

Submitting a complaint to State Licensing

Below, I am including an example of a complaint submitted to Licensing and the citation, substantiating the complaint. Absent evidence of obvious overt abuse or neglect, the key to increasing the probability that your complaint will be substantiated is to submit evidence and make an argument as to why that evidence supports your allegation that there has been a violation. You will encounter, as some point, an investigator at State Licensing who will tell you that the only jurisdiction they have is to establish whether a violation of Title 22 has occurred and that they cannot consider issues of due process, decide on the validity of involuntary holds, or any violation of Welfare and Institutions code. For this reason, it is helpful to begin each written complaint with something resembling the following example.

“I am registering a complaint about the violation of a patient’s due process rights while being involuntarily detained at _____ Hospital.

According to Title 22, Section 71517(h). Admission, Transfer and Discharge Policies,
(h) Involuntary admission to the hospital shall be in conformity with the provisions of the Lanterman-Petris-Short Act (Welfare and Institutions Code, Section 5000 et seq.).

The hospital failed to ensure that ’s involuntary admission to the hospital conformed to the provisions of the Lanterman-Petris-Short Act (Welfare and Institutions Code, Section 5000 et seq.), based on the following facts, supported by the attached documentation.”

Notice that the above cited section of Title 22 covers pretty much any other code or regulation relating to the provision of treatment of persons with mental illness.

January 4, 2007

Patsy Stubbs
Department of Health Services
Licensing and Certification
850 Marina Bay Parkway, 1st floor
Richmond, CA 94804

Patsy,

I am enclosing additional information and documentation in regard to the complaint I registered on the death of D at John George Psychiatric Pavilion on December 30, 2006.

On the next page, please note statements made by D's mother to the Family/Caregiver Advocate on Thursday, January 4, 2007.

I am enclosing statements from several of my staff who witnessed, over time, the deteriorating condition of D. Some of the statements are descriptions of D's higher state of functioning midway through this hospitalization. Some statements are from staff who had more long-term contact with her and witnessed her decompensation. I hope these are helpful. Please feel free to contact any of these staff if you have further questions.

Also enclosed are excerpts from the chart and notations I make regarding my findings. I did find some notes that are of concern. There is documentation of a failure to take seriously and take action when D's condition markedly changed. Some of the notes indicate a disregard for the possibility that she was suffering from a physical condition that warranted careful examination by a physician. The notes by the doctor indicate that he considered that her "dependency" was a form of acting out.

We have typed up two of Dr. Johnson's notes that we consider significant in hopes that it will make up for the illegibility of his handwriting. I have attached some comments to a few of the chart notes included.

Please do not hesitate to contact me if there is anything I can do to assist in the investigation.

Please investigate this complaint. I am requesting that you send me a copy of your findings when they are complete.

Sincerely,

Francesca Tenenbaum
Director
Patients' Rights Advocates of Alameda County

Summary of Facts

On 12/30/06, D was found unconscious, without a pulse, and without respirations on the floor of her room on Unit B of John George Psychiatric Pavilion. Efforts were made to revive her, however she was declared dead approximately 45 minutes after she was discovered.

Her health had noticeably deteriorated for at least one week before her death, and the persons responsible for her care failed to take appropriate action to assure that she received appropriate medical care.

On the day that D was admitted to JGPP on 11/30/06, the doctor in Psychiatric Emergency Services noted that D had a history of Sleep Apnea. Her mother called JGPP to inform them that D suffered from Sleep Apnea and required the use of a CPAP machine when sleeping at night. D also informed a member of her treatment team that she was diagnosed with Sleep Apnea and needed her CPAP. D was denied the use of her medically necessary CPAP machine during her month-long hospitalization at JGPP. (See Attachment A)

Prior to D's medical decompensation, she was participating in activities, such as occupational therapy and socializing with her peers and staff members. She later was showing clear signs of medical distress, and various members of treatment staff noted observations of this in the chart. She was having problems with coordination, making it difficult for her to ambulate, speak, feed herself, and participate in occupational therapy activities.

Dr. Alonzo Johnson, the psychiatrist responsible for D's care, considered her symptoms of decreasing ability to care for herself to be a form of deliberate manipulation and wrote instructions in her treatment plan for staff to no longer assist her with activities such as feeding herself

Dr. Johnson requested a consultation for D with an internist from Highland Hospital. The internist, Dr. Yeh wrote in the record of his examination of her that her sedation was probably secondary to medications. He recommended that the administration of the medication, Ativan, be discontinued. Dr. Johnson's notes following the internist's examination incorrectly state that the internist recommended discontinuing "regular" administration of Ativan. He wrote an order for PRN administration of Ativan every six hours. After that, D was given 2 more doses of Ativan, one of those doses being given one and a half hours before she was found on the floor.

The fact that many of the treatment staff on Unit B observed signs of D's worsening condition and failed to assure she be provided with a complete exploration of the cause of her problems and that the psychiatrist failed to follow the internist's recommendation to discontinue Ativan is evidence of negligence on the part of her treatment team.

The following are typed versions of Doctor's notes from the chart:

DR. ALONZO JOHNSON ON DEC. 28,2006

"I was immediately approached by the charge nurse who informed me that Debra was badly over medicated, was so weak that she couldn't stand, eat or feed herself. (I observed staff putting spoonfuls of cereal into her mouth; which she then swallowed.) When I sat down with her she recognized me; called my name correctly. I then asked her why she was having staff put food into her mouth. She gave two or three sentences of rambling, disconnected vocal sounds and words that made no sense and had no connection. She was unable to give any information about how she got here, about Albertson's, etc. again. She again talked nonsense and gibberish. I'm not sure that her problem was over medication. She had an earlier Lithium level of 1.4. I suspect that some of what I saw was manipulation. I observed her to be walking later on.

"Plan:

(1) Decrease qhs Lithium Citrate from 600mg to 450mg, Serum lithium level on Jan 2, 2007.

(2) Continue other meds. Vital Signs were OK.

MEDICATIONS

(1) Cogentin 1 mg BID-p.o.,

(2) Risperdal 4mg concentrate qhs -p.o.

(3) Lithium Citrate 450mg BID,p.,o. (p.m.dose was reduced from 600mg to 400mg),

(4) Ativan 2mg q4h prn agitation not to exceed 8 mg/24 hours .

12/29/06 Referring to Dr. Yeh's order of the same date, "He essentially recommended:

1. Get rid of regular Ativan 2mgs BID

2. Starting meds to clear her nasal passage ways. These orders will be followed through on. Patient was confused. She can't do things like take a shower.

- Dr Yeh's order actually said: Sedation due to meds D/C Ativan D/C Benedryl

Plan: Meds will be rewritten.

1. Naso-synephrine 0.1% spray 1 puff each nostril BID X 8 days

2. Nasarel 2 puff in each nostril BID

3. Benedryl 50mgs BID - po

4. Lithium 450mgs BID - po

5. Haldol 10mgs BID - po

6. Cogentin 1mg BID - po

7. Ativan 1mg BID - po - pm

Further Facts and notations:

D's mother, Annette Salinas, contacted the Family/Caregiver Advocate at Mental Health Association of Alameda County for assistance in obtaining an investigation into her daughter's death.

She called the unit on Friday, December 29th, 2006 and spoke with the Social Worker, E Woods. She expressed her concern that D was having difficulty speaking on the phone. Ms. Woods told her "D is fine."

She can be contacted at 510-XXX-XXXX for further information. In the MTP note on 12/11/06, the treatment team reports that D shows improvement, such as following directions and attending groups.

Please note the inconsistency between the notes regarding attempts to resuscitate the patient. The progress note states that when D was found, that she had a "weak carotid pulse". The doctor's note states that there was no pulse/no respirations. If she had a "weak carotid pulse", why did they start compressions and AED if there was in fact a pulse?

The Psychiatric Emergency Services Note indicates a history of sleep apnea. On 12/5/06, D is quoted as saying, "did you know I have sleep apnea? I need my machine".

In the Physicians Orders, Dr. Johnson indicates that he wrote this medication order on 12/29/06 at 20:04. Our review of other patients' charts from that day does not show any notations by Dr. Johnson after 3pm that day.

The Internist saw D on 12/29/06. In his Assessment/Plan he assesses that her sedation is probably secondary to meds. He writes to discontinue Ativan and Benedryl. Dr. Johnson does not write an order to discontinue Ativan altogether. He leaves the PRN order and she receives 2 more doses.

Why was the patient administered the "discontinued: Ativan twice after the internist's orders were recorded? Medication records show that D received Ativan on 12/30/06 at 00:10 and again at 06:00 (one and a half hours before she was found unresponsive).

There were notations that D was in distress in the early morning hours of 12/29/06, "lethargic, slumped over across the bed". The next early morning, and approximately one and a half hours before she is found on the floor, the nursing progress note records that her pulse ox was 94% and her heart rate was 115 beats per minute. She was give Ativan shortly after. Given her history of sleep apnea and the absence of her CPAP machine, these are evidence that she was in some medical distress, yet she was given a sedative.