STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

January 13, 2022

Mr. Jafar Nezeer
Director of Behavioral Health
Garden City Hospital
6255 Inkster Road
Garden City, MI 48135

Dear Ms. Nazeer,

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 Sue Witting and Beverly Sobolewski and myself from December 14-December 15, 2021. 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 **219 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 **March 1, 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

cc:
Elizabeth Hertel, Director, MDHHS
Larry Horvath, Director, Community Health Systems, LARA
Heather Hosey, Director, Health Facility Licensing and Support Division, BCHS, LARA
Matt Jordan, Manager, State Licensing Section, BCHS, LARA
Torrie Richardson, Rights Advisor, Garden City Hospital

LPH: **Garden City Hospital**

ASSESSMENT DATES: **12/14/2021, 12/15/2021**

REVIEWERS: **Beverly Sobolewski, Sue Witting, Andrew Silver**

SECTION	MAXIMUM POSSIBLE SCORE	WEIGHT	MAXIMUM POSSIBLE SCORE (WEIGHTED)	YOUR BASE SCORE	YOUR WEIGHTED SCORE
1. LPH RESPONSIBILITIES	26	3	78	22	66
2. RIGHTS OFFICE OPERATIONS	14	3	42	10	30
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	12	12
7. COMPLAINT RESOLUTION - PROCESS	18	3	54	7	21
8. COMPLAINT RESOLUTION – CONTENT	34	3	102	9	27
9. COMPLAINT RESOLUTION - TIMEFRAMES	10	3	30	8	24
10. APPEALS	14	1	14	14	14
TOTAL SCORE	**148**		**374**	**94**	**219**

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 Date:

Andrew Silver

Report Reviewed by: Andrew Silver, Director, Education, Training and Compliance, MDHHS-(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	Organizational chart had no listing for ORR. Corrected while on site	
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	CNO act as the hospital director in his absence	
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 does not yet exist and no review of the funding process has been completed.	Committee to review the funding of ORR. Provide evidence of funding review to Beverly Sobolewski as soon as completed.
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	2		
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	There is no evidence of a process for investigating retaliation and harassment. GCH agreed to establish an method of investigating retaliation in circumstances other than toward a recipient. There have been no allegations of retaliation.	Recommend that GCH to establish a process to investigate retaliation and harassment in circumstances other than toward a recipient (i.e. staff-to-staff) Submit evidence that Human Resources has included retaliation and harassment in the progressive disciplinary structure.
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		Recommend that GCH ORR return to basic in person to reaffirm skills (possibly when new staff is trained)
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 is no current coverage in the absence of the rights advisor	Establish coverage for rights office in the absence of your rights advisor.
MHC 1755 (4)	1.4.3	The rights director has no clinical service responsibilities.	2	2		
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	2	No BTPs have yet been required. GCH states that it intends to utilize the CMH. A contract with the local CMH was not finalized at the time of the Assessment.	Establish committee or affirm with DWIHN use of BTPRC.
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	2	The contract reviewed had no language for rights training or protection. This was corrected via addendum to the contract while on site and a copy of the amendment signed by the contratee was presented to the assessors (copy in file)	

CITATION	STANDARD	SECTION 1 - LPH RESPONSIBILITIES	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
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	Documentation of explanation of rights to new admissions was inconsistent. Staff did indicate that rights are explained verbally and rights books are given to new admissions.	Assure the verbal explanation as well as a rights booklet being given per 1416 is documented in the recipient's record. Assure that explanations given to recipients who are potentially involuntary are also documented.

Section 1 Total	26	22

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		
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	1	The log did not contain required elements	Transcribe cases onto recipient rights log for accurate capture of required rights information.
MHC 1755[5][d]	2.4.2	ORR has established a mechanism for secure storage of all investigative documents and evidence.	2	2		
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	0	Grievance process was utilized when an investigation was required by law.	Ensure 1778 is followed for all recipient rights investigations.
MHC 1755 (5)(e)	2.7.1	The units are visited with the frequency necessary for the protection of rights.	2	1	ORR office on unit but no documentation to show monitoring of the unit.	Complete a formal site visit using the monitoring form at least once a year.

Section 2 Total	14	10

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		

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		

CITATION	STANDARD	SECTION 4 - EDUCATION AND TRAINING	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
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	0	96 % noncompliant with providing recipient rights training within 30 days of hire.	Ensure training within 30 days of hire. Recommend improvingMIPractices followed by brief face to face training with rights advisor.
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	1	Committee not yet established with Mental Health members	Submit evidence (meeting minutes) of training on policies to Beverly Sobolewski for 1 year
		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	Regarding the complaint process, the policies conflated recipient rights and complaint grievance process.	Develop policies for recipient rights processes as established in Chapter 7a of the MMHC. Establish policies to protect recipients from, and prevent repetition of, violations of rights as outlined in Chapter 7 of the MMHC. Separate policies for the psychiatric program from the general hospital policies.
MHC 1752[1]	5.1.2	Policies and procedures included, at a minimum, all those specifically delineated in MHC 330.1752 (1).	2	2		
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	Several sections from policies are missing language from the law. Other policies were confusing and combined general hospital and psychiatric program standards. See attached policy review.	Ensure language in polices comes from the MMHC not CMS or other accreditation agencies.
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	The person centered planning policy did not include clear language on limitations, exclusion of persons not wanted and referred to treatment planning by three different terms making this policy confusing and hard to follow.	Include language from MMHC and Administrative Rules. Choose a consistent term to refer to the Individual Plan of Service (IPOS) and use the same term throughout
		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	0	An advisory committee has not been established. However while onsite hospital director stated that they are going to integrate with the general hospitals Patient & Family Advisory Council and will add the required members as defend in 1758 of the MMHC.	Establish 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	2	This standard could not be assessed, as the RRAC does not exist	Submit evidence of meetings to Beverly Sobolewski after MH members are incorporated
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	This standard could not be assessed, as the RRAC does not exist	Submit list of names to Beverly Sobolewski after MH members are incorporated
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	This standard could not be assessed, as the RRAC does not exist	Submit list of categories of members to Beverly Sobolewski after MH members are incorporated
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	2	This standard could not be assessed, as the RRAC does not exist	Submit evidence of meeting minutes reflective of 6.1.5 to Beverly Sobolewski after MH members are incorporated
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	2	This standard could not be assessed, as the RRAC does not exist	Submit evidence of comments re: the annual report to Beverly Sobolewski after MH members are incorporated
MHC 1758	6.1.10	Minutes of the RRAC meetings are maintained.	2	2	This standard could not be assessed, as the RRAC does not exist	Submit evidence of meeting minutes to Beverly Sobolewski after MH members are incorporated
		Section 6 Total	14	12		

CITATION	STANDARD	SECTION 7 – COMPLAINT RESOLUTION - PROCESS	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
Case Reviews:		1 Investigations 0 Interventions 2 No Right Involved/Out of Jurisdiction				
MHC 1776[3]	7.1.1	Each rights complaint was recorded upon receipt by the rights office.	2	2	ORR utilized the grievance log instead of using a separate RR complaint log.	Use a recipient rights complaint log separate from the grievance log.
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	No evidence that an acknowledgment letter or copy of complaint sent to the complaint as required by the MMHC.	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 complaint to Beverly Sobolewski.

CITATION	STANDARD	SECTION 7 - COMPLAINT RESOLUTION PROCESS	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
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	1	Although the response was timely the process used was incorrect.	Ensure that all allegations of abuse, neglect, serious injury or death with apparent of suspected rights violation are investigated.
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	No other violations logged.	
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	The complaint log did not contain required dates for investigation activities.	Use a recipient rights complaint log.
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	0	A summary report was found in case file but no report of investigative findings.	Complete investigative reports as outlined in 1778 of the MMHC. Send the next 3 investigative reports to Beverly Sobolewski.
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	0	The Summary report was completed by ORR. No signature was found on the report.	Director to complete summary reports and ensure provisioned to all persons with appeal rights. Send the next 3 summary reports to Beverly Sobolewski.
MHC 1782[2]	7.7.1	Information in the summary report did not violate the rights of any employee.	2	2		Recommend establishing a process to inform persons with disciplinary action that information about them is being revealed.
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	0	No evidence of the required appeal notice found in the file reviewed.	Ensure that all summary reports have appeal notices attached.
		Section 7 Total	18	7		

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	ORR failed to correctly categorize complaints that were outside the juridiction of the Rights Office	ORR will submit log for review weekly for 6 weeks.
	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		
	8.1.3	The results of the intervention indicated whether a rights violation was substantiated.	2	2		
	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		

CITATION	STANDARD	SECTION 8 – COMPLAINT RESOLUTION - CONTENT	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
MHC 1778[5][a]	8.3.1	The written investigative report included a statement of alleged rights violation.	2	0	The rights advisor completed an investigation but no report was written. As a summary was completed, the investigative report elements were noted as not present in the IR. The contents were evaluated based on the 8.3 standards. The original allegation was not identified	Complete the investigative report for this case and send to Beverly Sobolewski within 10 days of receiving this report
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	No report was written for this investigation. Citations, as identified in the summary, were incomplete	Send reports as outlined in 7.5.1
MHC 1778[5][b]	8.3.3	The written investigative report included a statement of the issues involved.	2	0	Due to the citations, the issue questions were incorrect	Send reports as outlined in 7.5.1
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	The rights advisor completed an investigation but no report was written.	Send reports as outlined in 7.5.1
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	No report was present for this investigation. No analysis was presented.	Send reports as outlined in 7.5.1
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	0	No report was present for this investigation. Recommendions, as identified in the summary, were incomplete	Send reports as outlined in 7.5.1
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	0	Summary report does not indicate action taken	
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	0	There is no evidence of actual action taken noted in the summary	Complete the investigative report for this case and send as outlined in 1778 of the MMHC. Send the next 3 investigative reports to Beverly Sobolewski.
MHC 1780(2)	8.4.3	The remedial/disciplinary action was documented and made part of the rights case file.	2	0	There is no documentation of action in the file.	
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	0	The original allegation is not identified, the citations are incomplete, the report does not provide a summary of the findings.	Send reports as outlined in 7.6.1
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	0	No completed action was identified	Send reports as outlined in 7.6.1
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	0	There is no evidence that the summary was sent to the appropriate parties and no notice of right to appeal was sent	Send reports as outlined in 7.6.1
		Section 8 Total	34	9		

CITATION	STANDARD	SECTION 1 - LPH RESPONSIBILITIES	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION

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		
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	No interventions to review	
MHC 1778 (4)	9.1.3	For each investigation, status reports were issued every 30 days, as required.	2	0	No evidence of status letter found in file reviewed.	Ensure that required status reports are completed as outlined in 330.1778 of the Mental Health Code.
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	No past cases to review	Recommend current open case is closed within 90 days of receipt.
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	No past cases to review	
		Section 9 Total	10	8		

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	No contract at this time	
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	Hospital Director has completed a request to utilize MDHHS-ORR Appeals Committee. The request was submitted to the Board of Directors	Hospital Director to forward copy of signed agreement to Beverly Sobolewski as soon as completed
MHC 1774 (3)	10.1.3	Notices of appeal rights refer recipients to appropriate appeals committee.	2	2	No closed cases	
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	2		

CITATION	STANDARD	SECTION 10 – APPEALS	MAX SCORE	SCORE	FINDINGS	REQUIRED ACTION
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	14		

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restrictions.		
	Complaint and appeal process		
	Policy Name/Number: Policy revision date:	GCH Patients Rights Policy	
	The policy requires the following:		
A1	A process to assure that all recipients receive a summary of rights.	Page 5 of Patients Rights Policy	Incorrect verbiage
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	Page 3 of Informed Consent Policy	
A3	The Rights Office assures that recipients, parents of minors, guardians and others had ready access to complaint forms. [MHC 1776 (1), (5)]	Page 5 patient Rights policy	ok
A4	Each rights complaint is recorded upon receipt by the rights office. [MHC 1776 (3)]	Pages 1&7 of Patient Complaints Policy	What does page 7 mean?
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)]	Page 4 of Patient complaints policy	ok
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)]	Page 5 of Patient Complaints Policy	ok
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)]	Page 5 of Patient Complaints Policy	ok
A8	The rights office to assist the recipient or other individual with the complaint process, as necessary. [MHC 776 (5)]	Page 4 of Patient complaints policy	ok
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)]	Page 5 of the patient Complaints policy	ok
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)]	Page 5 of the patient Complaints policy	ok
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)]	Page 8 of the patient Complaints Policy	correct this language (not "another CMH")
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)]	Page 5 of the patient Complaints policy	Partial language is OK . No inclusion of reporting deaths within 48 hours of discharge
A14	The rights office must initiate investigation of apparent or suspected rights violations in a timely and efficient manner. [MHC 1778 (1)]	Page 5 of the patient Complaints policy	ok
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)]	Page 6 of the patient Complaints Policy	ok
A16	Investigations must be completed within 90 calendar days, unless awaiting action by external agencies. (CPS, law enforcement, etc.) [MHC 1778 (1)]	Page 7 of the Patient Complaints Policy	ok

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restrictions.		
A16	Investigation activities for each rights complaint will be accurately recorded by the office. [MHC 1778(2)]	Page 7 of the Patient Complaints Policy	ok
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	Page 9 of the Patient Complaints Policy	There are no statements about investigating
A18	Investigation activities for each rights complaint must be accurately recorded by the office. [MHC 1778 2)]	Page 7 of the Patient Complaints Policy	ok
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)]	Page 7 of the Patient Complaints Policy	ok
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)]	Page 8 of the patient Complaints Policy	ok
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)]	Page 8 of the patient Complaints Policy	ok
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)]	Page 8 of the patient Complaints Policy	ok
A23	Remedial action taken on substantiated violations is documented and made part of the record maintained by the rights office. [MHC 1780 (2)]	Page 9 of the Patient Complaints Policy	ok
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)]	Page 10 of the Patient Complaints Policy	ok
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)]	Page 9 of the Patient Complaints Policy	Does not state, "appropriate committee will be included"
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)]	Page 9 of the Patient Complaints Policy	g
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)]	Page 9 of the Patient Complaints Policy	I
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)]	Page 9 of the Patient Complaints Policy	i/j - choose (k?)
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.]	Page 10 of the Patient Complaints Policy	not in policy
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]	Page 10 of the Patient Complaints Policy	not in policy

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restriction**s.**		
A31	Appeals may be filed no later than 45 days after receipt of the summary report. [MHC 1784 (1)]	Page 11 of the patient Complaint policy	Complaint and appeal process
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)]		not outlined in policy
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)]	Page 10 of the Patient Complaints Policy	not in policy
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)]	Page11 of the Patient Complaints Policy	not in policy
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)]	Page 10 of the Patient Complaints Policy	appeals are not referred by CEO - fix language
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)]	Page 10 of the Patient Complaints Policy	is there agreement?
	A36i through xi applies ONLY to LPHs who have their own appeals committee & don't use the MDHHS-ORR appeals committee		
	Hospitals who use the state appeals committee should **SKIP** rows A36i-36xi		
A36i	The governing body of a licensed hospital will (a) appoint an appeals committee consisting of 7 members, none of whom will be employed by the department or a community mental health services program, 2 of whom will be primary consumers and 2 of whom will be community members. [MHC 1774 (4) (a)]	Page 7 of the Patient Complaints policy	if agreement not in policy - if not fix language
A36ii	The appeals committee may request consultation and technical assistance from MDHHS-ORR. [MHC 1774 (5)]		not in policy
A36iii	A member of the appeals committee who has a personal or professional relationship with an individual involved in an appeal will abstain from participating in that appeal as a member of the committee. [MHC 1774 (6)]	Patient Concerns and Grievances Policy	not in policy
A36iv	Within 5 business days after receipt of a written appeal, at least 2 members of the Appeals Committee will review the appeal to determine whether it meets criteria with respect to grounds, timeframe, and appellant. [MHC 1784 (4)]	Patient Concerns and Grievances Policy	not in policy
A36v	The results of the review will be provided, in writing, to the appellant, within 7 business days. [MHC 1784 (4)] [[2018 technical requirement; recipient rights appeal process]	Patient Concerns and Grievances Policy	not in policy
A36vi	If the appeal is accepted, a copy of the appeal will be provided to the hospital within 5 business days. [MHC 1784 (4)]		not in policy
A36vii	Within 30 days after the written appeal is received, the Appeals Committee will meet and review the facts as stated in all complaint investigation documents. [MHC 1784 (5)]	Patient Concerns and Grievances Policy	not in policy

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restriction**s.**		
A36viii	The Appeals Committee will take one of the following actions in deciding upon an appeal: a) uphold the findings of the rights office and the action taken or plan of action proposed, b) return the investigation to the rights office with request that it be reopened or reinvestigated, c) uphold the investigative findings of the rights office but recommended that hospital take additional or different action to remedy the violation, or d) recommended that the Board of the hospital request an external investigation by the MDHHS Office of Recipient Rights. [MHC 1784 (5) (a-d)]	Patient Concerns and Grievances Policy	not in policy
A36ix	The Appeals Committee will document its decision and justification for the decision in writing. [MHC 1784(6), [2018 technical requirement; recipient rights appeal process]	Patient Concerns and Grievances Policy	not in policy
A36x	Within 10 days after reaching its decision, the Appeals Committee will provide copies of the decision to the appellant, recipient if different than appellant, (parent of a minor recipient), recipient's guardian if one has been appointed, the hospital, and the rights office. [MHC 1784 (6)]	Patient Concerns and Grievances Policy	not in policy
A36xi	If appropriate, the written decision of the Appeals Committee will include a statement of appellant's right to appeal to Level 2, the time frame for appeal (45 days from receipt of decision) and the ground (reason) for appeal (investigative findings of the rights office are inconsistent with facts, or with law, rules, polices or guidelines.). [MHC 1784 (6) (1786)]	Patient Concerns and Grievances Policy	not in policy
A37	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. [2019 contract attachment**/technical requirement, APL 133; recipient rights appeal process]	Patient Concerns and Grievances Policy	not in policy
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]	Patient Concerns and Grievances Policy	not in policy
A39	If a request for additional or different action is sent to the Director, a response will be sent within30 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. [MHC 330.1784(5)(c), 2019 contract attachment/technical requirement, APL 133; recipient rights appeal process]	Patient Concerns and Grievances Policy	not in policy
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]	Patient Concerns and Grievances Policy	not in policy
	Consent to treatment and services		
	Policy Name/Number: Policy revision date:	**GCH Informed Consent policy**	

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restrictions.		
	The policy requires the following:	Page 1 of informed consent policy	
B1	Consent is defined in accordance with the definition in the Mental Health Code 330.1100a (19).	Page 1 of informed consent policy	p2 #5
B2	Informed consent is defined in accordance with the definition in the Administrative Rules 330.7003 (1) (a-d)	Page 1 of informed consent policy	missing statement & language from AR7003 - definition of comprehension is incorrect
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)]	Page 2 of informed consent policy	ok
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.	Page 2 of informed consent policy	not in policy
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)]	Page 1 of informed consent policy	ok
B6	Information is presented in a manner the recipient understands and a mechanism for evaluating comprehension is utilized. [AR 7003(1)(c) (2) (4)]	page 3 of informed consent policy	only states, "read" or "read to" - use code language
B7	The recipient has free power of choice without force, fraud, deceit, duress, constraint, coercion, etc. [AR 7003 (1) (d)]	Page 2 of informed consent policy	ok
B8	The recipient/guardian is informed that if they withdraw consent this can be done without prejudice toward the recipient. [AR 7003 (1) (d)]	Page 2 of informed consent policy	ok
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)]	page 3 of informed consent policy	ok
	Abuse and neglect, including detailed categories of type and severity		
	Policy Name/Number: Policy revision date:	**GCH -Identifying Abuse and Neglect Policy**	
	The policy requires the following:		
C1	Abuse is defined in accordance with the definitions in AR 7001 (a-c), AR 7001 (z). [AR7035 (2) (a).	Page 2 of Abuse and Neglect Policy	remove "or another patient"
C2	Neglect is defined in accordance with the definitions in AR 7001 (i-k). [AR7035 (2) (a).	Page 5 of Abuse and Neglect policy	ok
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]	Pages 8-13 of Abuse and Neglect Policy	4Ab excludes ORR - fix language
C4	Investigations of abuse/neglect allegations are conducted by the Rights Office. [MHC 1778 (1)]	Page 10 of the Abuse and neglect Policy	remove p9, p10 incorrect
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)]	Pages 10-12 of Abuse and Neglect Policy	not in policy

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restrictions.		
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)]	Page 10 of the Abuse and neglect Policy	not in policy
C7	Reporting is required of criminal abuse including vulnerable adult abuse and child abuse to local law enforcement. [MHC 1723]	Page 10 of the Abuse and neglect Policy	definition but no process - fix language
C8	There is delineation as to who will prepare written reports to law enforcement agencies regarding criminal abuse. [MHC 1723 (2)]	Page 10 of the Abuse and neglect Policy	policy gives ORR the responsibility - would only cover ORR working hours (delay) need to give to staff
C9	The policy defines degrade and threaten in a clear manner (not mandatory)	Abuse and Neglect Policy	not in policy - consider additional language
	Right to be treated with dignity and respect		
	Policy Name/Number: Policy revision date:	**GCH Dignity and Respect Policy**	
	The policy requires the following:		
D1	The LPH protects and promotes the dignity and respect to which a recipient of services is entitled. [MHC 1704 (3), 1708 (4)]	Page 1 of Dignity and Respect Policy	p1 Purpose
D2	There are definitions of dignity and respect. [MHC 1704 (3)]	Page 1 of Dignity and Respect Policy	p1 Definitions
D3	Family members are treated with dignity and respect. [MHC 1711]	Page 1 of Dignity and Respect Policy	p2 C, D
D4	Family members are given an opportunity to provide information to the treating professionals. [MHC 1711]	Page 2 of Dignity and Respect Policy	p2 D 1 - needs a how for staff
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]	Page 2 of Dignity and Respect Policy	p2 D 2 - needs a how for staff
	Fingerprinting, photographing, audiotaping, and use of 1-way glass		
	Policy Name/Number: Policy revision date:	**GCH Finger Printing, Photographs policy**	
	The policy requires the following:		
E1	Identification of the circumstances under which audiotapes, or photos may be taken, and 1-way glass used. [MHC 1724 (7) (a-c)]	GCH Finger Printing, Photographs policy	indicates no use ever - use code language
E2	Identification of the parameters for use of fingerprints, photos, or audiotapes for the purpose of recipient identification. [MHC 1724 (4)]	GCH Finger Printing, Photographs policy	indicates no use ever - use code language
E3	Prior written consent to any of the above (E2). [MHC 1724 (2)] [AR 7003 (1) (c)]	GCH Finger Printing, Photographs policy	not in policy - insert code language
E4	The procedures for withdrawing consent. [AR 7003 (1) (d)]	GCH Finger Printing, Photographs policy	not in policy - insert code language
E5	The ability of recipients to object when photos are for personal use or social purposes. [MHC 1724 (6)]	GCH Finger Printing, Photographs policy	not in policy - insert code language
E6	A method of safekeeping of fingerprints, photos, and audiotapes is identified. [MHC 1724 (4)]	GCH Finger Printing, Photographs policy	not in policy - insert code language
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)]	GCH Finger Printing, Photographs policy	not in policy - insert code language
E8	The need for audio taping, photographing/fingerprinting or use of 1-way glass is reviewed periodically. [MHC 1724 (5)]	GCH Finger Printing, Photographs policy	not in policy - insert code language

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restrictions.		
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)]	GCH Finger Printing, Photographs policy	not in policy - insert code language
E10	Identification of the locations where the surveillance images will be recorded and saved. [MHC 1724 (9) (a)]	GCH Finger Printing, Photographs policy	not in policy - insert code language
E11	How recipients and visitors will be advised of the video surveillance. [MHC 1724 (9) (b)]	GCH Finger Printing, Photographs policy	not in policy - insert code language
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)]	GCH Finger Printing, Photographs policy	not in policy - insert code language
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)]	GCH Finger Printing, Photographs policy	not in policy - insert code language
E14	A process to retrieve a distributed video when the purpose for which it was distributed no longer exists. [MHC 1724 (9) (e)]	GCH Finger Printing, Photographs policy	not in policy - insert code language
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)]	GCH Finger Printing, Photographs policy	p1
E16	Prohibition on maintaining a recorded video surveillance image as part of a recipient's clinical record. [MHC 1724 (9) (g)]	GCH Finger Printing, Photographs policy	not in policy - insert code language
	Confidentiality and disclosure		
	Policy Name/Number: Policy revision date:	GCH Confidentiality and use of PHI	
	The policy requires the following:	Confidential and use of Disclosure of PHI policy	
F1	All information in the record and that obtained in the course of providing services is confidential. [MHC 1748 (1)]	Confidential and use of Disclosure of PHI policy	This is not in the policy - insert code language
F2	A summary of section 1748 of the Mental Health Code is made part of each recipient file. [AR 7051 (1)]	Confidential and use of Disclosure of PHI policy	This is not in the policy - insert code language
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)]	Confidential and use of Disclosure of PHI policy	P31/32 - contradicted by c on p 32

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restriction**s.**		
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)]	Confidential and use of Disclosure of PHI policy	p 32 iv, does not indicate who can make the request and the criteria named is not from the code.
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)]	Confidential and use of Disclosure of PHI policy	GCH policy changes the intent of p33 vi. Remove whether - replace with what
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)]	Confidential and use of Disclosure of PHI policy	p33 - is there a time records would be off site? If no, remove from policy
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)]	Confidential and use of Disclosure of PHI policy	not in policy - insert code language
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]	Confidential and use of Disclosure of PHI policy	not in policy - insert code language
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)]	Confidential and use of Disclosure of PHI policy	not in policy - insert code language
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)]	Confidential and use of Disclosure of PHI policy	The policy needs to clearly state the mandatory disclosures

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restrictions.		
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)]	Confidential and use of Disclosure of PHI policy	p 24 several parts of this section are missing from the policy. Insert the full code language. If inserting the name, use Disability Rights of Michigan
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)]	Confidential and use of Disclosure of PHI policy	not in policy - insert code language
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)]	Confidential and use of Disclosure of PHI policy	NA
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)]	Confidential and use of Disclosure of PHI policy	not in policy - insert code language
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)]	Confidential and use of Disclosure of PHI policy	not in policy - insert code language
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)]	Confidential and use of Disclosure of PHI policy	not in policy - insert code language
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	Confidential and use of Disclosure of PHI policy	p 25 c has added verbiage - remove excess language
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)]	Confidential and use of Disclosure of PHI policy	no clear language in policy - insert code language

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restrictions.		
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])	Confidential and use of Disclosure of PHI policy	not in policy - insert code language
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)]	Confidential and use of Disclosure of PHI policy	p20 ok
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)]	Confidential and use of Disclosure of PHI policy	p 25 b ¶ 2
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)]	Confidential and use of Disclosure of PHI policy	not in policy - insert code language
	Change in type of treatment / services suited to condition		
	Policy Name/Number: Policy revision date:	**GCH Services Suited to Condition**	
	The policy requires the following:		
G1	A person-centered planning process is used to develop a written IPOS in partnership with the recipient. [MHC 1712 (1)]	Page 1 services suited to condition policy	p2 Services Suited
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)]	Page 2 of services suited to Condition policy	p2
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)]	Pages 2 &3 of the Services suited to condition Policy	Right to include is partially in policy. Need to include method of solicitation in the policy.
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)]	Page 3 of the services suited to condition Policy	p3
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)]	Page 3 of the services suited to condition Policy	p3
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)]		the policy states the opposite of its intent. Limitations on behavior NOT due to active diagnosis need to be reviewed. Committee composition needs to be included or an agreement with the CMH of contract

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restriction**s.**		
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)]	Page 2 of services suited to Condition policy	p2 D - remove child/adolescent language; otherwise ok
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]	Page 3 of the services suited to condition Policy	Move I to its own policy or to the end of the policy with the process. Process is not addressed here
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)]		Is there an ED? If no = NA
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]		Is there a statement in any of the policies (IE admission? That addresses this)?
G11	A process for explaining rights of admission and termination of voluntary hospitalization verbally to recipients, upon voluntary admission, is included in the explanation of rights and documented on the admission form, including documentation of delay and alternative methods utilized. [MHC 1416]		Is there a statement in any of the policies (IE admission? That addresses this)?
	Change and type of treatment / person centered planning		
	Policy Name/Number: Policy revision date:	**GCH - Change in Treatment Policy**	
	The policy requires the following:		
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)]	Pages 1&2 of Change in Treatment Policy	"weekly" no language about "review if necessary"
H2	There is a procedure to assure that the plan is kept current and modified when indicated, or when necessary. [MHC 1712 (1)]	Pages 1&2 of Change in Treatment Policy	Change in Tx p2 ¶ 2
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]	Page 2 of Change in Treatment policy	not the language from the law - "during review of treatment" - add code language.
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)]	Page 3 of Change in Treatment Policy	Change in Tx p2 V A, p 3 D - conflict with each other
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)]	Page 3 of Change in Treatment Policy	Change in Tx p2 V A, p 3 D - conflict with each other there is no process identified for completion
	Sterilization, contraception, and abortion		

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restrictions.		
	Policy Name/Number: Policy revision date:	GCH Family Planning	
	The policy requires the following:		
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)]	Page 1 of Family Planning Policy	If you don't treat minors, don't put them in your policy
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)]	Page 2 of Family Planing Policy	who is providing referral assistance?
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]	Page 1 of Family Planning Policy	Is there a copy of the notice? This language needs to be in the notice
	Communication and visits		
	Policy Name/Number: Policy revision date:	**GCH Patient Telephone use/Patient**	
	The policy requires the following:		
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)]	Page 1 of Patient Telephone use	p1 B
J2	Telephones must be reasonably accessible and funds for telephone usage are available in reasonable amounts. [MHC 1726 (2)]	Page 1 of Patient Telephone use	p1 A
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)]	Page 1 of Patient Mail Policy	Mail III A 3 ORR is responsible for taking outgoing mail & processing it. III A 7 references staff opening or destroying mail… No indication of writing materials or funds for telephone
J4	Space will be made available for visits. [MHC 1726 (2)]	Patient Visiting Policy	Visiting p2 III 13
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)]	Page 2 of Patient telephone Policy	Telephone p2 III A States the time phone calls may be made but does not state that times are posted. A 10 minute limit is posted. Visiting p1 III 1 - is posted
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)]	Patients Rights Policy	limitations telephone p3 III F "documented in the progress notes" - needs to be documented in the IPOS, Mail p2 III A 4
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)]	Page 3 of Patient Telephone Policy	Telephone P3 G, Mail III A 4,
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]	Page 3 of patient Telephone Policy	Telephone p3 III H, Visiting p2 III 15

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restrictions.		
	Medication procedures		
	Policy Name/Number: Policy revision date:	GCH Use of Psychotropic Medications	
	The policy requires the following:		
K1	Psychotropic medication (psychotropic drug) is defined in accordance with AR 330.7001 (p).	Page 2 of Psychotropic medication Policy	Use of Psychotropic Medication policy (UPMp) p2
K2	A doctor's order for medication is required. [AR 7158 (1)]	Page 1 of Psychotropic medication Policy	UPMp p1
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)	Page 1 of Psychotropic Medication Policy	Patient Medication Instructions Policy p2
K4	There must be periodic medication reviews as specified in the plan of service and based on recipient's clinical status. [AR 7158(4)]	Page 3 of Psychotropic Medication Policy	UPMp "occurs at team conference weekly" p3 or "weekly" p4
K5	Medications must be administered by personnel who are qualified and trained. [AR 7158 (5)]	Page 2 of Psychotropic medication Policy	Only RN or LPN p2
K6	Procedures on when and how documentation regarding medication administration is to be placed in recipient's clinical record. [MHC 1752, AR 7158 (6)]	Page 4 of Psychotropic Medication Policy	"RN/LPN shall record the administration of all medication in the recipient's clinical record" p4 no procedures of when & how
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)]	Page 4 of Psychotropic Medication Policy	UPMp p4 #6
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)]	Page 3 of Psychotropic Medication Policy	available to ensure the recipient has an adequate supply until he or she can become established with another provider" is missing
K9	A procedure to ensure that medication brought by the recipient, and stored by the LPH, must be returned at discharge [MHC 1728 (7)]	Medication Administration Policy	not in UPMp or personal property policy - add language
	Use of psychotropic drugs		
	Policy Name/Number: Policy revision date:		
	The policy requires the following:		
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]	Page 3 of Psychotropic Medication Policy	p3 #5
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)]	Page 1 of Psychotropic Medication Policy	p1 #5

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
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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)]	Page 2 of Psychotropic Medication Policy	p2 #8
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)]	Page 2 of Psychotropic Medication Policy	p1 #4 ¶ 2
L5	Medication must not be used as punishment or for staff's convenience. [AR 7158 (3)]	Page 4 of Psychotropic Medication Policy	p4 #8
	Treatment by spiritual means		
	Policy Name/Number: Policy revision date:	GCH Treatment by Spiritual Means	
	The policy requires the following:		
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)]	Page 3 of Treatment by Spiritual Means Policy	p3 III definitions
M2	Access to treatment by spiritual means is upon request by a recipient, guardian, or parent of a minor recipient. [AR7135 (1)]	Page 1 of Treatment by Spiritual Means Policy	p1 II A
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)]	Pages 1&2 of Treatment by Spiritual means policy	p1 II C
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)]	Page 2 of Treatment by Spiritual Means policy	p2 II F what is the procedure?
M5	There is a procedure for an administrative review or appeal process when treatment by spiritual means is denied. [AR 7135 (7)]	Page 2 of Treatment by Spiritual Means policy	p2 II G
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)]	Page 2 of Treatment by Spiritual Means policy	NA
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)]	Page 2 of Treatment by Spiritual Means policy	p1 II B
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)]	Page 2 of the Medication Refusal Policy	p2 II D Policy indicates guardian may consent if patient refuses - not true.
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)]	Page 2 of the Medication Refusal Policy	p2 II E
	Property and funds		
	Policy Name/Number: Policy revision date:	GCH Personal Property Policy	
	The policy requires the following:		

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
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N1	Identification of items that recipients may not possess (including weapons, sharp objects, explosives, drugs, and alcohol). [MHC 1728 (3)]	Page 1 of Personal Property Policy	not in policy (is this somewhere else? - could be attached)
N2	Any exclusions of personal property must be in writing and posted in each unit. [MHC 1728 (3)]	Page 1 of Personal Property Policy	p1 II B
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)]	Page 1 of Personal Property Policy	individual designated is not in policy
N4	A recipient is to be permitted to inspect personal property at reasonable times. [MHC 1728 (2)]	Page 2 of Personal Property Policy	p2 II G
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)]	Page 2 of Personal Property Policy	what does the waiver look like - attached? IPOS designates documentation but time limit is "as determined by the physician"
N6	Conditions under which a search for contraband items may be conducted. [AR 7009 (7)]		
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)]	Page 2 of Personal Property Policy	p 2 II H "justification for search & confiscation" - should use the language from the rule.
N8	Any property taken for into possession by the hospital must be given to the recipient at the time of discharge [MHC 1728 (7)]	Page 3 of Personal Property Policy	p 2 H
	Right to entertainment material, information, and news		
	Policy Name/Number: Policy revision date:	**GCH Entertainment Materials Policy**	
	The policy requires the following:		
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)]	Page 1 of Entertainment Materials Policy	p1 I A, D
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)]	Page 1 of Entertainment Materials Policy	p1 I A, D, E
O3	Limitations/restrictions must be removed when no longer clinically justified. [AR 7139 (4)]	Page 2 of Entertainment Materials Policy	p2 I F
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)]	Page 2 of Entertainment Materials Policy	NA - confusing to have in policy if there are no minors
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)]	Page 2 of Entertainment Materials Policy	NA - confusing to have in policy if there are no minors
O6	There is a process for implementing general program restrictions on access to entertainment materials. [AR 7139 (6) (a)]	Page 2 of Entertainment Materials Policy	not in policy - what is the process?
O7	There is a process for determining recipient's interest for provision of a daily newspaper. [AR 7139 (6) (b)]	Page 2 of Entertainment Materials Policy	not in policy - what is the process?
O8	There is a process for recipients to appeal the denial of their right to entertainment, information, news material. [AR 7139 (6) (d)]	Page 2 of Entertainment Materials Policy	names ORR in policy - what is the process? Who does ORR give the request for reconsideration to?\

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restriction**s.**		
O9	There is a process for imposing specific restrictions for the therapeutic benefit the recipients as a group. [AR 7139 (6) (e)]	Page 2 of Entertainment Materials Policy	not in policy - what is the process?
	Resident labor		
	Policy Name/Number: Policy revision date:	**GCH Patient Labor Policy**	
	The policy requires the following:		
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)]	Patient Labor Policy	Patients do not perform labor
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)]	Patient Labor Policy	not applicable
P3	A process for providing compensation when performing labor which benefits another person or the hospital. [MHC 1736 (3)]	Patient Labor Policy	not applicable
P4	Labor of personal housekeeping nature is not eligible for payment. [MHC 1736 (5)]	Patient Labor Policy	not applicable
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)]		not applicable
	Least restrictive setting / Freedom of movement		
	Policy Name/Number: Policy revision date:	**GCH Least Restrictive Setting**	
	The policy requires the following:		
Q1	There is a requirement that the recipient receives placement in the least restrictive setting appropriate and available.[MHC 1708 (3)]	Page 1 of Least Restrictive Setting Policy	not in policy recommend language be added to include recipients will be d/c to a less restrictive setting as soon as clinical condition warrants & placement is available
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)]	Page 1 of Least Restrictive Setting Policy	Freedom of Movement Policy p1 II C
Q3	Any limitations to the freedom of movement must be justified in the IPOS and be time limited. [MHC 1744 (2)]	Page 2 of Least Restrictive setting Policy	"record" - use code language
Q4	Any limitation on freedom of movement is removed when the circumstances that justified its adoption cease to exist. [MHC 1744 (3)]	Page 2 of Least Restrictive setting Policy	not in policy - use code language
	Use of restraint		
	Policy Name/Number: Policy revision date:	**GCH Seclusion and Restraint Policy**	

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restrictions.		
	The policy requires the following:		
R1	Restraint is defined, as in [MHC 1700 (i)]	Page 1 of Seclusion and Restraint Policy	p1 A - definition differs from MHC - review & resolve
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)]	Page 1 of Seclusion and Restraint Policy	p1 Philosophy, p3 B
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)]	Page 1 of Seclusion and Restraint Policy	p3 B, p7 A1
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)]	Page 1 of Seclusion and Restraint Policy	Not on p1, not in Behavioral Health section of the policy
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)]	Page 4 of seclusion and Restraint Policy	p7, A1 does not include "emergency" p8 #2 does not require immediate notification of a physician
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)]	Seclusion and Restraint Policy	p3 E 2, not in the behavioral med portion of the policy
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]	Garden City Hospital - Seclusion and Restraint Policy	p8 #6 remove 1 hour
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]	Garden City Hospital - Seclusion and Restraint Policy	The policy does not include the 1st sentence of R8 - please include the language from the MHC
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)]	Garden City Hospital - Seclusion and Restraint Policy	Not in policy - add language from MHC
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)]	Garden City Hospital - Seclusion and Restraint Policy	Not in policy - add language from MHC
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)]	Garden City Hospital - Seclusion and Restraint Policy	Not in policy - add language from MHC
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]	Garden City Hospital - Seclusion and Restraint Policy	Not in policy - add language from MHC
R13	Restraints must be removed every 2 hours for not less than 15 minutes, unless medically contraindicated. [MHC 330.1740 (7)]	Garden City Hospital - Seclusion and Restraint Policy	Not in policy - add language from MHC

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
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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)]	Garden City Hospital - Seclusion and Restraint Policy	Not in policy - add language from MHC
R15	A recipient must not be restrained in a prone position unless medically contraindicated. [AR 7243 (11) (ii)]	Garden City Hospital - Seclusion and Restraint Policy	Not in policy - add language from MHC
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]	Garden City Hospital - Seclusion and Restraint Policy	p9 #12
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)]	Garden City Hospital - Seclusion and Restraint Policy	p8 # 7
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	Garden City Hospital - Seclusion and Restraint Policy	Not in policy - add language from MHC
R19	A separate permanent record of each instance of restraint must be kept and must comply with applicable standards. [AR330.7243 (1)]	Garden City Hospital - Seclusion and Restraint Policy	p11 Documentation - Not in policy - policy states documentation is in EHR. add language from MHC
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]	Garden City Hospital - Seclusion and Restraint Policy	p6 W contains CMS reporting but not MHC form 5949 or timeframes - add MHC language to policy
	Use of seclusion		
	Policy Name/Number: Policy revision date:	**GCH Seclusion and Restraint Policy**	
	The policy requires the following:		
S1	Seclusion is defined using the most protective definition. [MHC 1700 (j)	Garden City Hospital - Seclusion and Restraint Policy	p2 I - included in Time Out definition - is not the definition from the MHC - please use MHC language

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restrictions.		
S2	Time out is defined using the most protective definition. [AR 7001(x)]	Garden City Hospital - Seclusion and Restraint Policy	p2 I - Time Out definition - is not the definition from the Rule - please use MHC language - "a voluntary response to the therapeutic suggestion to a recipient to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome."
S3	Therapeutic de-escalation is defined. [AR 7001 (w)]	Garden City Hospital - Seclusion and Restraint Policy	Not in policy - add language from MHC/Rule
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)]	Garden City Hospital - Seclusion and Restraint Policy	Policy does not distinguish between seclusion & restraint & allows seclusion for self harm - use MHC language
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)]	Garden City Hospital - Seclusion and Restraint Policy	partial language throughout policy - needs to be stated in a cohesive manner
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)]	Garden City Hospital - Seclusion and Restraint Policy	the policy does not include the 1st sentence of S6 - use MHC language
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)]	Garden City Hospital - Seclusion and Restraint Policy	p3 E 2, not in the behavioral med portion of the policy
S8	The attending physician must be consulted as soon as possible if the attending physician did not order the seclusion. [MHC 1742]	Garden City Hospital - Seclusion and Restraint Policy	p8 #6 remove 1 hour
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)]	Garden City Hospital - Seclusion and Restraint Policy	p9 #12
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)]	Garden City Hospital - Seclusion and Restraint Policy	p8 # 7

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restrictions.		
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	Garden City Hospital - Seclusion and Restraint Policy	The policy does not include the 1st sentence of R8 - please include the language from the MHC
S12	Seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. [MHC 1742 (8)]	Garden City Hospital - Seclusion and Restraint Policy	Not in policy - add language from MHC
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]	Garden City Hospital - Seclusion and Restraint Policy	Not in policy - add language from MHC/Rules
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)]	Garden City Hospital - Seclusion and Restraint Policy	Scattered in the policy - consolidate to mirror the language of the Code/Rules
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)]	Garden City Hospital - Seclusion and Restraint Policy	Requirement to enter into record is in policy, separate record is not - update to include language of the law
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]	Garden City Hospital - Seclusion and Restraint Policy	p6 W contains CMS reporting but not MHC form 5949 or timeframes - add MHC language to policy
	Policy Name/Number: Policy revision date:	**GCH Assessment and Reassessment Policy**	Comprehensive examinations
	The policy requires the following:		
T1	Within 24 hours of admission, each recipient must receive a comprehensive physical and mental examination. [MHC 1710}	Assessment and Reassessment Policy	P2 B & C - what is the process for readmission within 30 days?
	Policy Name/Number: Policy revision date:	GCH Recipient Rights Staff Training Policy	Qualifications and training for recipient right staff
	The policy requires the following:		
U1	Staff of the Office of Recipient Rights to receive annual training in recipient rights protection. [MHC 755 (2)(e)]	Page 1 of RR Staff Training Policy	p1
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)]	Page 1 of RR Staff Training Policy	p1

	HOSPITAL POLICY REVIEW	LOCATION	COMMENTS
	When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restrictions**.**		
U3	The education, training, and experience required is identified either in policy or position description. [MHC 755(4)]	Page 1 of RR Staff Training Policy	states is in PD
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 DET (Developing Effective Training) [LPH/CMHSP Contract referencing the MDHHS/CMH Master Contract]	Page 1 of RR Staff Training Policy	p1 recommend inserting Building Blocks after Basic Skills
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]		not in policy - include as stated in U5
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)		not in policy - include as stated in U6
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)	`	not in policy - include as stated in U7