will complete the written report to law enforcement.
2	C9	The policy defines degrade and threaten in a clear manner (not mandatory)		
		Right to be treated with dignity and respect		
		Policy Name/Number: Policy revision date:	Recipient right to be treated with dignity and respect	The policy contains a statement regarding referral to ORR if the recipient alleges a violation of dignity and respect. This is incorrect and should be part of the complaint policy. It is extraneous in this policy.
		The policy requires the following:		
1	D1	The LPH protects and promotes the dignity and respect to which a recipient of services is entitled. [MHC 1704 (3), 1708 (4)]	1.0	This policy addresses four additional rights in the Policy statement. Keep the language that pretains to the policy. Move the other statements of rights to the policies that address them.
1	D2	There are definitions of dignity and respect. [MHC 1704 (3)]	2.0	The definitions are present but quite vague; Amend the policy to reflect clearer language.
2	D3	Family members are treated with dignity and respect. [MHC 1711]	3.0	
0	D4	Family members are given an opportunity to provide information to the treating professionals. [MHC 1711]	3.0	This language is not in the policy. Add the MHC language.
2	D5	Family members are provided an opportunity to request and receive general educational information about the nature of disorders, medications and their side effects, available support services, advocacy and support groups, financial assistance, and coping strategies. [MHC 1711]	3.0	The statement allowing family members to request information is not in the policy. Add the MHC language.
		Fingerprinting, photographing, audiotaping, and use of 1-way glass		

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
		Policy Name/Number: Policy revision date:	Fingerprinting, video, audio recording	
		The policy requires the following:		
1	E1	Identification of the circumstances under which audiotapes, or photos may be taken, and 1-way glass used. [MHC 1724 (7) (a-c)]	1.0 2(a-c)	"this section" refers to the section in the law. Use section 724 or "this policy"
2	E2	Identification of the parameters for use of fingerprints, photos, or audiotapes for the purpose of recipient identification. [MHC 1724 (4)]	1.0 2(a-c)	
2	E3	Prior written consent to any of the above (E2). [MHC 1724 (2)] [AR 7003 (1) (c)]	1.0(2)	
0	E4	The procedures for withdrawing consent. [AR 7003 (1) (d)]		This is not in the policy. Add the language from the MHC.
2	E5	The ability of recipients to object when photos are for personal use or social purposes. [MHC 1724 (6)]	1.0(6)	Does the hospital take social photographs? If not, state that in the policy.
2	E6	A method of safekeeping of fingerprints, photos, and audiotapes is identified. [MHC 1724 (4)]	1.0(4)	
2	E7	Fingerprints, photographs, or audiotapes, in the record of a recipient, and any copies of them, will be given to the recipient, or destroyed, when they are no longer essential to achieve provision of services or obtain information regarding identity, or upon discharge of the recipient, whichever occurs first. [MHC 1724 (5)]	1.0(5)	
0	E8	The need for audio taping, photographing/fingerprinting or use of 1-way glass is reviewed periodically. [MHC 1724 (5)]	1.0(5)	This is not in the policy. If it is not used, state in the policy it is not.
0	E9	Video surveillance may only be conducted for the purposes of safety, security, and quality improvement; in common areas (hallways, nursing station, social activity areas). [MHC 1724 (9)]	1.0(9)	This policy quotes the MHC, which requires that all the aspects of the policy be identified/explained. The policy states that there will be a policy. The policy must answer the policy requirements with the facts of video surveillience at Brightwell.
0	E10	Identification of the locations where the surveillance images will be recorded and saved. [MHC 1724 (9) (a)]	1.0 9(a)	
0	E11	How recipients and visitors will be advised of the video surveillance. [MHC 1724 (9) (b)]	1.0 9(b)	
0	E12	Security provisions include: (i) Who may authorize viewing of recorded surveillance video. (ii) Circumstances under which recorded surveillance video may be viewed. (iii) Who may view recorded surveillance video with proper authorization. (iv) Safeguards to prevent and detect unauthorized viewing of recorded surveillance video. (v) Circumstances under which recorded surveillance video may be duplicated and what steps will be taken to prevent unauthorized distribution of the duplicate. [MHC 1724 (9) (c)]	1.0 9(c)(i-v)	
0	E13	Documentation, and maintenance of that documentation, regarding each instance of authorized access, viewing duplication, or distribution of a surveillance video. [MHC 1724 (9) (d)]	1.0 9(d)	
0	E14	A process to retrieve a distributed video when the purpose for which it was distributed no longer exists. [MHC 1724 (9) (e)]	1.0 9(e)	
1	E15	Archiving footage of surveillance recordings for up to 30 days where an incident requires investigation by various entities, including law enforcement, Office of Recipient Rights, state licensing entity, and Centers for Medicaid and Medicare Services. [MHC 1724 (9) (f)]	1.0 9(f)	The policy must indicate that video used in an investigation will be subject to Brightwell's retention policy for recipient rights case files
2	E16	Prohibition on maintaining a recorded video surveillance image as part of a recipient's clinical record. [MHC 1724 (9) (g)]	1.0 9(g)	
		Confidentiality and disclosure	Confidentiality/disclosure	
		Policy Name/Number: Policy revision date:		
		The policy requires the following:		
2	F1	All information in the record and that obtained in the course of providing services is confidential. [MHC 1748 (1)]	1.0 Policy	
2	F2	A summary of section 1748 of the Mental Health Code is made part of each recipient file. [AR 7051 (1)]	5.0 (1.)	
1	F3	For case records made after March 28, 1996, information made confidential by 330.1748 will be disclosed to a competent adult recipient (adult without a guardian) upon the recipient's request. The information is released as expeditiously as possible, but in no event later than the earlier of 30 days of the request or prior to release from treatment. [MHC 1748 (4)]	5.0 J.	The policy quotes the MHC. Attach the process as an addendum.

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
1	F4	Except as otherwise provided in F3 [330.1748(4)], if consent has been obtained from: a) the recipient, b) the recipient's guardian who has the authority to consent, c) a parent with legal custody of a minor recipient, or d) court appointed personal representative or executor of the estate of a deceased recipient, information made confidential by 1748 may be disclosed to: 1) a provider of mental health services to the recipient, or 2) the recipient, his or her guardian, the parent of a minor, or another individual or hospital unless, in the written judgement of the holder {of the record} the disclosure would be detrimental to the recipient or others. [MHC 1748 (6)]	5.0 K.	This section is missing from the policy. Add the language from MHC section 1748 (6)
1	F5	A procedure for the review by the director of the hospital of a request for confidential information by a person not covered under 1748(4). The procedure will include a provision that requires the director, once the decision has been made not to release information based on detriment, to determine the part of the information requested that may be released. A full record may not be withheld. [AR 7051 (3)]	5.0 K.	This section is missing the language regarding releasing what can be released. Add the language from the AR 7051
2	F6	The timeframe for the review and determination will not exceed 3 business days if the record is on-site, or 10 business days if the record is off–site. [AR 7051 (3)]	5.0 L.	
2	F7	The requestor may file a complaint with the hospital's Office of Recipient Rights if he/she disagrees with the decision of the director regarding the portions of the record withheld. [AR 7051 (3)]	5.0 M.	The detriment determination described in M contains references to rights offices not in the hospital. Remove the other rights offices
2	F8	A recipient, guardian, or parent of a minor recipient, after having gained access to treatment records, may challenge the accuracy, completeness, timeliness, or relevance of factual information in the recipient's record. The recipient, guardian, or parent of a minor recipient shall be allowed to insert into the record a statement correcting or amending the information at issue. The statement shall become part of the record. The process for amending the record is defined. [MHC 1748 (4), (6) 1749]	5.0 N.	Add process and form to the policy.
2	F9	A record is kept of disclosures including a) Information released, b) To whom it is released, c) Purpose stated by person requesting the information, d) Statement indicating how disclosed information is germane to the state purpose, e) The part of law under which disclosure is made, f) Statement that the persons receiving the disclosed information could only further disclose consistent with the authorized purpose for which it was released. [AR 7051 (2) (a-e)]	5.0 H.(i-iv.) (5.0 B)	
2	F10	Confidential information must be disclosed under one or more of the following circumstances: a) an order or subpoena of a court of record or a subpoena of the legislature, unless the information is privileged by law, b) to a prosecuting attorney as necessary for the prosecutor to participate in a proceeding governed by the MHC, c) to a recipient's attorney with the consent of the recipient, the recipient's legal guardian (if they have authority to consent) or parent of a minor who has legal and physical custody, d) to the Auditor General, e) when necessary to comply with another provision of law, f) to MDHHS as necessary for the department to discharge a responsibility placed upon it by law, or g) to a surviving spouse or if none, closest relative of the recipient in order to apply for and receive benefits, but only if spouse or closest relative has been designated the personal representative or has a court order. [MHC 1748 (5) (a-g)]	5.0 K.	
2	F11	The hospital must grant a representative of Disability Rights of Michigan Protection access to the records of all of the following: a) a recipient, if the recipient, the recipient's guardian with authority to consent, or a minor's parents with physical and legal custody of the recipient, have consented to the access, b) a recipient, including a recipient who has died or whose location is unknown, if all of the following apply: (i) because of mental or physical condition, the recipient is unable to consent to the access, (ii) the recipient does not have a guardian or other legal representative or the recipient's guardian is the State, (iii) the protection and advocacy system has received a complaint on behalf of the recipient, or has probable cause to believe, based on monitoring or other evidence, that the recipient has been subject to abuse or neglect, c) a recipient who has a legal guardian or other legal representative if all the following apply: (i) a complaint has been received by the protection and advocacy system or there is probable cause to believe the health or safety of the recipient is in serious and immediate jeopardy, (ii) upon receipt of the name and address of the recipient's legal representative, the protection and advocacy system has contacted the representative and offered assistance in resolving the situation, (iii) the representative has failed or refused to act on behalf of the recipient. [MHC 1748 (8)]	5.0 O.	
2	F12	Attorneys representing recipients may review records only upon presentation of identification and the recipient's consent or a release executed by the parent or guardian. Attorney's must be permitted to review the record on hospital premises. [AR 7051(4)(b)]	5.0 P.	

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
2	F13	An attorney who has been retained or appointed to represent a minor pursuant to an objection to hospitalization must be allowed to review the records. [AR 7051 (4) (a)]	5.0 P.	The policy discusses minors and parents of minors. Remove references to minors.
2	F14	Attorneys who are not representing recipients may review records only if the attorney presents a certified copy of an order from a court directing disclosure of information concerning the recipient to the attorney. [AR 7051 (4) (b)]	5.0 P.	
2	F15	Attorneys will be refused information by phone or in writing without the consent or release from the recipient unless the request is accompanied or preceded by a certified copy of an order from a court ordering disclosure of information to that attorney. [AR 7051 (4) (c)]	5.0 P.	
2	F16	A private physician or psychologist appointed by the court or retained to testify in civil, criminal, or administrative proceedings must, upon presentation of identification and a certified copy of a court order, be permitted to review the records of the recipient on the hospital premises. Before the review, notification must be provided to the reviewer and to the court if the records contain privileged communication which cannot be disclosed in court, unless disclosure is permitted because of an expressed waiver of privilege or because of other conditions that, by law, permit or require disclosure. [AR 7051 (5) (a-b)]	5.0 Q.	
2	F17	A prosecutor may be given non-privileged information or privileged information which may be disclosed if it contains information relating to names of witnesses to acts which support the criteria for involuntary admission, information relevant to alternatives to admission to a hospital or facility, and other information designated in policies of the governing body. [AR 7051 (6) (a-c)]	5.0 R.	
2	F18	Information must be provided as necessary for treatment, coordination of care, or payment for the delivery of mental health services, in accordance with the health insurance portability and accountability act of 1996, Public Law 104-191. [MHC 1748 (7) (b)]	5.0 S.	
2	F19	The hospital, when authorized to release information for clinical purposes by the individual or the individual's guardian or a parent of a minor, releases a copy of the entire medical and clinical record to the provider of mental health services. (MHC 1748 [10])	5.0 T.	
0	F20	Disclosure of information that enables a recipient to apply for or receive benefits without the consent of the recipient or legally authorized representative only if the benefits will accrue to the provider or will be subject to collection for liability for mental health service. [MHC 1748 (7) (a); AR 7051 (7)]	5.0 S.	This language is missing from the policy. Amend the policy to include the MHC language.
2	F21	Records, data, and knowledge collected for or by individuals or committees assigned a peer review function including the review function under section 143a (1) of the Mental Health Code are confidential, are used only for the purpose of peer review, are not public records, and are not subject to court subpoena. [MHC 1748 (9)]	5.0 U.	
0	F22	The hospital, upon a written request from Child Protective Services, must grant access to review, and provide pertinent records and information within 14 days of the request. [MHC 1748a (1)]	N/A (No minor patients)	This section of the law is missing. This language must be added as 1748a applies to the records of adults as well as minors.
		Change in type of treatment / services suited to condition	Services suited and plan of service	
		Policy Name/Number: Policy revision date:		
		The policy requires the following:		
2	G1	A person-centered planning process is used to develop a written IPOS in partnership with the recipient. [MHC 1712 (1)]	1.0 policy	
2	G2	There is documentation of the recipient's participation in the treatment planning meeting, or an explanation as to the reason the recipient did not attend.[MHC 1712 (1) AR 7199 (2) (a)]	5.0 II.	
2	G3	There is documentation of the persons that the recipient desired to be part of the planning process. There is a method for soliciting names of, and including persons of the recipient's choice, in the IPOS. The justification for exclusion of individuals chosen by the recipient to participate in the IPOS process must be documented in the record. [MHC 1712 (3)]	5.0 III.	
2	G4	The IPOS includes assessments of the recipient's need for food, shelter, clothing, health care, employment opportunities (when appropriate), educational opportunities (when appropriate), legal services and recreation. [AR 7199 (h)]	IV.	
2	G5	The IPOS identified any limitations of the recipient's rights and includes documentation describing how the limitation is justified and time-limited. Documentation must be included that describes attempts that have been made to avoid limitations, as well as what actions will be taken as part of the plan to ameliorate or eliminate the need for the limitations in the future. [AR 7199 (g) (ii)]	V.	

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
1	G6	Any restrictions, limitations or intrusive behavior treatment techniques that are not related to the active diagnosis are reviewed by a formally constituted committee comprised of at least 3 individuals, 1 of whom must be a fully or limited-licensed psychologist with the formal training or experience in applied behavior analysis, and 1 of whom must be a licensed physician/psychiatrist (may include evaluation by a behavioral analyst from the CMH, as allowed by contract). [AR 7199 (2)(g)]	VI.	The policy implies in 5.0 VI that the hospital has a behavior treatment plan review committee. If the hospital does not, there should be some communication with the CMH as to how the CMH would be alerted if a BTP more required. The policy should reflect that the hospital does not have a committee but will contact the CMH who has admitted the recipient to the hospital if the committee is needed.
2	G7	The plan must be agreed to by the hospital, the recipient, the guardian, or the parent with legal custody of a recipient, unless it is part of a court order. Objections must be noted in the plan. [AR 7199 (4), (5)]	VII.	Remove parent with legal custody of a recipient.
1	G8	The LPH ensures that a recipient is given a choice of physician or mental health professional within the limits of available staff. The process is documented. [MHC 1713]	VIII.	Policy states that the process for change of physician is documented but does not state how it is documented. Amend the policy to indicate how the documentation occurs. Recommend adding language as to what the actual process is.
0	G9	A process whereby a recipient, who is assessed in the LPH emergency room by LPH staff and denied hospitalization by the pre-admission screening unit (PSU), must receive information on the ability to request a second opinion from the appropriate CMH. (Not required of LPHs without emergency room evaluations) [MHC 1409 (4)]	.	Remove this section
2	G10	An individual 18 years of age or over may be hospitalized as a formal voluntary recipient if the individual executes an application for hospitalization as a formal voluntary recipient or the individual assents and the full guardian of the individual, the limited guardian with authority to admit, or a recipient advocate authorized by the individual to make mental health treatment decisions under the estates and protected individuals code, 1998 PA 386, MCL 700.1101 to 700.8102, executes an application for hospitalization and if the hospital director considers the individual to be clinically suitable for that form of hospitalization. [MHC 1415]	X.	
1	G11	A process for explaining rights of recipients during the mental health treatment, including the right to object to the mental health treatment, must be orally communicated to the patient and to the individual who executed the written consent. In addition, a copy of the written consent must be given to the patient and the individual who executed the written consent and to 1 other individual designated by the patient. Completion is documented on the admission form, including documentation of delay and alternative methods utilized. [MHC 1416]	.	This Language in this section is out of date and has been repealed and replaced. This section needs to be updated to include the 1416 language that was amended in 2019.
		Change and type of treatment / person centered planning	Change in Treatment	
		Policy Name/Number: Policy revision date:		
		The policy requires the following:		
1	H1	The written IPOS has a specific date or dates when the overall plan and any of its sub-components will be formally reviewed for possible modification or revision. [AR 7199(2)]	5.0 Treatment Team	Page 3 master treatment plan review identifies time frame for review but does not indicate that these will be entered as dates on the plan. Amend the policy to reflect practice.
0	H2	There is a procedure to assure that the plan is kept current and modified when indicated, or when necessary. [MHC 1712 (1)]	5.0 Treatment Team/Intervention	This not in the policy. Insert a statement indicating how changes in recipient behavior on the unit would affect the person centered planning process. Amend the policy to reflect practice.
0	H3	The recipient must be informed orally and in writing of his or her clinical status and progress at reasonable intervals established in the IPOS in a manner appropriate to his or her clinical condition. [MHC 1714]	5.0 Treatment Team	This not in the policy. Insert a statement indicating how recipients will be updated on their progress and that the plan will include the dates of the updates

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
2	H4	If the recipient is not satisfied with his/her individual plan of services, the recipient or his/her guardian, or parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. [MHC 1712 (2)]	5.0 Master treatment plan review	
2	H5	The review required in H4 is completed within a reasonable period of time. (no later than 30 days or prior to d/c, whichever is sooner) There are procedures for requesting and conducting the review. [MHC 1712 (2)]	5.0 Master treatment plan review	
		Sterilization, contraception, and abortion		
		Policy Name/Number: Policy revision date:		
		The policy requires the following:	Language from MHC must be contained in policy	The policy is not requiring services. The law requires the provision of information.
0	I1	Notice by the individual in charge of the recipient's written plan of service to recipients, their guardians, and parents of minor recipients, of the availability of family planning and health information. [AR 7029 (1)]	N/A	Language from MHC must be contained in policy.
0	I2	Referral assistance to providers of family planning and health information services upon request of the recipient, guardian, or parent of a minor recipient. [AR 7029 (1)]	N/A	Language from MHC must be contained in policy.
0	I3	The notice includes a statement that mental health services are not contingent upon requesting or not requesting family planning or health information services. [AR 7029]	N/A	Language from MHC must be contained in policy.
		Communication and visits	Communication by telephone and communication by mail	
		Policy Name/Number: Policy revision date:		
		The policy requires the following:		
2	J1	Recipients must be offered 2 telephone calls upon admission (by petition and certification), and following submission of paperwork to court, initiating the involuntary admission process. A call must not be limited to less than 5 minutes. Under circumstances in which the individual cannot make a call, or if it is necessary to restrict calls that are at hospital expense, the hospital must place the calls for the individual if so requested. Staff must assist if the recipient is unable to independently complete the call. [MHC 1447 R 4045 (2)]	4.0 II.	Although the policy is correct, remove "by petition and certification" to keep the practice non-discriminatory.
2	J2	Telephones must be reasonably accessible and funds for telephone usage are available in reasonable amounts. [MHC 1726 (2)]	4.0 III. C.	
2	J3	Correspondence can be conveniently and confidentially received and mailed (i.e. postal box or daily pickup and deposit), and writing materials and postage are provided in reasonable amounts. [MHC 1726 (2)]	II. F.	The policy indicates that mail may be restricted from an individual. Amend the policy to indicate when a limitation on mail can be added to the IPOS. Remove witholding as a restriction.
0	J4	Space will be made available for visits. [MHC 1726 (2)]	1.0 Policy	Add visiting to the policy. Use the language of the MHC.
2	J5	Reasonable time and place for the use of telephones and for visits must be established and must be in writing and posted on the unit. [MHC 1726 (3)]	1.0 Policy	
0	J6	The right to communicate by mail or telephone or to receive visitors must not be further limited except as authorized in the recipient's plan of service. [MHC 726 (4)]	.	Telephone limitations are incomplete. Add information about discontinuation when no longer necessary.
2	J7	Limitations on communication do not apply to a recipient and an attorney or court, or any other individual, if the communication involves matters that may be the subject of legal inquiry. [MHC 1726 (5)]	4.0 III. A.	
2	J8	If a recipient can secure the services of a mental health professional, he or she must be allowed to see that person at any reasonable time. [MHC 1715]	4.0 XI.	
		Medication procedures	Psychotropic medication administration	
		Policy Name/Number: Policy revision date:		
		The policy requires the following:		
2	K1	Psychotropic medication (psychotropic drug) is defined in accordance with AR 330.7001 (p).	4	
2	K2	A doctor's order for medication is required. [AR 7158 (1)]	5.0 A.	

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
2	K3	Before initiating a course of psychotropic drug treatment for a recipient, the prescriber, or a licensed health professional acting under the delegated authority of the prescriber must do both of the following: (a) explain the specific risks and most common adverse side effects associated with that drug, and (b) provide the individual with a written summary of those common adverse side effects. (MHC 1719)	5.0 IV. A./V. A.-B.	
2	K4	There must be periodic medication reviews as specified in the plan of service and based on recipient's clinical status. [AR 7158(4)]	5.0 XII.	
2	K5	Medications must be administered by personnel who are qualified and trained. [AR 7158 (5)]	5.0 I.	
2	K6	Procedures on when and how documentation regarding medication administration is to be placed in recipient's clinical record. [MHC 1752, AR 7158 (6)]	5.0 VII. (VI and VII)	
2	K7	Medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the recipient's record. [AR 7158 (7)]	5.0 VII.	
2	K8	Only medications authorized by a physician are to be given at discharge. Enough medication is made available to ensure the recipient has an adequate supply until he or she can become established with another provider. [AR 7158 (9)]	5.0 X.	
2	K9	A procedure to ensure that medication brought by the recipient, and stored by the LPH, must be returned at discharge [MHC 1728 (7)]	5.0 X.	
		Use of psychotropic drugs	Psychotropic medication administration	
		Policy Name/Number: Policy revision date:		
		The policy requires the following:		
2	L1	Psychotropic drugs (medication) must not be administered to an individual who has been hospitalized by medical certification or by petition under chapter 4 or 5 of PA 258 of 1974 on the day preceding and on the day of his or her court hearing unless the individual consents or unless the administration of the psychotropic drugs is necessary to prevent physical injury to the individual or others. [MHC 1718]	5.0 IX.	There is an extra sentence in this section about a recipient awaiting a court hearing having medication ordered by a court. Remove the extraneous sentence.
2	L2	The administration of psychotropic medication to prevent physical harm or injury occurs: ONLY when the actions of a recipient, or other objective criteria, clearly demonstrate to a physician that the recipient poses a risk of harm to himself, herself, or others, and 2) ONLY after signed documentation of the physician is placed in the recipient's clinical record and [AR 7158 (8) (b)]	5.0 VIII.	The sequencing of these sections of the policy is confusing. VIII should be subsequent to IX. Reevaluate the sections identified in the (L) policy review for best arrangement in the policy.
2	L3	Initial administration of psychotropic chemotherapy (medication) under L2 be as short as possible, at the lowest therapeutic dosage possible and be terminated as soon as there is no longer a risk of harm. [AR 7158 (8) (c)]	5.0 XIII.	
2	L4	Initial administration of psychotropic chemotherapy (medication) as identified in L2 must be limited to a maximum of 48 hours unless there is consent. [AR 7158 (8) (c)]	5.0 XIII.	
2	L5	Medication must not be used as punishment or for staff's convenience. [AR 7158 (3)]	5.0 II.	
		Treatment by spiritual means	Treatment by Spiritual Means	
		Policy Name/Number: Policy revision date:		
		The policy requires the following:		
2	M1	"Treatment by spiritual means" is defined as a spiritual discipline or school of thought that a recipient wishes to rely on to aid physical or mental recovery. [AR 7001 (y)]	3.0 I	
2	M2	Access to treatment by spiritual means is upon request by a recipient, guardian, or parent of a minor recipient. [AR7135 (1)]	3.0 III	Remove parent of a minor
2	M3	Requests for printed, recorded, or visual material essential or related to treatment by spiritual means, and to a symbolic object of similar significance must be honored and made available at the recipient's expense. [AR7135 (3)]	3.0 I	
1	M4	There is a procedure for informing a person requesting treatment by spiritual means of a denial of the request and the reason for the denial. [AR 7135 (6) (b)]	4.0 VI	The person who informs the recipient of the denial is not identified. Amend the policy to identify the responsible person.
1	M5	There is a procedure for an administrative review or appeal process when treatment by spiritual means is denied. [AR 7135 (7)]	4.0 VI and 4.0 VII	The person or persons who conducts the administrative review is not identified. Amend the policy to identify the responsible person or persons.

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
2	M6	There is a procedure to ensure recourse to court when there is refusal of medication or other treatment for a minor under the guise of treatment by spiritual means. [AR 7135 (6) (a)]		
2	M7	On site contact with agencies providing treatment by spiritual means is provided in the same manner as contact with private mental health professionals (reasonable times and space). [AR 7135 (2)]	4.0 I	
2	M8	The recipient may refuse medications if: a) spiritual treatment predates current allegation of mental illness or disability, b) no court order empowering the guardian or facility to make decisions regarding medication, c) the recipient is not imminently dangerous to self or others and has not consented to medication. [AR 7135(4) (a) (b)]	4.0 II (A.-C.)	
2	M9	There are legal restrictions for a) mechanical, chemical, or organic compounds that are physically harmful, b) activity prohibited by law, c) activity harmful to self or others, d) activity inconsistent with court ordered custody or placement by person other than recipient. [AR 7135 (a – d)]	4.0 IV (A.-D.)	
		Property and funds	Personal property and funds	
		Policy Name/Number: Policy revision date:		
		The policy requires the following:	.	
2	N1	Identification of items that recipients may not possess (including weapons, sharp objects, explosives, drugs, and alcohol). [MHC 1728 (3)]	.	The policy identifies the ability to keep items when a waiver is signed, but there is no further discussion of the waiver. Add an addendum to the policy to discuss when a waiver might be appropriate.
2	N2	Any exclusions of personal property must be in writing and posted in each unit. [MHC 1728 (3)]	5.0 3.	
2	N3	A receipt for property taken for into possession by the hospital must be given to the recipient and to an individual designated by the recipient. [MHC 1728 (7)]	5.0 7.	
2	N4	A recipient is to be permitted to inspect personal property at reasonable times. [MHC 1728 (2)]	5.0 2.	
2	N5	The plan of service must be utilized to limit property in order to prevent the recipient from physically harming himself, herself, or others, or to prevent theft, loss, or destruction of the property, unless a waiver is signed by the recipient. Limitations of property must be justified and documented in the record of the recipient. [MHC 1728 (4) (a), (5)]	5.0 4.	
2	N6	Conditions under which a search for contraband items may be conducted. [AR 7009 (7)]	5.0 8.	
2	N7	Documentation must be made in the record of the circumstances surrounding searches which include: (i) the reason for initiating the search, (ii) the names of the individuals performing and witnessing the search, (iii) the results of the search, including a description of the property seized. [AR 7009 (7)]	5.0 8.	
2	N8	Any property taken for into possession by the hospital must be given to the recipient at the time of discharge [MHC 1728 (7)]	5.0 7.	
		Right to entertainment material, information, and news	Right to entertainment materials	
		Policy Name/Number: Policy revision date:		
		The policy requires the following:		
2	O1	Recipients must not be prevented from obtaining, reading, viewing, or listening to entertainment, information or news related materials obtained at his/her own expense for reasons of, or similar to, censorship. [AR 7139 (1)]	7	
2	O2	A limitation of access to entertainment materials, information, or news can occur only if such a limitation is specifically approved in the recipient's individualized plan of service. Staff in charge of the plan of service must document each instance when a limitation is imposed in the recipient's record. [AR 7139 (2) (3)]	8	
2	O3	Limitations/restrictions must be removed when no longer clinically justified. [AR 7139 (4)]	8	
2	O4	Minors have the right to access material not prohibited by law unless the legal guardian of a minor objects to this access. [AR 7139 (5)]	N/A	
2	O5	The person in charge of the plan of service must attempt to persuade the parent/guardian of a minor to withdraw their objections to these materials. [AR 7139 (6) (c)]	N/A	

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
0	O6	There is a process for implementing general program restrictions on access to entertainment materials. [AR 7139 (6) (a)]	9	Section (6) is addressing the hospital's ability to have general restrictions, not specific limitations: A provider shall establish written policies and procedures that provide for all of the following: (a) Any general program restrictions on access to material for reading, listening, or viewing. Amend the policy to address this standard.
1	O7	There is a process for determining recipient's interest for provision of a daily newspaper. [AR 7139 (6) (b)]	9	Language in section 9 is confusing. The language in the administrative rule is more clear: (b) Determining a resident's interest in, **and provide for**, a daily newspaper. A dialy newspaper (or some similar on-line service) is NOT at the recipient's expense and is separate from the other sections of this policy. Amend the policy to address this standard.
0	O8	There is a process for recipients to appeal the denial of their right to entertainment, information, news material. [AR 7139 (6) (d)]	.	The policy states that the recipient can appeal but does not state how or to whom. Amend the policy to add the process for appeal.
0	O9	There is a process for imposing specific restrictions for the therapeutic benefit the recipients as a group. [AR 7139 (6) (e)]	5. (b.)	This section of the policy is missing. Amend the policy to address this standard: (6) A provider shall establish written policies and procedures that provide for all of the following: (e) Any specific restrictions on a living unit or for the therapeutic benefit of the residents as a group
11	18	61%		
		Resident labor	Recipient labor	
		Policy Name/Number: Policy revision date:		
		The policy requires the following:		
2	P1	A recipient may perform labor that contributes to the operation and maintenance of the LPH, for which the LPH would otherwise employ someone, only if, 1) the recipient voluntarily agrees to perform the labor, 2) engaging in the labor would not be inconsistent with the IPOS for the recipient, 3) the amount of time or effort necessary to perform the labor would not be excessive, and 4) in no event must discharge or privileges be conditioned upon the performance of labor. [MHC 1736 (1)]	4.0 III (1)	If the hospital does not use recipient labor, the hospital can indicate as a policy statement "it is the policy of Brightwell Behavioral Health services that patients will not perform labor that contributes to the operation or maintenance of the facility. This does not preclude activities of daily living, which are a normal part of the therapeutic milieu." Having policy language for things the hospital does not do is confusing for new staff.
2	P2	A recipient who performs labor that contributes to the operation and maintenance of the LPH, for which the hospital would otherwise employ someone, must be compensated appropriately and in accordance with applicable federal and state labor laws, including minimum wage and minimum wage reduction provisions. [MHC 1736 (2)]	4.0 III (2)	Having a policy for something the hospital does not do is confusing for staff
2	P3	A process for providing compensation when performing labor which benefits another person or the hospital. [MHC 1736 (3)]	4.0 III (5)	
2	P4	Labor of personal housekeeping nature is not eligible for payment. [MHC 1736 (5)]	4.0 II	
2	P5	The policy requires that one-half of any compensation paid to a resident for labor performed shall be exempt from collection for payment of mental health services provided. [MHC 1736(6)]	4.0 VIII	

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
10	10	100%		
		Least restrictive setting / Freedom of movement	Freedom of Movement	
		Policy Name/Number: Policy revision date:		
		The policy requires the following:		
0	Q1	There is a requirement that the recipient receives placement in the least restrictive setting appropriate and available.[MHC 1708 (3)]	1.0	The policy addresses movement & restriction within the unit. It does not address least restrictive setting. That is in the dignity & respect policy. Move the language to the applicable policy. Section 4.0 IV indicates that non-resolution by the treatment team of a freedom of movement issue will be referred to ORR. 4.0 V refers issues to the medical director. These sections should match (medical director)
2	Q2	The freedom of movement of a recipient must not be restricted more than is necessary to provide mental health services to him/her, to prevent injury to him/her or to others, or to prevent substantial property damage. [MHC 1744 (1)]	4.0 (I.)	
2	Q3	Any limitations to the freedom of movement must be justified in the IPOS and be time limited. [MHC 1744 (2)]	4.0 II (A.)	72 hours is implied for review in section 4.0 IV. Amend the policy to clearly indicate that it applies to this section.
2	Q4	Any limitation on freedom of movement is removed when the circumstances that justified its adoption cease to exist. [MHC 1744 (3)]	4.0 II (C.)	
		Use of restraint	Restraint and Seclusion	
		Policy Name/Number: Policy revision date:		
		The policy requires the following:		
2	R1	Restraint is defined, as in [MHC 1700 (i)]		
2	R2	All recipients have the right to be free from physical or mental abuse, and corporal punishment. All recipients have the right to be free from restraint of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint may only be imposed to ensure the immediate physical safety of the recipient, a staff member, or others and must be discontinued at the earliest possible time. [MHC 1740 (2)]	4.0 definitions	
2	R3	The type or technique of restraint used must be the least restrictive intervention that will be effective to protect the recipient, a staff member, or others from harm. [MHC 1740 (2)]	2.0 A/B	
2	R4	The use of restraint must be: (i) In accordance with a written modification to the recipient's plan of care; and (ii) Implemented in accordance with safe and appropriate restraint techniques as determined by hospital policy in accordance with Michigan law, (iii) If a recipient is restrained repeatedly, the recipient's individual plan of services must be reviewed and modified to facilitate the reduction of the use of restraints. [MHC 330.1740 (9)]	5.0	
1	R5	Restraint may be initiated temporarily in an emergency. Immediately after the imposition of the restraint, a physician must be contacted. If, after being contacted, the physician does not order or authorize the restraint within 30 minutes, the restraint must be removed. [MHC 330.1740 (3)]	4.0 definitions	Add 30 minutes to the policy.
2	R6	Orders for the use of restraint must never be written as a standing order or on an as needed basis (PRN). [MHC 1740 (2)]	p 5 E	
1	R7	The attending physician of an adult recipient must be consulted as soon as possible if the attending physician did not order the restraint. The treatment team physician must be the one ordering the restraint if they are available. [MHC 1740]	5.0 A.	Language is LIP & should say physician. Amend the policy to reflect physicain.
1	R8	A recipient may be restrained pursuant to an order by a physician made after personal examination. An order for restraint must continue only for that period of time specified in the order or for up to the following limits, whichever is less: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; (C) 1 hour for children under 9 years of age. [MHC 1740]	Restraints/seclusion management requirements	Amend to 4 hours. Should match p5 D. Amend language to separate timeframes for seclusion/restraint. The timeframe noted was for seclusion. Restraint is 2 hours
2	R9	Before writing a new order for the use of restraint for the management of violent or self-destructive behavior, a physician must see and assess the recipient. [MHC 1740 (5); AR 7243 (6) (b)]	5.0 E.	

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
2	R10	The required examination by a physician must be conducted not more than 30 minutes before the expiration of the expiring order for restraint. [MHC 1740 (5); AR 7243 (6) (b)]	5.0 F.	
2	R11	Restraint must be discontinued at the earliest possible time, regardless of the length of time identified in the order. [MHC 1740 (7); 42 CFR 482.13 (e) (9); 42 CFR 483.358 (e) (2)]	Restraints/seclusion management requirements	
2	R12	A restrained recipient must: (i) Continue to receive food, (ii) Be given hourly access to toilet facilities, (iii) Be bathed as often as needed, but at least every 24 hours, (iv) Be clothed or otherwise covered, (v) Be given the opportunity to sit or lie down [MHC 330.1740 (6), AR 330.7243]	5.0 B.	
2	R13	Restraints must be removed every 2 hours for not less than 15 minutes, unless medically contraindicated. [MHC 330.1740 (7)]	Restraints/seclusion management requirements M	
2	R14	An assessment of the circulation status of restrained limbs is conducted and documented at 15 minute intervals or more often if medically indicated. [AR 330.7243 (9)]	5.0 D. p6 N	
2	R15	A recipient must not be restrained in a prone position unless medically contraindicated. [AR 7243 (11) (ii)]	Restraints/seclusion management requirements	
2	R16	The condition of the recipient who is restrained must be monitored by a physician or trained staff that have completed the training criteria specified in the paragraph below of this section at an interval determined by hospital policy. [MHC 1742 (9]	5.0 F.	
2	R17	When restraint is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the recipient, a staff member, or others, the recipient must be seen face-to-face within 1 hour after the initiation of the intervention to evaluate: (A) The recipient's immediate situation; (B) The recipient's reaction to the intervention; (C) The recipient's medical and behavioral condition; and (D) The need to continue or terminate the restraint. [MHC 1740 (4)]	Restraints/seclusion management requirements	
2	R18	When restraint is used, there must be documentation in the recipient's medical record of the following: (i) The 1-hour face-to-face medical and behavioral evaluation by a physician if restraint is used to manage violent or self-destructive behavior; (ii) A description of the recipient's behavior and the intervention used; (iii) Alternatives or other less restrictive interventions attempted (as applicable); (iv) The recipient's condition or symptom(s) that warranted the use of the restraint; and (v) The recipient's response to the intervention(s) used, including the rationale for continued use of the intervention. [AR330.7243 (3)]	5.0 G.	
2	R19	A separate permanent record of each instance of restraint must be kept and must comply with applicable standards. [AR330.7243 (1)]	Restraints/seclusion management requirements	
2	R21	The hospital must report all deaths to the department utilizing "Psychiatric Notification of Death Report (MDHHS - 5949)". This form must be completed and submitted to MDHHS-ORR within 72 hours from when the hospital became aware of the recipient's death on the psychiatric unit including deaths that occurred within 48 hours after discharge. [MHC 330.1720]	5.0 K.	
		Use of seclusion	Restraint and Seclusion	
		Policy Name/Number: Policy revision date:		
		The policy requires the following:		
	S1	Seclusion is defined using the most protective definition. [MHC 1700 (j)	4.0 definitions	Definitions include self harm. Remove self-harm language.
2	S2	Time out is defined.-[AR 7001(x)]	4.0 definitions	
	S3	Therapeutic de-escalation is defined. [AR 7001 (w)]	4.0 definitions	
2	S4	All recipients have the right to be free from physical or mental abuse, and corporal punishment. All recipients have the right to be free from seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Seclusion may only be imposed to ensure the immediate physical safety of a staff member, or others and must be discontinued at the earliest possible time. [MHC 1742 (3)]	Policy 2.0 A-B	
1	S5	The use of seclusion must be:(i) In accordance with a written modification to the recipient's plan of care; and (ii) Implemented in accordance with safe and appropriate seclusion techniques as determined by hospital policy in accordance with Michigan law, (iii) If a recipient is secluded repeatedly, the recipient's individual plan of services must be reviewed and modified to facilitate the reduction of the use of seclusion [MHC330.1742 (9)]	5.0	Amend policy to separate seclusion and restraint. Putting them together is confusing and incorrect.

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
2	S6	The use of seclusion must be in accordance with the order of a physician. Seclusion may be initiated temporarily in an emergency. Immediately after the recipient is placed in seclusion, a physician must be contacted. If, after being contacted, the physician does not order or authorize the seclusion within 30 minutes, the recipient must be removed from seclusion. [MHC 330.1742 (4)]	4.0 definitions	
2	S7	Orders for the use of seclusion must never be written as a standing order or on an as needed basis (PRN). [MHC 1742 (3)]	Restraints/seclusion order management requirements	
2	S8	The attending physician must be consulted as soon as possible if the attending physician did not order the seclusion. [MHC 1742]	5.0 A.	
2	S9	The condition of the recipient who is secluded must be monitored by a staff who has completed the training criteria specified in paragraph S20/21 of this section at an interval determined by hospital policy. [MHC 1740 (8)]	Restraints/seclusion order management requirements	
2	S10	When seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of a staff member, or others, and the physician was not present at the initiation of the seclusion, the recipient must be seen face-to-face within 1 hour after the initiation of the intervention by a physician. Additionally, the recipient must be seen at 1 hour to evaluate; (A) The recipient's immediate situation; (B) The recipient's reaction to the intervention; (C) The recipient's medical and behavioral condition; and (D) The need to continue or terminate the seclusion. [MHC 1742 (5)]	5.0 E.	
2	S11	A recipient may be secluded pursuant to an order by a physician made after personal examination. An order for seclusion must continue only for that period of time specified in the order or for up to the following limits, whichever is less: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1 hour for children under 9 years of age; and before writing a new order for the use of seclusion for the management of violent behavior, a physician must see and assess the recipient. The required examination by a physician must be conducted not more than 30 minutes before the expiration of the expiring order for seclusion. [MHC 1742; AR 330.7243 (6b)]	Restraints/seclusion order management requirements	
2	S12	Seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. [MHC 1742 (8)]	5.0 B.	
2	S13	A secluded recipient must (i) Continue to receive food, (ii) Be given hourly access to toilet facilities, (iii) Be bathed as often as needed, but at least every 24 hours, (iv) Be clothed or otherwise covered, (v) Be given the opportunity to sit or lie down [MHC330.1742 (6), [AR 330.7243]	p6 K	
2	S14	When seclusion is used, there must be documentation in the recipient's medical record of the following: (i) The 1-hour face-to-face medical and behavioral evaluation if seclusion is used to manage violent behavior; (ii) A description of the recipient's behavior and the intervention used; (iii) Alternatives or other less restrictive interventions attempted (as applicable); (iv) The recipient's condition or symptom(s) that warranted the use of the seclusion; and (v) The recipient's response to the intervention(s) used, including the rationale for continued use of the intervention. [AR330.7243 (3)]	5.0 B. h.	
2	S15	The LPH must ensure that documentation of staff monitoring, and observation is entered into the medical record of the recipient. And a separate permanent record of each instance of seclusion must be kept and must comply with applicable standards. [AR330.7243 (1) (3)]	p8 F	
0	S16	The hospital must report all deaths to the department utilizing "Psychiatric Notification of Death Report (MDHHS - 5949)". This form must be completed and submitted to MDHHS-ORR within 72 hours from when the hospital became aware of the recipient's death on the psychiatric unit including deaths that occurred within 48 hours after discharge. [MHC 330.1720]	5.0 C.	Add language to the policy or develop independent policy re: death reporting
		Comprehensive Examinations	Comprehensive examination of recipient	
		Policy Name/Number: Policy revision date:		
		The policy requires the following:		
2	T1	Within 24 hours of admission, each recipient must receive a comprehensive physical and mental examination. [MHC 1710}	1.0 Policy	
		Qualifications and Training for Recipient Rights Staff		
		Policy Name/Number: Policy revision date:	Office of recipient rights/ patient rights advocate	
		The policy requires the following:		
2	U1	Staff of the Office of Recipient Rights to receive annual training in recipient rights protection. [MHC 755 (2)(e)]	5.0 D.	

Score		HOSPITAL POLICY REVIEW	LOCATION	COMMENTS/REQUIRED ACTION
2	U2	The director of the Office of Recipient Rights must have the education, training, and experience to fulfill the responsibilities of the office. [MHC 755 (4)]	5.0 A./5.0 E.	
2	U3	The education, training, and experience required is identified either in policy or position description. [MHC 755(4)]	5.0 C.-H.	This is not in the policy. The job description has a minimum requirement unrelated to the responsibilities in recipient rights. Amend the policy or job description to reflect the requirements of the job.
2	U4	All rights officers, advisors and alternates attend MDHHS-ORR ORR Basic Skills Training Programs within 3 months of hire. Rights officers, advisors and alternates are encouraged to attend Building Blocks and DERT (Developing Effective Rights Training) [LPH/CMHSP Contract referencing the MDHHS/CMH Master Contract]	5.0 C.	
2	U5	Rights officers, advisors and alternates will attain 36 hours of continuing education every 3 years, with 12 credits in "operations" or "legal" (or comply with the continuing education requirements identified in the CMH contract{mirroring the MDHHS-CMHSP contract attachment} . [LPH/CMHSP Contract referencing the MDHHS/CMH Master Contract]	5.0 H.	
2	U6	The policy requires that a minimum of 12 of the required 36 hours were approved as either Category I or II. MHC 1755[2][e], CMHSP 6.3.2.3 (A)	5.0 H.	
2	U7	The policy requires that rights staff acquire at least 3 continuing education credits each calendar year MHC 1755[2][e], CMHSP 6.3.2.3 (A)	5.0 G.	