DRAFT
Piedmont Geriatric Hospital
Local Human Rights Committee
Meeting Minutes

August 2, 2010

The Piedmont Geriatric Hospital (PGH) met on August 2, 2010 to conduct fact finding conferences/hearings for CT, JM and WD.

CT was advised of his right to an open or closed hearing and he opted to have a closed hearing.

The motion was made and passed to go into Executive Session pursuant to Virginia Code, 2.2-3711A (4 & 15), for the purpose of a conducting a fact finding conference/hearing for CT. This review necessarily involved discussion and consideration of mental and medical records excluded and information excluded from the Freedom of Information Act.

Upon reconvening in public session, the Piedmont Geriatric Hospital Local Human Rights Committee unanimously certified that to the best of each Local Human Rights Committee member's knowledge, only public business matters lawfully exempt from statutory open meeting requirements, and only public business matters identified in the motion to convene the Executive Session were discussed in the Executive Session.

After reviewing submitted evidence and hearing testimony from CT, the Committee determined VCBR violated his rights as outlined in 12VAC35-115-50.A.Dignity. The Committee determined CT was not treated with dignity as the services he received concerning his hernia were not person centered as required by this regulation. Specifically, no evidence was presented concerning VCBR's attempts to manage CT's pain while he was waiting to have his hernia surgery. While the VCBR records do not indicate any evidence of reported pain or treatment, CT reported his pain in his 15 March complaint only perfunctorily responded to by VCBR. Additionally, while on a round at the facility in mid-March, Advocate Mr. Small and others observed CT struggling in the passageway's, hanging onto railings to help him walk. Mr. Small that day, approached Chief of Staff Dr. Chaudry on CT's problem and he was issued a cane. The issuance of that cane for his pain did not make it into the record either

The Committee determined that VCBR did not violate CT's rights as outlined in 12VAC35-115-60.B.2.Services. The Committee's decision is based on evidence presented which indicated VCBR needed to consult with several outside physicians to gain medical clearance before CT could have his needed hernia surgery. Therefore VCBR had no control over the scheduling of his surgery and cannot be held responsible for the length of time needed for

CT to receive his surgery. Committee felt that considering the state of CT's overall health issues and the need to ensure it was safe to operate to repair his hernia, his wait was not excessive.

The Committee recommendations were as follows:

1. VCBR responses to resident complaints should contain more substance and demonstrate an understanding of the resident's issues and should show a greater attempt to resolve the complaint.
2. Based on the evidence presented at the hearing, there was no documentation that explained the surgical determination process has been explained to the resident. VCBR needs to ensure their efforts to explain any and all processes to residents are clearly documented.

Upon the agreement of **JM and WD**, the Committee conducted their hearings jointly as both had identical complaints and WD was the chosen representative for JM. VCBR was not in favor of the hearings being held jointly and the Committee noted the objection.

JM and WD were advised of their right to an open or closed hearing and both opted to have an open hearing. The Committee notes in the record that the Piedmont Geriatric Hospital Local Human Rights Committee is concerned about the preservation of patient privacy and the confidentiality of medical records. For this reason, the Committee wishes to record that the right to a closed hearing has been reviewed with JM and WD and that both are authorizing the disclosure of information that would otherwise be exempt from public dissemination.

The Committee conducted the fact finding conference/hearing for JM and WD in open session pursuant to their requests.

PGH LHRC Members in attendance: John K. Fyfe, Chair, James Dyson, David Patterson and Patricia Fyfe-Horne

Others presents: JM, WD, complainants, Walter Small, Human Rights Advocate Senior-PGH/VCBR, Cheryl Young, Resident Complaints Manager-VCBR, Dr. Mario Dennis, Director of Behavioral Services-VCBR, Cheryl Young, Resident Complaint Manager-VCBR, Dr. Andrew Heck, Acting Chief Operating Officer-VCBR and Sherry Miles, Regional Advocate (technical assistant)

After reviewing submitted evidence and hearing testimony from JM; WD; Chad Houser, Director of Security-VCBR; and Dr. Heck, the Committee determined each consumer's rights were violated as outlined in 12VAC35-115-50.A., C.3a&b., D.1., D.2. Dignity. The

Committee determined the actions taken by VCBR were not the least restrictive and that the search policy (6.13-Search) in place at the time of the event directly conflicted with the human rights regulations. Pat down searches of the entire population as part of a quarterly sweep is a violation of existing human rights rules and regulations. VCBR's position is quarterly sweeps with pat downs are necessary for the safety of the population and that existing human rights guidelines are too restrictive. The Committee felt that VCBR lost control of the situation because of these conflicting procedures. There are no procedures that require that refusing a pat down search will lead to a strip search and the need for the ensuing strip search was not substantiated to the Committee under the circumstances of the event. Additionally, the VCBR "responses" to the resident complaints were superficial and non-responsive.

The Committee recommendations were as follows for JM and WD:

1. That VCBR follow the human rights regulations in all situations. If VCBR opines that the human rights regulations limits their ability to manage their population, they need to seek and promulgate additional exemptions or seek to see the existing rules changed.
2. That VCBR responses to resident complaints must contain more substance and demonstrate and communicate an understanding of the resident's issues if they are serious about resolving complaints. Because human rights issues if not resolved come to this committee and possibly the State Committee, VCBR needs to include specific actions or steps taken to resolve complaints. This additional detail will better serve the complainant, VCBR and the LHRC in the resolution process.

The Committee's responses to the requested relief from JM are as followings:

1. JM requested a letter of apology from Dr. Herrick and Dr. Heck. The Committee determined that VCBR send JM a letter acknowledging they did not follow existing human rights policy and their justification for the action they took.
2. JM requested that all behavioral notes incurred while exercising and protecting his rights be expunged from his records. As behavioral notes were not submitted as evidence by either party, the Committee cannot make a determination on whether these can be expunged from the resident's file. However, the resident can utilize steps in 12VAC35-115-90. Access to and amendment of services records to address this issue.
3. JM requested that Security Director, Chad Houser be terminated. The Committee determined it does not have the authority to hire or fire any employee of VCBR and therefore cannot take action on this requested relief. The Committee did not feel that Mr. Houser should be fired but that he needs to be more in tune with the rules and regulations he may not agree with but is subject to adhere to.
4. JM requested that policy be established to ensure no staff retribution when staff become involved in a situation to stop a human rights violation from occurring. The Committee felt that staff certainly should not be threatened by their pointing out

conflicts with operating policy and governing rules and regulations. The Committee recommends VCBR review personnel policies to ensure a free flow of communication is encouraged between staff and management in striving for a safe, calm environment and in meeting all the rules and regulations that govern the facility.

5. JM requested compensation for mental and emotional anguish. The Committee determined that it does not have the authority to award any compensation nor did they feel compensation is warranted.
6. JM requested his treatment at VCBR be one on one with a staff member he can trust. The Committee heard from JM that he had subsequent discussion with staff and that some level of trust has been reestablished. In light of the other recommendations made regarding this complaint, Committee feels these issues should continue to be addressed with the treatment team in order to reestablish an acceptable level of trust and ultimately determine the best course of treatment for JM.

The Committee's responses to the requested relief from WD are as followings:

1. WD requested a letter of apology from Dr. Herrick and Dr. Heck. The Committee determined that VCBR send WD a letter acknowledging they did not follow existing human rights policy and their justification for the action they took.
2. WD requested that all behavioral notes incurred while exercising and protecting his rights be expunged from his records. As behavioral notes were not submitted as evidence by either party, the Committee cannot make a determination on whether these can be expunged from the resident's file. However, the resident can utilize steps in 12VAC35-115-90. Access to and amendment of services records to address this issue.
3. WD requested that Security Director, Chad Houser be terminated. The Committee determined it does not have the authority to hire or fire any employee of VCBR and therefore cannot take action on this requested relief. The Committee did not feel that Mr. Houser should be fired but that he needs to be more in tune with the rules and regulations he may not agree with but is subject to adhere to.
4. WD requested that policy be established to ensure no staff retribution when staff become involved in a situation to stop a human rights violation from occurring. The Committee felt that staff certainly should not be threatened by their pointing out conflicts with operating policy and governing rules and regulations. The Committee recommends VCBR review personnel policies to ensure a free flow of communication is encouraged between staff and management in striving for a safe, calm environment and in meeting all the rules and regulations that govern the facility.
5. WD requested compensation for mental and emotional anguish. The Committee determined that it does not have the authority to award any compensation nor did they feel compensation is warranted.

The meeting was adjourned.