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METRO EAST REGIONAL HUMAN RIGHTS AUTHORITY

REPORT OF FINDINGS

HRA CASE # 12-070-9008

ALTON MENTAL HEALTH CENTER

MARCH 15, 2012

INTRODUCTION

The Metro East Regional Human Rights Authority (HRA) has completed its investigation of a complaint at Alton Mental Health Center (Center), a state-operated facility (SOF) that has 125 inpatient beds in Alton. The allegation states that the Center may have violated a consumer's rights when it did not follow protocol after a complaint to the Office of Inspector General (OIG) and when it retaliated by taking the consumer's property after he made an allegation of abuse and neglect. If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code and the Illinois Administrative Code (59 Ill Admin Code 50.2)

Specifically, the allegation states that the Center violated the consumer's rights when a nurse called him an asshole and that nurse continued working on the unit. Also, the day after the consumer made that allegation; staff came to him and took a bracelet from him as a form of retribution for having made the complaint.

METHODOLOGY

To pursue the investigation, an HRA team visited the Center and interviewed a Security Officer, a Licensed Social Worker (LCSW) and the Medical Director. With consent, the HRA reviewed portions of the consumer's record.

FINDINGS

The consumer stated that on October 24, 2011, after a disagreement at the nursing station an RN called him an "asshole" in the presence of several staff members. According to the consumer a complaint was made to the OIG; however, after the allegation was made, the staff who called him the name continued to work on the unit. Several days after the incident staff required the consumer to turn over a bracelet that he had been allowed to have since admission. The consumer felt that making him forego the property at that time was retaliatory for having complained to the OIG.

The Security Officer stated that the allegation of the RN calling the consumer an "asshole" was received via phone call from the Director of Nursing on October 24, 2011 and that is when security contacted the OIG. According to the Security Officer, the OIG informed him that staff do not have to be removed from working with an individual when allegations of abuse are not egregious.

The Director of Nursing (DON) stated that he reports all allegations of abuse and neglect to OIG by contacting Center security. The DON explained that he did not recall this case specifically, if security reported that he had contacted them on October 24, 2011; that is the date he was informed of the allegation.

The Medical Director explained that the Center's Director determines when employees should be barred from contact with a consumer on whose behalf an allegation of verbal abuse has been initiated. In this case there was no credible evidence at the time of the allegation to cause the removal of the staff.

According to the LCSW, the treatment team had discussed the consumer's bracelet and determined that it was not appropriate for the unit prior to the OIG allegation and that they "just hadn't acted on it." The LCSW stated that the timing was bad; however, when he asked the consumer to turn over the bracelet, he did so without incident. When asked, the LCSW said that the consumer was not issued a Notice of Restriction form regarding the bracelet.

Record review did not reveal any documentation that the consumer or any staff discussed or contacted the OIG on October 24, 2011. Also, there was no documentation that the team discussed the consumer's bracelet or that a Notice of Restriction form was provided.

DOCUMENTATION

Progress notes state:

> October 21, 2011 @ 1410: RN progress note: [late entry for 1245]. RN was present in the medication station when [the consumer] walked up abruptly reported he was in need of immediate medical attention related to discomfort he was experiencing in his [right] shoulder as well as his spine. Client was irritated making statements such as 'I am an asshole, but just because I am an asshole doesn't mean you can lock me up. RN [this writer] provided education related to pain [i.e. irritability with increased pain] Client on 10/21/11 @ 1410 did not verbalize understanding. He reported the onset of pain as 'yesterday' [10/20/11] client became further irritated when RN [this writer] explained on 10/21/11 @ 1410 the necessity for client to remain on unit for further monitor [medical unit pass]. Client made statement that 'you are always trying to take something.' RN explained these measures were

being taken so that staff could monitor condition/safety. Client again failed to verbalize understanding.

October 22, 2011 Physician's Note: patient assessed for pain on [right] side of neck and right upper arm. He claims Ibuprofen and Naproxen are not alleviating the pain but slept for five hours last night. Will continue observation.

October 24, 2011: Late psychologist's note for 10/21/11 @ 1600: Complaining of neck pain, which he had brought to the attention of the nurse. Wanted to process results of yesterday's treatment plan review.
Encouraged to focus on discharge as soon as possible.

The HRA notes that there were no Progress note entries on October 24, 2011 indicating that an incident of abuse or neglect had taken place.

The Office of Inspector General's Investigative report dated December 19, 2011 states:

On October 24, 2011 the Office of Inspector General [OIG] received a reported allegation of abuse from the Alton Mental Health Center [AMHC] it was alleged that Registered Nurse [RN] called individual [the consumer] an asshole.

[The RN] ....last received abuse/neglect training on February 14, 2011. He continued working during the conduct of this investigation.

The investigation disclosed [the RN] in the presence of [the consumer] referred to him as an asshole. This was heard by [the consumer] and [two security therapy aides (STA)]. [A third STA] stated she too heard [the RN] say 'asshole,' but stated she does not know whom it was directed, although she knew [the RN] had been speaking to [the consumer]. Finding: Based on the facts in this case, the following was concluded: the allegation of mental abuse against [the RN] is substantiated....

[The RN] ....continued working during the conduct of this investigation....

[The consumer] said [the RN] called him an asshole as he,[the RN] was closing the door [to the nurses station] and [STA 1], who was standing in the door, heard it. After hearing [the RN] saying this, he said, 'did you call me an asshole?' [The RN] said 'I didn't say that' He then said 'I wasn't talking to you.' When [the RN] saw [STA 1]

he knew she heard it and that he [the RN] was 'popped.' He said there were other staffs in the documentation station. When asked how he felt, he said the comment upset him and made him feel like 'shit.' That, had he said this to [the RN], he would have to remain longer at this facility. [The consumer] said if [the RN] has the balls to say this in front of staff what else would he do and say to clients in private.

[The RN] acknowledged speaking to [the consumer] concerning his desire to be seen by a physician. However, he denied making the comment at any time and denied [STA 1] was present when he was speaking to [the consumer]. He said [the consumer] had told him that he was not a physician, was demanding to see a physician immediately and was refusing to answer questions. [The consumer] had commented to him that 'all you do is give me attitude.' He said after entering the documentation station he was going to the medication room when [the consumer] made the accusation. He said he could not say why [STA 2] would say she had heard him said [sic] the comment. Concerning [STA 1], he said he has initiated discipline action against her and feels she may be doing this as retribution.

[STA 1] said she was present by the documentation door and heard [the consumer] ask [the RN] to call a physician. [The RN] told [the consumer] that a Physician would see him as soon as possible. [The RN] then reentered the documentation station, and as the door was closing, she heard him say 'asshole.' She heard this clearly, and it was loud enough that she was able to hear it while standing in the hall. [The consumer] also heard it and said, 'did you hear that?' She said [the consumer] did not get upset, and [the consumer] told [the RN] that all he has ever given him is attitude. [The RN] had said he had not called him and ass hole. She said [the RN] knows she was present, as she was the staff who had called for the nurse to speak to [the consumer] and then called security at [the consumer]'s request

[STA 2] said she was in the documentation station and heard [the consumer] asking [the RN] to see a physician. She said she did hear [the RN] say 'ass hole' after talking to [the consumer]. She said the door to the documentation station was closed or closing and [the RN] was walking on the chart side of the documentation station when he made this comment. [STA 2] said she does not know to whom this comment was directed.

[Two other STA's were interviewed and one stated that he heard the RN say asshole and the second STA denied hearing the

comment.]

In conclusion, [the RN] an employee, was speaking with [the consumer] in the presence of [STA 1] concerning his request to see a physician. During the conversation, [the consumer] was telling [the RN] that he did not want to speak to him and accused [the RN] of having an attitude. Once the conversation was over, [the RN] entered the documentation station, and as the door was closing [the RN] said, 'asshole.' This was overheard by [the consumer], [STA 1] [STA 2] and [a third STA] and there is little doubt that it was in response to his conversation with [the consumer] and pertained to [the consumer]. [The RN] denied making this comment at any time. The comment caused [the consumer] to become upset stating he felt like 'shit.' Therefore, the action of [the RN] rises to the level of mental abuse as defined in 59 Illinois Administrative Code, chapter 1, section 50 as [the consumer] suffered emotional distress. The allegation of mental abuse against [the RN] is substantiated.

Recommendation: The Office of Inspector General recommends the facility address the action of [RN] in his providing false statements to the facility security and OIG, which impeded the OIG investigation in violation of Title 59, chapter 1, Section 50.50.

Personal Property Receipt completed on the day of admission September 4, 2011 states:

White bracelet with charms and white ring. Keeping on him.

MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CODE

The following rights are guaranteed under these Sections:

(a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefore to:

The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefore in the recipient's record.... (405 ILCS 5/2-201)

Every recipient who resides in a mental health or developmental disabilities facility shall be permitted to receive, possess and use personal property...

(a) Possession and use of certain classes of property may be restricted by the facility director when necessary to protect the recipient or others from harm, provided that notice of such restriction shall be given to all recipients upon admission.

(b) The professional responsible for overseeing the implementation of a recipient's services plan may, with the approval of the facility director, restrict the right to property when necessary to protect such recipient or others from harm.... [405 ILCS 5/2-104]

The Secretary of Human Services and the facility director of each service provider shall adopt in writing such policies and procedures as are necessary to implement this Chapter. Such policies and procedures may amplify or expand, but shall not restrict or limit, the rights guaranteed to recipients by this Chapter. [405 ILCS 5/2- 202].

Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a recipient of services indicates, based upon credible evidence, that an employee of a mental health or developmental disability facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with recipients of services of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. [405 ILCS 5/3-210]

The Illinois Administrative Code states:

Definition: "Credible evidence". Any evidence that relates to the allegation or incident and that is considered believable and reliable.

a) Reporting - by a facility, community agency or employee

1) If an employee witnesses, is told of, or suspects an incident of physical abuse, sexual abuse, mental abuse, financial exploitation, neglect or a death has occurred, the employee, community agency or facility shall report the allegation to the OIG hotline according to the community agency's or facility's procedures. The employee, community agency or facility shall report the allegation immediately, but no later than the time frames specified in subsections [a] [2] and (3) of this Section. Such an employee or representative of a community agency or facility shall be deemed the "required reporter" for purposes of this Part. Such reporting will additionally meet any requirements of 59 Ill. Adm. Code 115, 119 and 132 and Department administrative directives, as applicable.

2) Within four hours after the initial discovery of an incident of alleged physical abuse, sexual abuse, mental abuse, financial exploitation or neglect, the required reporter shall report the following allegations by phone to the OIG hotline:

A) Any allegation of physical, sexual or mental abuse by an employee;

B) Any allegation of neglect by an employee, community agency or facility; [59 Ill. Admin. Code 50.20]

a) Availability of OIG

....f) Authorized representative
If the allegation of abuse, neglect or financial exploitation is within the jurisdiction of OIG, the authorized representative or his or her designee of a community agency or facility shall:

1) Ensure the immediate health and safety of involved individuals and employees, including ordering medical examinations when applicable; and

2) Remove alleged accused employees from having contact with individuals at the facility or agency when there is credible evidence supporting the allegation of abuse pending the outcome of any further investigation, prosecution or disciplinary action against the employee [405 ILCS 5/3-210]; and

3) Ensure OIG is notified; and

4) Unless otherwise directed by OIG, initiate the preliminary steps of the investigation by a designated employee who has been trained in the OIG-approved methods to gather evidence and documents and for whom there is no conflict of interest. This may include the need to:

A) Secure the scene of the incident and preserve evidence, if applicable;
B) Identify, separate potential witnesses, and interview when applicable;

C) Identify and record the names of all persons at the scene at the time of the incident and, when relevant, those who had entered the scene prior to the scene being secured;

D) Secure all relevant documents and physical evidence, such as

clothing, if applicable;

E) Photograph the scene of the incident and the individual's injury, when applicable.

g) OIG may determine what further action, if any, is necessary to protect the safety of any individual, secure the scene of the alleged incident, preserve the evidence and maintain the integrity of the investigation. Such action may include immediate emergency referrals (such as medical or housing services), the notification of law enforcement officials, requesting hospital services or contacting the Department or other State agencies for assistance. [59 Ill. Admin. Code 50.30]

The Illinois Administrative Code 59-110.30 on Personal Property in State Mental Health Facilities states:

a) Individuals may possess a reasonable amount of personal property for personal use under the following conditions:

1) Possession and use of certain classes of property may be restricted by the facility director when necessary to protect the recipient or others from harm, provided that notice of such restriction shall be given to all recipients upon admission so long as the restriction does not otherwise conflict with the rights provided in this Section....

3) Property must be approved by the individual's treatment team prior to use. Any personal property that the treatment team determines, in the exercise of its professional judgment, may pose harm to the individual or to others shall be restricted. Property shall not be restricted on political, philosophical or religious grounds. Property intended as a medically reasonable accommodation of a known disability shall not be restricted except when determined by a physician and the treatment team, in exercise of their professional judgment, that the accommodation may pose harm to the individual or others. A restriction of rights shall be issued in accordance with the Mental Health and Developmental Disabilities Code [405 ILCS 5/2-201] within 48 hours. When the restriction of rights is issued, the treatment team member shall inform the individual of his/her ability to request a review under subsection (a) (5). The individual will have the option of placing the personal property in storage or returning it to its place of origin....

ALTON MENTAL HEALTH CENTER POLICY

Alton Mental Health Center handbook states:

CONTRABAND

The following items are considered contraband. This means contraband items are not allowed on the units and are either illegal or prohibited by Department and /or Division PPD's or AMHC P/P's. The list is as follows:

1. Any items that in staff's judgment, and with treatment team review the next business day, could be used, fashioned into, or is designed to be a weapon. This is to include items that the patient has identified as a weapon through comment, verbal threat, or physical posturing. The outcome of the treatment team's decision must be clearly documented in the patient's clinical record.....

6. Rope, yarn, twine, string or similar item; not to exceed 8 inches....

Patients may also lose access to items not listed above due to clinical issues and/or issues of abuse. Reasons for these restrictions MUST be clearly documented in the patient's clinical record. Further, staff and patients must be informed of these restrictions.

Alton Mental Health Center Policy 1g.03.017 states:

A. AT THE TIME OF ADMISSION:

Personal Property

1. As part of the admission process, the patient's personal belongings are accounted for and checked for dangerousness. Due to storage space, each patient is allowed one (1) document box for storage; all extra property is sent to the patient's home. An address will be kept on file in the security office for mailing purposes....

4. The Personal Property Receipt (IL462-0001), is completed for all property kept at the facility and retained by the patient. The Personal Property Receipt will have listed in detail all items retained by the patient, items put in grooming boxes, contraband items given to security, and those items sent to the security office. The patient or guardian will sign or place his/her mark on the proper line for each item retained in addition to the bottom of the document. The staff member completing the form will also sign the bottom of the

form. If the patient has no personal property, he/or she must still sign a completed the IL462-0001 form and indicate NO PERSONAL PROPERTY. It must be documented on the form if the patient refuses to sign the form. If the patient refuses to sign the form, the form will require two (2) staff signatures next to each item in addition to two (2) staff signatures on the bottom of the form. The patient or guardian will receive the second copy (bottom) of the IL462-0001 form after it is processed and returned from the security office.

Alton Mental Health Center Policy 1g.03.019 states:

1. Immediately upon receiving/observing an event or allegation of abuse or neglect, the employee/patient shall call Security at 474-3808. (If no answer, call AFC Control [474-3800] and they will radio security to respond to the designated number). Security will notify the unit nurse of where the incident occurred and she/he will secure the area of the incident and preserve the evidence as required until Security arrives.

2. The Security Officer will identify all perpetrators, victims, and witnesses and obtain a written statement from each. If one of these individuals is not present at the time of the allegation, a written statement will be obtained as early as possible. All efforts will be made to interview staff before the completion of their shift. If necessary, the Clinical Nurse Manager (CNM) may authorize overtime so that the employees may be interviewed.

3. Security will complete an Incident Tracking System Supplemental Form.

4. The unit nurse will assure that an examination of the patient by a physician is completed ASAP_which notes any injuries (physical and/or psychological) from the event/allegation and any treatment which may be required.

5. Security will contact the OIG Hotline, the Hospital Administrator/designee, and the AOD with the facts of the case within four (4) hours of discovery.

The Hospital Administrator/designee will consult with the

6. Clinical Nurse Manager or designee and others as required to complete a Credible Evidence Determination to determine if the employee shall be removed from the work site or reassigned from the work site pending investigation. This will be documented on the

last section of the Incident Tracking Form.

7. The determined action will be carried out by the Clinical Nurse Manager/designee and the Hospital Administrator/designee will notify Security of the outcome so Security may appropriately note the action. Security will complete the Administrative Review of Allegations of Mistreatment/Abuse/Neglect form (601) recording the times of the contacts, and initiate the OIG Contact Summary (601A).

8. Security will submit a copy of the case file to the Hospital Administrator's Office and the original to the OIG Liaison. The case will be entered into a database file by the OIG Liaison.

9. The OIG Liaison will maintain responsibility for working with OIG to complete the investigation, including collecting additional information for OIG, arranging for interviews or communicating concerns to the OIG Liaison's office. The OIG Liaison will be responsible for monitoring the status of the case.

10. It is a violation of the act to take retaliatory action against an employee who acts in good faith in conformance with his or her duties as a required reporter.

Credible Evidence Determination

Section 3-210 of the Mental Health and Developmental Disabilities Code states:

When an investigation of a report of suspected abuse of a recipient of services indicates, based upon credible evidence, that an employee of a mental health or developmental disability facility is the perpetrator of abuse, that employee shall immediately be barred from any further contact with recipients of services of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee.

The Office of the Inspector General, whose policy determines the facility's implementation of the above law, has made a change in their practice of notification to the Facility regarding the determination of credible evidence in allegations of recipient abuse and neglect. As a result of this change, it has become necessary that the Facility also change our practice.

When an allegation of abuse or recipient neglect is reported, it is also necessary to make a determination of credible evidence immediately, or as soon as possible after discovery of the

allegation. This can be accomplished just as soon as the immediate facts are gathered. The responsibility for determining if credible evidence exists is now vested in the following Managers:

Clinical Nurse Manager - if the allegation is made against STA/MHT or RN, during normal workweek, involving their respective units.

Department Head - if the allegation is made against other staff, during the normal work week.

AOD - All staff, after regular hours, holidays and weekends.

When an allegation is reported, the responsible Manager must be made aware of the allegation immediately and provided all relevant facts known at the time. Should additional information be gained that would impact the credibility determination, such information must also be conveyed to the responsible Manager so that any determination can be changed, when necessary. When a determination is made requiring action, such as removal or reassignment of the alleged perpetrator, appropriate Management staff must immediately implement that decision. In all cases, the determination of credible evidence and the action to be taken, if any, must be reported to Security and the Unit Nurse as soon as the determination has been made. The Manager who made the determination must write a Memo detailing the facts upon which the decision was based and the reason for the determination. This memo must be taken to the OIG Liaison

CONCLUSION

According to the Illinois Administrative Code if an employee witnesses mental abuse, the employee or facility shall report the allegation to the OIG Hotline according to the facility's procedures. The employee shall immediately, but no later than within four hours after the initial discovery of an incident of alleged mental abuse report the allegations by phone to the OIG Hotline.

The Mental Health Code states that when an investigation of a report of suspected abuse of a recipient of services indicates, based upon credible evidence, that an employee of a mental health facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with recipients of services of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. [405 ILCS 5/3-210]

The Alton Mental Health Center policy handbook that lists contraband does not include bracelets. The documentation confirms that upon admission the

consumer was allowed to possess and wear the bracelet and that when the bracelet was confiscated, no Notice of Restriction Form was issued.

Progress notes written that on October 21, 2011 and the RN's statement to the OIG contain statements that the consumer wanted to be seen by a physician because of pain to his shoulders neck and spine and on the same date the RN documented a verbal exchange that included the term "ass hole." There is no documentation regarding a confrontation between staff and the consumer on October 24, 2011.

The allegation states that the Center may have violated a consumer's rights when it did not follow protocol after a complaint to the Office of Inspector General (OIG) and when it retaliated by taking the consumer's property after he made an allegation of abuse is substantiated. The abuse perpetrator was not removed from contact with the consumer as per Code requirements and there no was evidence of a facility review addressing consumer/perpetrator contact as per facility policy.

With regard to the property issue, the consumer's property was removed even though the property was not part of the contraband list, there was no clear documented safety justification for the property removal and no restriction of rights notice was issued.

RECOMMENDATIONS

The HRA recommends that the facility ensures that:

1. Staff are trained regarding Mental Health Code and Rule 50's requirements.

2. Staff are reminded to document in consumer's records when incidents such as those stated in this report occur.

3. Adhere to Mental Health Code, Rule 50 and facility policy and when there is credible evidence of an allegation of abuse, the staff are barred from consumer contact.

4. Follow facility policy regarding the credible evidence determination review.

5. Consumers are allowed to retain property that is not contraband or document that the property restriction is necessary to protect the consumer or others from harm.

6. Issue Notice of Restriction Forms when consumers are not allowed to have all of their property.