
**FOR IMMEDIATE RELEASE**

**Egyptian Regional Human Rights Authority**
**Report of Findings**
**18-110-9002**
**Chester Mental Health Center**

The Egyptian Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning Chester Mental Health Center:

1. **Recipients are not being served in the least restrictive environment.**
2. **Recipients have inadequate programming.**
3. **The facility is not communicating with a recipient's guardian**
4. **The internal Office of the Inspector General, or OIG, investigative process is inadequate.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5 et al.), the Illinois Administrative Code (59 IL ADC 50 et al.) and facility policies. Chester Mental Health Center is a state-operated mental health facility serving approximately 250 recipients; it is considered the most secure and restrictive state-operated mental health facility in the state. To investigate the allegations, an HRA team interviewed the recipients, reviewed their records with consent, and examined pertinent policies and mandates.

**Complaint Statement:** A recipient reportedly received several injuries in the first 3 weeks at the facility, including a black eye two weeks after admission, 9 staples to his head the following week and a week after that, 6 sutures in his chin. When allegations of abuse are presented to the OIG, a representative would allegedly call the facility first upon receiving a complaint and speak with a coordinator of services to see if the complaint was valid before conducting an investigation. The recipient's guardian reportedly had only received one treatment plan in 3 months and it was not signed. The guardian had requested to be included in treatment meetings by telephone but the facility still had not contacted her about monthly meeting dates. Two other individuals have been "housed" in the infirmary for over 10 years and are not receiving programming and are watching television all day. These issues have allegedly been reported numerous times to the facility's internal staff as well as the statewide central office with no resolution.

## I. Interviews:

A. Recipient 1: The recipient informed the HRA that approximately 2-3 months prior to his meeting with the HRA he was in an altercation with staff. He was in another patient's room and staff hit him in the face and chest and took him to the restraint room where he was choked while in restraints. The recipient said he passed out briefly. As a result of the altercation he had a black eye and the incident was reported to the OIG. The recipient reported that an investigator came to speak with him but he could not recall exactly how long after the incident they came to interview him, but he thought it was less than a week. The recipient stated that he attends his treatment meetings and his guardian had not been attending but at the most recent treatment plan meeting his guardian had participated by telephone. He had not had any issues with staff for 1½-2 months.

B. Recipient 1 Guardian: The guardian told the HRA that the recipient had hit a nurse at a community hospital and was placed in jail from October until February; during that time he regressed. One state operated facility close to his hometown would not take him so he was sent to Chester Mental Health. Since being at Chester, the recipient has had several accidents/incidents which have required him to have staples in his head, stitches in his chin and black eyes. The OIG was contacted and called Chester but was told there was no swelling or bruising and the guardian does not believe an investigation occurred. Therefore, another call was made to the OIG and the guardian said they may have investigated then, but she was unsure. The guardian was told by staff (unknown name) that one of his injuries was due to him being placed on blood pressure medication and Clozaril and he fell and hit is head on the toilet. However, the nurse said he had never had blood pressure medications but was on 130 mg of Clozaril. The guardian said he has been on up to 900 mg before without any issues. The recipient has been in restraints once and staff reported that he threw himself on his bed during the incident and hit his chin on the bed which required stitches. However, the recipient reported that a Security Therapy Aide (STA) blackened his eyes and threw him on the bed. In June, 2017 the recipient and guardian had requested that he be transferred to another state operated facility to be closer to family but he had not yet met criteria set by the treatment team at Chester for a transfer to occur.

C. Recipient 2: The HRA questioned this recipient regarding allegations that he remained in the infirmary for 10 years or more and had no programming during the day. The recipient answered questions of the HRA but did not have much conversation beyond direct questioning. The recipient also requested that a STA stay with him during the interview and the STA helped answer some questions as well. The recipient said he would like to leave Chester and the STA stated that he has talked a lot about leaving and the facility took him twice to visit a nursing home along with his Uncle. The first visit he did alright but he had some anxiety and behaviors following the second visit. The recipient usually attends his treatment meetings and participates in them; he is his own guardian but does have family involvement. He remains in the infirmary during the day rather than attending rehabilitation classes and usually watches television. He does not go to the cafeteria for meals, instead the meals are brought into the infirmary. He had been on 1:1 supervision for safety reasons due to frequent falls and had to be removed from 1:1 before he would be able to transfer to another facility. At the time of our interview, the recipient had been off of 1:1 for approximately a month. The STA was of the opinion that he would like to move but is also nervous about the move.

D. Recipient 2 Therapist: This recipient's therapist was questioned on barriers to transfer and programming. The therapist informed the HRA that the recipient had declined offers to go to the gymnasium and other activities, but they continue offering them to him frequently. The therapist stated that he has not been in the infirmary for the entire duration of his admission and had gone back and forth between the infirmary and regular units but living on the unit did not last long. At one point he was able to stay on the regular unit for a full 6 months; housing him in the regular unit was the goal of his treatment team and they encouraged him to be active. When on the units, he would break the telephones which upset other patients. He was also having frequent falls which was thought to be a medical issue so tests were ordered in the infirmary and all tests came back clear and showed no medical reason for the falls. Next, the recipient refused to walk so he had to be placed in a wheelchair and then the wheelchair became a positive reinforcement for his maladaptive behavior of intentionally falling and refusing to walk. Since wheelchairs could not be on the regular units for safety reasons, he remained in the infirmary. The facility tried physical therapy and exercises to try to get him out of the wheelchair and he was placed on 1:1 for fall precautions. Due to him being in a wheelchair and no longer needing a maximum security facility, placement at a nursing home was sought by the facility. He went to a community nursing home with his uncle twice for visits. The first visit went fairly well, but after the second visit he was afraid and hesitant about moving. He had anxiety issues such as pulling out his fingernails following the visit. At that time, his Uncle preferred for him to stay at Chester due to his extreme anxiety over moving. The therapist tried talk therapy about being afraid of the nursing home and he "nitpicked" small things such as the toilet seats and remained fixated on those things so the therapy was unsuccessful. He was placed on mood and anxiety medications to help address those issues. In order to help facilitate a transfer, the treatment team had recently moved him to the medium security unit which would help with placement.

E. Recipient 3: The recipient was interviewed in August. It was a brief interview as the recipient was unable to communicate much. He mostly mimicked or repeated what the HRA said. When asked if he stayed on the unit; he nodded, yes. When asked where he eats, he said "cafeteria." When asked if he went outside every day, he replied "every day." When asked if he went to the gymnasium daily he nodded, yes.

F. Therapist Recipient 3: The therapist stated that she had been meeting with this recipient for over a year. She meets with him every other day. In the infirmary, the activity therapist would check with him to see if he wanted to go to the gym or yard activities when his behavior was okay. He chose to go once every few weeks, but less stimulation is better for him typically. When his behavior was bad he inflicted serious injury to others. The recipient hears voices and calls people demons and "goes after them." The facility had completed a Petition for Guardianship recently due to his lack of communication skills and his future needs. The therapist explained that he was placed in the infirmary initially due to a serious head injury he had received on the unit from a peer. He had severely regressed after that accident so he remained in the infirmary while trying to find placement in a nursing home. It had been difficult to find a nursing home willing to accept him because he was too violent. They did not move him to the unit for his own safety due to potential for harm from others because of his level of regression. They had previously tried moving him to a regular unit and that only lasted a day because at that point it was too much stimulation for him and was a new environment that he did not adjust to well. Approximately 3 months prior to our interview, the recipient had moved to a

regular unit due to the infirmary closing because of a staff shortage. He was doing well with the move and seemed to be happier although he would still bang on things and yell a lot but had not hurt anyone. Since moving to the regular unit he had attended gym and yard activities more frequently, but he tends to sit and watch more than participate in activities. He does not have the attention span to attend rehabilitation classes. His current barrier for transferring to a less secure facility is finding a placement that can meet his needs and is willing to accept him. The guardianship was still pending in their legal department as far as the therapist knew, but she stated there had not been a court date yet.

## II. Clinical Chart Review:

### A. Recipient 1:

The recipient was admitted 2/22/17. There was a letter in the chart from the guardian dated 2/28/17 which stated that the recipient had left her a message on 2/23/17 that he was transferred to Chester and the guardian stated she had been trying to reach him since that date with no success. The guardian left her contact information in the letter. Also on 2/28/17 the guardian's attorney sent a facsimile to Chester Mental Health notifying them that the guardian had been appointed as temporary guardian of the estate and person of the recipient on 2/27/17 and had attached a copy of the Letters of Office.

An Order for Physical Hold dated 6/26/17 at 4:17 p.m. stated that the recipient was "disruptive and refused redirection. Jumped face down on bed and struck chin on foot board. When pt [patient] sat up he attempted to hit staff was placed in PH [physical hold] continued to struggle, bleeding continuously, metal cuffs applied and pt placed in 5 point FLR [full leather restraints] due to thrashing on bed." It was noted that metal cuffs were applied from 4:20-4:25 p.m. The injury report dated 6/26/17 at 4:15 p.m. regarding this same incident stated that the recipient had a laceration to his chin with moderate bleeding which required sutures. The section entitled "what happened?" indicated that the recipient's response was "I hit my face."

90 Day Fitness Evaluation/Progress Report dated 7/26/17 reported a diagnosis of schizoaffective disorder, hypertension and hyperlipidemia. He was admitted as Unfit to Stand Trial (UST). The recipient was not compliant with psychotropic medications. It was documented that he had several recent acts of aggression toward staff resulting in emergency enforced medication and being placed in restraints. He was described as being "quite irritable" and having trouble controlling anger. His ability to rationalize and think clearly was limited at that point. It was reported to the court that the treatment team was of the opinion that he was still UST.

Infirmary Admission and Discharge Summary dated 5/17/17 stated that the recipient had a "syncopal [fainting] episode" with head trauma to the scalp. The injury report dated 5/17/17 documented a laceration to the back right head with moderate, active bleeding. It stated that the recipient fell in his room and struck his head on the toilet. Ice and pressure were applied and medical staff was notified. The physician's examination section documented that the recipient passed out while on the toilet and hit his head sustaining a 1 ½ cm laceration to the right occipital area. The recipient was described as dizzy and pale, alert but drowsy. His blood pressure was 74/52. An IV was started and emergency medical services were called.

Case Notes: A 4/6/17 Therapist note documented that the psychiatrist ordered a Clozaril "work up" and the guardian was notified and gave verbal consent; paperwork was sent to her for signature. It was noted that the psychiatrist also increased the Haldol but there was no documentation if the guardian consented to that. A 4/12/17 nursing note documented that the OIG reported the guardian called and filed a complaint because she visited the recipient on 4/9/17 and reported a bruise to his left eye. An injury report dated 4/12/17 documented that the recipient was examined by a nurse at 12:50 p.m. and no injury was noted upon assessment and documented "mother alleged there was a bruise around his left eye. None noted upon assessment today." The physician's examination comments noted that the recipient stated "I lay on that side" and that he denied any injury. No edema or bruising was noted to left orbital area. On 4/12/17 a nursing note documented an attempt to reach the guardian but no reason why was noted. 5/15/17 Nursing Notes indicated a new order received to titrate up Clozapine by 5 mg daily from 125mg BID to 175mg BID and then repeat lab work. 5/17/17 therapist restriction note documented that the recipient's restrictions were reviewed and continued for water restriction in his room for flooding. He was given off unit privileges back to allow him to go to the dining room. On 5/17/17 a nursing note documented an attempt to notify the guardian of a transfer to the hospital due to requiring stitches after "syncopal episode." The case note at 11:45 documented the recipient was on the toilet and "passed out" hitting his head and sustaining a 2-3 cm laceration. He was taken to the emergency department at 12:17 p.m. A nursing note on 5/17/17 at 1:50 p.m. documented that the nurse spoke with the guardian regarding the recipient's fall and injury. On 5/18/17 a nursing note documented that a new order was received to start Lisinopril (for high blood pressure); another note on 5/23/17 showed it as being discontinued. On 5/24/17 a restriction note from the therapist documented that the recipient's water restriction was reviewed and discontinued. It was also noted that his Clozaril dose of 50 mg BID (twice daily) was effective and he was doing well on that dose. It also documented that *"when medication was being changed and being increased [recipient] had an episode where he fell and hit his head on the toilet which required a visit to [community hospital] where he received 7 staples to his head."* If he continued to do well it was noted that the plan was to allow him to resume attending all activities again and he would be started in fitness education. On 6/26/17 a STA note documented that the recipient was asked to lie down to receive a PRN shot and the recipient *"jumped in the air and landed on the bed, busting his chin open on footboard."* It was also documented that after the nurse finished cleaning his chin and left the room the recipient "attempted to strike staff. Recipient was placed in a physical hold at 1617 and recipient became increasingly combative with staff. Recipient was then placed in metal cuffs at 1620. Recipient was then escorted to the restraint room where restraints were applied and metal cuffs were removed at 1625. A chest posey was utilized due to recipient thrashing on bed." On 6/27/17 a therapist note documented that the guardian had left a voice mail and the therapist attempted to return the call at 4:20 p.m. but was unable to reach the guardian and left a voice mail that she would try again the following day. On 6/28/17 it was documented that another phone call to the guardian was attempted with no answer and another message was left. On 7/7/17 a nursing note documented that the recipient's Clozaril had been increased and that he denied any complaints. There was no documentation in this note what dose it was increased to or if the guardian had given consent for the increase. On 8/2/17 a Therapist note documented that she left a message for the guardian on 8/1/17 to have her return a call to set up a time for the recipient's treatment plan on 8/2/17. The guardian returned the call at 8:40 a.m. and the treatment plan was scheduled

for 1:30 p.m. that day. On 8/2/17 a nursing note documented another order being received to increase Clozaril to 75 mg in the morning and 100 mg at hour of sleep and then to increase to 100 mg twice daily and repeat the Clozapine level test after 30 days. On 8/2/17, a therapist note detailed the treatment plan meeting that was held that day and noted that the guardian participated by telephone. The treatment team discussed the increase in Clozaril medication and the plan to increase it gradually over the following weeks. It was documented that the guardian disagreed with the slow titration and stated that previously he was on a much higher dose of 900 mg. The psychiatrist explained his reasoning for titrating slowly was due to him falling and hitting his head on the toilet when he was first started on Clozaril. The medication was started on 5/5/17 and the fall occurred on 5/17/17. The treatment team then discussed the injuries he recently had. The recipient stated when he hit his head on the toilet "it felt like I had a dose of heroin." When asked why he dove onto the bed hitting his chin on 6/27/17 the recipient stated it was because "I had been up all night the night before and I couldn't walk to my room the way I usually do." There was no mention of staff abuse at this treatment meeting. The discussion returned to medication and the recipient's inability to sleep well. Alternatives were discussed and the guardian requested to just increase the Clozaril rather than starting another medication for sleep since the Clozaril would help with sleep too. The psychiatrist agreed with the guardian's input and wrote an order to increase his Clozaril and not start a new medication. Another treatment meeting was held on 8/30/17. It was documented that the recipient refused to attend but his guardian participated by telephone. The guardian was still advocating for an increase in Clozaril due to continued maladaptive behaviors and the psychiatrist agreed to check his levels the following week to see if he could tolerate an increase.

Treatment Plan Reviews (TPR): The initial TPR dated 2/22/17 documented that the recipient was admitted as Unfit to Stand Trial and refused offers of medication to treat his mental illness and would not sign consent for them. The therapist and nurse were to each meet with him once weekly to educate him on his mental illness and need for medication. It was noted that the recipient had a guardian and listed her address and phone number in the TPR. An interim treatment meeting was held two days later due to him becoming physically aggressive towards staff requiring restraints. The treating psychiatrist was to be consulted too regarding emergency medication or a possible petition for court enforced medication. On 3/8/17 another interim treatment meeting was held due to the recipient hitting staff in the face with a closed fist. His medication was increased at that time "due to his instability. He was also counseled about his inappropriate behavior and the need to follow rules." Another interim meeting was held on 6/26/17 due to the recipient being upset that he was on red level and was not allowed to go to the courtyard. He escalated, refused medication and emergency medication was ordered. The recipient "dove onto his bed hitting chin on footboard, splitting his chin open." The HRA found no guardian signatures on any TPRs and no documentation that the guardian was invited to the treatment meetings with the exception of a notice of treatment panel meeting for medication review which documented that it was mailed to the guardian on 5/4/17 for a 5/18/17 meeting at 7:30 a.m. The signature pages for the regular 30 day TPRs beginning with the July TPR documented that the guardian participated by telephone, but still did not contain a guardian signature on the form. More details were provided in the TPR about the 6/26/17 incident that resulting in a chin injury. The guardian requested that the recipient be moved to a facility closer to family. The team explained that due to his recent aggressive behaviors, it was doubtful that another facility would accept him for transfer. She was also informed that even if a transfer was

possible it would disrupt his treatment and could possibly result in him having to be hospitalized for a longer period of time. The team assured the guardian that the recipient was improving on his current medication which was slowly being increased to a therapeutic level. It was noted that his last fitness test resulted in a score of 85% which was an increase from the previous 75%. Once stable, the treatment team would recommend that he be returned to court. The guardian expressed concern about the injuries the recipient had received since admission including staples to head, sutures to chin and a black eye. The 8/2/17 TPR documented that the guardian participated by telephone. The signature page included a signature from the recipient but not the guardian. However, there was a handwritten note on the signature page that the guardian participated by telephone.

Medication Information: A psychiatrist note dated 7/3/17 documented that the recipient's Haldol was being tapered down and the Clozapine was being tapered up. It was noted that he had still been in restraints "numerous times this reporting period prior to starting Clozapine." The recipient had reported being on 400 mg in the morning and 250 mg in the evening previously. When the Clozapine titration began, the recipient had a "decrease in mental status." Since starting with Clozapine there had been no restraints, however it was noted that he fell and hit his head, but the Psychiatrist documented that he was "currently on Clozapine 75mg BID [twice daily]…doing well on current Clozapine dose…medication compliant. Pt does remain paranoid. Reclusive." A 2/27/17 consent to medication form was signed by the recipient but not the guardian. A box was checked above the physician's signature line that stated *"The client was examined and has the current capacity to make informed decisions regarding treatment."* A 3/3/17 medication consent form contained the guardian's signature and above the patient signature line stated *"see other consent"* Two nurses signed as witnesses where the form indicated *"required for verbal consents only"* and no physician signature was on the form. The same box was checked stating the client was examined and had capacity to make informed decisions regarding treatment. The 4/4/17 medication consent form was signed by both the recipient and the guardian and a nurse and social worker signed the witness required for verbal consents only section and a physician signature was present. The box indicating the client has capacity to make informed decisions was also checked on this form. The HRA also reviewed medication orders dated 5/17/17 in which the psychiatrist ordered Clozaril to be held for a re-evaluation. This would have been after his fall which resulted in staples to the recipient's head. There was also an order to monitor blood pressure and an order for Lisinopril [blood pressure] on 5/19/17 to be held unless his Systolic blood pressure was 180/110 or higher. It was documented that this was a telephone order from a physician on 5/19/17 at 8:40 a.m. which was read back twice. There was no documentation in the chart as to why the monitoring and Lisinopril was ordered. The May 2017 Medication Administration Record (MAR) listed Lisinopril as starting on 5/20/17 but there were circles on 5/20, 5/21 and 5/22 indicating no medication was given and then it was discontinued. The June 2017 (MAR) listed Clozapine 25 mg daily and indicated administration twice daily through June 19th. Starting June 19th the dosage had increased to 62.5 mg in the morning and 50 mg given in the evening. Starting with the evening dose on June 26th the Clozapine had increased to 62.5 in the evening and 75 mg in the morning.

OIG (Office of the Inspector General) Report: The OIG report regarding an allegation of abuse involving the recipient's black eye was reviewed. The recipient reported to the OIG that he went into another individual's room and that is when he was punched in the eye and put into restraints.

There was no facility video recording available. The STA reported that while helping a trainee flush the recipient's toilet, the recipient attacked him. When staff intervened, the recipient chased them down the hallway and hit a staff in the head several times. Staff attempted to place him in a physical hold but he continued fighting. He ended up in a room on the unit where they all fell on the bed; after that the recipient was escorted to the restraint room. Both STAs denied abusing the recipient. Several staff gave consistent and corroborating statements that they witnessed no abuse of the recipient but stated that the recipient was observed attacking staff, therefore, he was placed in a physical hold and then into restraints. The nurse examining the recipient following the restraint episode documented no injuries or bruising. The OIG liaison took photographs of a bruise under the recipient's left eye as was alleged. However, the allegation was reported 10 days late by the recipient so it was hard to determine where it came from. There was another OIG complaint of neglect that was still under investigation at the time of this report.

**B. Recipient 2:**

Progress Notes: A psychiatrist note dated 4/26/17 listed the recipient's primary diagnosis as Schizophrenia, paranoid type; chronic: non-compliance with treatment; Obsessive-compulsive disorder with self-injurious behavior and property destruction. The secondary diagnosis was listed as personality disorder NOS (not otherwise specified) with obsessive-compulsive; passive aggressive and immature traits. The clinical course was listed as *"patient is being primed for potential residential care placement at this time. Relevant issues are being explored and addressed. This has included physical therapy consultation and patient has been quite cooperative thus far. A visit to the residential care facility is also being scheduled on 4/28/17 and he maintains his interest with this plan."* The recipient was on medication for anxiety, obsessive compulsive disorder, two medications for psychosis and aggression, a medication for mood instability and another for agitation. In May, 2017 the case notes indicated the recipient was on 1:1 observation for safety from 0700-1200 and frequent observation from 2300-0700 as well as 1:1 observation during meals and snacks due to increased risk for choking. It was also documented that he had not had any falls and was up in his chair more frequently and could transfer from his bed to the wheelchair. A 5/4/17 nursing note documented that the recipient reported *"being scared of the nursing home…It's different."* The recipient was counseled on how the feeling of being scared could be a good thing because it is excitement. A 5/7/17 note documented that "exercises are encouraged but the patient refuses." On 5/9/17 the recipient was agitated and was placed in restraints. On 5/10/17 a nursing note documented that the recipient "appeared in a somewhat down state. Remaining in room, only participating out in common area for dinner that required much prompting by staff. Recip. Is not as cooperative with staff." On 5/23/17 a nursing note documented that the recipient had episodes of agitation over the weekend and tried to hit staff (an STA and a nurse). He was noted to be uncooperative and unmotivated. On 6/23/17 a nursing note documented that the recipient was escorted to a community nursing home with his therapist and a STA. The therapist also noted that his uncle met them there and the recipient was receptive to discussion and the tour but showed some "labile mood" overall it was a good trip. On 6/24/17 at 0900 it was documented that the recipient was agitated, yelling and cursing at staff and tried to grab the nurse's glasses. He was offered and accepted Haldol for agitation. On 7/7/17 a therapist note documented that the recipient "continues to have conflicted feelings about going to a nursing home. His biggest complaint is being off 1:1. He states he's lonely. He is encouraged to be mobile and get out of his room and socialize with the other peers

and staff in day room. Yesterday when encouraged to get up and walk he reached for glasses the STA was wearing who was assisting him." On 7/24/17 the therapist note documented that the recipient had been off 1:1 for over a month. Overall he was adjusting and still complained that he wanted back on 1:1. When this occurred he was encouraged to sit in the day room to socialize with others. Attempts were still being made to transfer him to a nursing home and it was noted that "last week information packets had to be faxed again for review." The note also indicated he was met with on a regular basis, sometimes daily. On 8/9/17 at 0218 a nursing note documented that the recipient was on his bed picking at his feet when the STA was making rounds and it was discovered that he had picked all of his toenails off. It was cleaned and the bleeding was stopped and the recipient stated *"I'm sorry I want to be 1:1."* On 8/9/17 at 0750 the recipient had picked his finger nail off. He was treated and stated *"I'm sorry I won't do it again."* He was placed on 1:1 for self-injurious behavior monitoring and it was noted that his mood is depressed and he yelled at a physician while being reviewed and was described as being "unpredictable and needs monitoring." On 8/10/17 he was returned to frequent observation with his door open at night for monitoring of safety.

Treatment Plan Reviews (TPR): The original 72 hour TPR was dated 6/17/88. It documented a full scale IQ of 61 in 1976 and 82 in 1982. In 1988 his full scale IQ was noted to be 73. He was transferred to Chester; his "serious incidences of behavioral problems include self-mutilation, property destruction and injury to others" at a less secure state operated facility. It was noted at that time that he would be housed on a regular unit. The more recent TPRs included a history which indicated that the recipient signed his original voluntary application for admission on 6/6/14 and continued to remain on voluntary status by signing reaffirmations every 60 days. He was admitted to Chester Mental Health on 6/16/88 as a transfer from another state operated facility due to repeated acts of property destruction, self-mutilation and injury to others. His original admission to the other state operated facility was 2/17/88 which was his first admission (he was 21 years old). Developmental delays were noted at 18 months of age and behavioral problems began at age 5 when he had behaviors of pulling off people's eyeglasses and breaking them and destroying property at home as well as being assaultive to his mother, property, staff and residential placement. His uncle assumed care of him in March, 1987 when his mother and father were both deceased. He was admitted to a residential care facility in January, 1988 but became so unmanageable within the first week that he was taken to a psychiatric unit and transferred to a state operated facility where he remained until transferring to Chester due to assaultive and destructive behavior. The 4/8/15 Transfer Recommendation noted that he was "currently housed in the infirmary due to weakness and unsteady gait. He spends most of his day in bed and requires regular prompting to get up and walk around. [Recipient] did receive his Merry Walker this reporting period and attended a physical therapy appointment on 3/2 in order to learn how to use it properly." The 4/26/17 TPR listed in the extent to which benefitting from treatment section that he had been in restraints 9 times between August and October, 2016 for breaking a nurse's glasses, throwing a chair at staff and throwing liquid medication in the nurse's eyes. It was noted that he had been housed in the infirmary since 8/16/16. Criteria for separation was listed as exhibit an ability to inhibit significant impulses to engage in aggressive behaviors of violence for at least 3 months; a genuine desire for transfer; be cooperative in his adjustment as exhibited by statements, taking medications deemed as essential; participation in activities on/off the unit and making of reasonable plans. On 5/9/17 an interim treatment plan noted that he threw his bed alarm at staff and kept trying to grab glasses and hit at staff. When asked

during a follow up discussion if he wanted to go to the nursing home, he shook his head no and turned away and refused to discuss it further. The 5/24/17 TPR listed the same criteria for separation and it was noted that "he has made good improvement this month." The continuity of care section documented that once the recipient has met separation criteria, he would be transferred to a less-secure facility. He would require "intensive outpatient treatment in a group home or skilled nursing facility due to the amount of time he has spent in an institutional setting." The 5/24/17 psychiatrist progress note documented that the recipient's interest in nursing home placement "appears to wax and wane at this time. Staff continues to provide him reassurance and support, taking into consideration that allowing him time, will elicit a positive effect, towards encouraging him to embrace placement sooner or later." The 6/21/17 TPR documented in the discussion section that the recipient's TPR meeting was held in the infirmary where he was housed. He was encouraged to continue avoiding restraints and aggression. "Nursing home placement continues to be pursued & [the recipient] continues to be encouraged to be more independent." It was noted that his 1:1 had been "incrementally decreased." On 6/6/17 he was taken off 1:1 for gait/safety and was only on it for meals and snacks. However, he was still asking to be placed back on 1:1. It was noted in the 7/18/17 TPR that the recipient last visited the nursing home on 6/23/17. Nothing was mentioned in the TPR as to how that visit went. However, there was a restriction of rights dated 6/24/17 documenting that emergency medication was administered due to the recipient being "extremely agitated, cursing, yelling at staff. Threw wheelchair arm at STA then punched STA. [patient] was asked if he needed more medication, replied 'yes.'" The HRA also found 7 releases for community nursing homes in this recipient's chart.

**C. Recipient 3:**

Progress notes: Nursing notes for the month of June, 2017 while the recipient was housed in the infirmary documented several maladaptive behaviors which included pacing on the unit, intentionally urinating and defecating on the floors both in his room and in the hallways, yelling, banging on doors, crawling on the floors and coming out of his room naked. There were 20 documented instances from June 1st – 24th of him receiving PRN medication (as needed) for his maladaptive behaviors. There were also instances documented where the PRN medication was not effective in controlling his behaviors. It was also documented that he was on 1:1 supervision during meals for an increased risk of choking. In September, 2017 the recipient was moved to a regular unit once the infirmary closed. He was placed on 1:1 observation for his safety to be within eye sight of staff which was discontinued during sleeping hours. A 9/6/17 note documented that he had not had any incidents of injuries since returning to the unit and the treatment team agreed to discontinue 1:1 observation with the exception of 0700-1200 to assist with ADLs (activities of daily living) and during meals. Some maladaptive behaviors of yelling, slamming doors, getting in staff/peer personal space, becoming upset at redirection and attempting to pull the sink off the wall in his room. He had a total of 13 PRNs between 8/30/17 (when he moved from the infirmary to the regular unit) and October 30, 2017. On 10/2/17 it was documented that the recipient signed a voluntary reaffirmation for 60 days. The therapist also stated that the recipient "has shown good adjustment over the past month to Unit has not required restraints and his last FLR [full leather restraint] was 8/19/17. He requires redirection and assistance from staff for all of his ADLs. A report has been submitted recommending guardianship for him. He appears happy most the time and does a lot of mimicking of words and

behavior. Today in a joking manner he pushed table at a peer. He smiled and laughed when redirected. The peers on module have been very patient with him. He no longer is on special observation except the 1:1 for meals/snacks due to choking risk." A 10/27/17 therapist note documented that the recipient "continues to have no major behavioral issues on unit. He needs a lot of redirection and assistance from staff. His application requesting guardianship has been accepted by the Office of State Guardian and awaiting a court date." On 12/1/17 the recipient signed a 60-day voluntary reaffirmation to remain at Chester. The recipient "expressed that he likes it at CMHC and wants to stay here. Patient denied concerns and returned to watching television. Therapist will continue to meet for progress management."

Treatment Plan Reviews: The 8/15/17 TPR documented the reason for admission as "required restraints on several occasions due to aggression toward peers and staff. He also engaged in other aggressive acts such as throwing dinner trays and garbage cans, spitting and threatening others." The most recent admission to Chester was on 7/10/98. He also had a prior admission from 4/8/84 until 8/13/96 when he was transferred to a less secure state operated facility until being transferred back in 1998. It was noted that the treatment meeting was held in the infirmary where he was housed. The continuity of care section noted that the recipient would be transferred back to the less secure state operated facility once he has met criteria for separation. He would then require intensive outpatient treatment (supervised setting or skilled nursing facility) due to the amount of time he has spent in an institutional setting. The criteria for separation is listed as "must exhibit: an ability to inhibit any significant impulses to engage in aggressive behaviors of violence or sexually inappropriate behaviors for at least 3 months; a genuine desire for transfer; be cooperative in his adjustment as exhibited by his statements, the taking of any medications deemed as essential, the participation in activities on/off the unit, and the making of reasonable plans." The "Problem #1 psychosis with verbal/physical aggression and sexually inappropriate behavior" section listed the goal to be a decrease in symptoms of disorganized thinking, disorganized behavior, auditory hallucinations, impulsive aggression such as hitting, kicking and spitting at others, property destruction, poor boundaries, delusional thinking, pressured speech and mood swings. The plan of action is for him to "participate in 3 therapeutic activities per week to help build a foundation." The Activity Therapy staff will "encourage leisure activities and peer relations focusing on: concentrating on reality based activities, acknowledging and respecting the roles of others, sharing materials with others, planning and follow through, understanding and follow the rules of an activity, being patient while waiting for his turn, expressing frustration in socially adaptive ways, evaluating his performance in an objective manner." The Activity Therapist's comments stated that "being housed in the infirmary and staffing issues have limited his activity involvement. He attended <10% of activities offered with moderately interactions with others." The "Extent to which Benefitting from Treatment (Psychiatric and Medical)" section stated that the recipient "continues to benefit from the structured environment of Chester MHC where his aggression can be monitored and he is able to receive scheduled medications and PRN medication. He continues to have multiple physical and behavioral issues. He will remain in the Infirmary. His last episodes of restraints were 7/25/17, 5/13/17, 4/6/17, 12/29/16, 9/22/16, 8/11/16, 07/20/16 and 06/22/16." The 10/10/17 TPR listed the current barriers to transfer as "psychosis." The long term goal/discharge criteria was for him to "have a decrease in his symptoms of (Disorganized thinking; disorganized behavior; auditory hallucinations; impulsive aggression such as hitting, kicking and spitting at others; property destruction; poor boundaries; delusional thinking;

pressured speech and mood swings.) He will also demonstrate the ability to control impulses of violence towards others. [Recipient] will not exhibit sexually inappropriate behavior." The 11/7/17 TPR listed the current barriers to transfer as "patient is a danger to others and psychosis." The 12/5/17 TPR listed the current barriers to transfer as "patient is a danger to others and psychosis."

## Facility Policies

RI.01.01.02.01 Patient Rights policy states *"A patient shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual treatment plan."*

CC.01.02.00.02 Transfer Recommendation of Behavior Management Patients policy ensures that "*All transfers of behavior management recipients from the Chester Mental Health Center are effected in accordance with the Mental Health and Developmental Disabilities Code which mandates that treatment occur in the least restrictive alternative appropriate to that recipient. The recipient's treatment team must evaluate on an ongoing basis the recipient's continuing need for a maximum security environment. At such time the treatment team determines the recipient is clinically suitable for transfer to a less secure facility…the psychiatrist is to prepare a transfer recommendation."* The remainder of the policy outlines the specific steps to be followed when transferring a patient to a less secure environment.

IM 03.01.01.03 Treatment Plan: This policy outlines the treatment planning process and responsibilities and states this about treatment plan reviews: *"It is the responsibility of all disciplines to participate in the development of a multidisciplinary treatment plan. It is the responsibility of the primary therapist to serve as the coordinator of the treatment plan, ensuring the following:*

*A. Treatment plan meetings happen within all the required time frames.*

*B. All discipline input is gathered and utilized for treatment plan reviews.*

*C. The plan is comprehensive and individualized based upon the assessment of the individual's clinical needs, strengths and limitations and is written in behaviorally defined and measurable terms.*

*D. The treatment plan reflects current treatment…*

H. *If the patient has a guardian, the therapist will notify the guardian of all scheduled meetings and this will be documented in a progress note, and a copy of the treatment plan will be mailed to the guardian."*

DHS Directive 01.02.03.170 Reporting Misconduct states "*Employees shall report all incidents of suspected abuse, injury, neglect, or death that occur with regard to an individual with mental or physical disabilities within a State-Operated facility and/or a facility licensed, funded or certified by DHS to the DHS Office of Inspector General (DHS OIG)…A report to DHS OIG shall be made to the DHS OIG Hotline no later than four (4) hours after the initial discovery of the incident of alleged abuse or neglect which occurs within a State-Operated or funded facility or community agency… Whistle Blower Protection No employee shall retaliate against, punish or penalize any person for doing any of the following:*

*A. Disclosing, or threatening to disclose, to a supervisor or public body any practice or action that the State employee reasonably believes is in violation of the law;*
*B. Providing information to, or testifying before, any public body conducting an investigation or inquiry into any violation of the law by any officer, member of the General Assembly, State employee, or State agency;*
*C. Assisting or participating in a proceeding to enforce the State Officials and Employees Ethics Act; or*
*D. Complaining to, cooperating with or assisting in an investigation.*

*II. Discipline*
*Any employee who:*
*A. Intentionally violates his or her responsibility to report misconduct;*
*B. Intentionally makes a false report alleging misconduct;*
*C. Fails to cooperate with the DHS OIG and/or the OIEG; or*
*D. Intentionally violates the provisions protecting whistle blowers set out in Section IV. above, may be subject to disciplinary action up to and including discharge, and/or may be subject to criminal charges, where so provided by statute."*

Statutes

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) states *"A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan…"*

The Code (405 ILCS 5/2-112) provides that *"Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect"*

The Code (405 ILCS 5/3-209) requires that *"Within three days of admission under this Chapter, a treatment plan shall be prepared for each recipient of service and entered into his or her record. The plan shall include an assessment of the recipient's treatment needs, a description of the services recommended for treatment, the goals of each type of element of service, an anticipated timetable for the accomplishment of the goals, and a designation of the qualified professional responsible for the implementation of the plan. The plan shall include a written assessment of whether or not the recipient is in need of psychotropic medications. The plan shall be reviewed and updated as the clinical condition warrants, but not less than every 30 days."*

With regard to transfers between state-operated facilities, the Code (405 ILCS 5/3-908) states *"The facility director of any Department facility may transfer a recipient to another Department*

*facility if he determines the transfer to be clinically advisable and consistent with the treatment needs of the recipient."*

The Illinois Administrative Code (59 IL ADC 50.20) says this about reporting allegations of abuse: *"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;*
*C) Any allegation of financial exploitation by an employee, community agency or facility; and*
*D) Any injury or death of an individual that occurs within a facility or community agency program when abuse or neglect may be suspected.*
*E) At a minimum, required reporters to the OIG hotline shall provide details concerning:*
*i) Information about the victim, including name, date of birth, sex, disability, identification number and/or social security number (if known);*
*ii) Information about the incident, including what happened, when it happened, where it happened, how it happened and the identification of all witnesses;*
*iii) Information about the accused employee (if known), including name, contact information and if the accused employee/facility/agency is presently working with or will be working with the victim; and*
*iv) Information about the person initiating the complaint, including name, contact information, relationship to the victim and the need for anonymity (if applicable)…*
*Notifications*
*A) Within 3 days after receipt of an allegation, OIG shall notify the authorized representative of the community agency or facility or his or her designee that an allegation has been received unless such notification compromises the integrity of the investigation, such as, an allegation involving the authorized representative or his or her designee.*
*B) Within 24 hours after notification of an allegation, the authorized representative of the community agency or facility shall notify the victim or guardian (if applicable) and the accused employee that an allegation has been received. If the authorized representative or designee is unable to reach the guardian by phone, a letter of notification shall be sent within 24 hours.*
*C) Immediately, but no later than within 3 days after receipt of an allegation, OIG shall also contact the complainant regarding the allegation."*

The Administrative Code (59 IL ADC 50.30) states that *"a) Availability of OIG: OIG shall be available 24 hours a day to assess reports of allegations of abuse, neglect financial exploitation or death and provide any technical assistance with making the report. b) Responsibility of OIG for receiving the report: OIG staff receiving the report of the allegation are responsible for assessing, based on the information received at intake, whether the allegation could constitute abuse, neglect, or financial exploitation and whether OIG has the authority to investigate in accordance with the Act. OIG shall make these assessments within one day after receiving the call…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."*

## Conclusion

The allegations involving recipient 1 were that the facility is not communicating with his guardian and the internal OIG investigative process is inadequate. For recipients 2 and 3, the allegations were that they were not being served in the least restrictive environment and were not receiving programming.

When reviewing the chart information for recipient 1, the HRA found that the facility was notified 6 days after admission that the recipient had a guardian. Documentation in April indicated the guardian was contacted for consent for lab work and other communications, but Chester failed to notify her of treatment meetings or attempt to include her in those meetings. The treatment plans prior to July 2017 did not mention a guardian's participation or contain a signature from the guardian, only the recipient. July and later TPRs noted that the guardian participated by telephone, but did not contain a guardian's signature indicating agreement with the treatment plan and there was no documentation that the treatment plans were sent to the guardian. Also, there was no documentation that guardian consent was always secured for medication increases, some medication forms listed the recipient as having capacity when a guardian was involved and at least one form had no physician signature. Therefore, this allegation is **substantiated.** The HRA **recommends** the following:

**1. Staff should be trained on the Mental Health Code requirements as well as the facility policy (IM 03.01.01.03 Treatment Plan) for communication with guardians regarding treatment meetings, medication consents and restriction notices as well as documentation of this communication. The therapist and unit director should ensure that adequate notice is being provided to guardians to allow him/her the opportunity to participate either by telephone or in person.**

In regard to the allegation of an inadequate OIG investigative process, the recipient had an incident which required staples to his head and there was another allegation that he had a black eye from an unknown cause. The case notes documented that the recipient fainted and hit his head on the toilet on 5/17/17. The guardian reported that a staff person stated that he had been on blood pressure medication; however, the MAR showed no blood pressure medication at that time but was ordered 2 days later. According to the case notes, on 5/15/17 the recipient's Clozapine was being titrated up. The therapist noted that on 5/17/17 after Clozapine was being changed and being increased, the recipient had an episode where he fell and hit his head on the toilet which required a visit to hospital where he received 7 staples to his head. The infirmary note also stated that he fainted and hit his head. There was no OIG complaint found regarding the head injury and it was well documented that the recipient fainted which was the cause of the injury. Regarding the black eye, the recipient was unsure when the OIG came to speak with him regarding his black eye that occurred prior to 4/9/17 but he thought it was within a week of it being reported. The HRA found documentation of a restraint episode on March 30th but nothing again until mid-April after the black eye was reported to OIG following the guardian's 4/9/17 visit with the recipient. It is plausible that bruising could have occurred during the restraint episode, but the post episode debriefing did not note any injuries except a cut to his lip and there was no documented abuse allegation by the recipient following the restraint episode. The OIG report documented that the allegation was not reported to the OIG for 10 days. However, the

case notes indicated that OIG investigated the allegation on 4/12/17 and the nurse also assessed the recipient for a black eye on that same day. The recipient stated he had a black eye and commented that it must have been from the mats as he sleeps on that side. The final incident reported to the HRA occurred on 6/26/17 that required stitches to his chin. The case notes documented that he threw himself on his bed during a maladaptive behavior which led to restraints. The recipient reported no abuse at the time of injury report, just that he "hit his chin." The OIG complaint was still under investigation at the time of this report therefore no OIG report was available for review. Since there was documentation of an investigation being completed for the chin injury and regarding the black eye, the OIG investigated soon after it was reported and no bruising was found, this allegation is **unsubstantiated.** The HRA offers the following suggestion:

1. The HRA was concerned that the guardian noticed bruising and the recipient admitting that he had bruising however, there was no documentation in the chart prior to the OIG investigation of any bruising. The HRA suggests that staff be reminded to document any injuries discovered on an injury report form and in case notes.

The allegations involving recipients 2 and 3 were that they were not being served in the least restrictive environment and that they had inadequate programming. It was reported that both recipients resided in the infirmary for approximately 10 years and spent their days watching television. According to the therapist, staff offered activities to recipient 2 but he would refuse to participate. The therapist also stated that the recipient had been moved back and forth from the infirmary and the regular units but the moves did not last long due to the recipient's maladaptive behaviors on the unit such as breaking telephones, frequently falling and refusing to walk which required him to use a wheelchair. Wheelchairs cannot be on the regular units for safety reasons, therefore the recipient was moved back to the infirmary. Medical reasons for the falls were ruled out but the recipient continually refused to walk so he was unable to return to the regular units. The facility also offered physical therapy to help him gain his strength back and to help facilitate independent mobility again. The facility had taken him twice to visit a nursing home. The first visit went well but the second resulted in extreme anxiety and self-injurious behaviors including removing his fingernails. The recipient's uncle requested that he remain at Chester at that time due to the extreme anxiety the potential move was causing him. The therapist gave examples of how she was using talk therapy to address his anxiety over moving to a less secure facility. His medications were adjusted and he was moved to the medium security unit to help facilitate a transfer to a less secure facility. The recipient's barrier to transfer was his anxiety and resulting maladaptive aggressive behaviors occurring as recently as July 2017 which were the final case notes reviewed by the HRA. These barriers were being addressed in treatment planning and talk therapy. His lack of programming was a personal choice and not due to staff not offering activities. Therefore, this portion of the allegation is **unsubstantiated.** The HRA makes the following suggestion:

1. The therapist discussed the recipient's maladaptive behaviors of refusing to walk, falling and SIB which seemed to be manipulative in nature. It was also documented in the chart that this recipient requested a 1:1 staff after his was removed because he felt lonely. A behavior intervention plan should be developed to determine the most appropriate way to address his

maladaptive behaviors to help facilitate a transfer to a less secure facility. Utilizing a behavior analyst should be considered.

Recipient 3 did not communicate well and mostly just repeated what the HRA said when he was questioned. His therapist was also interviewed and she explained that he is asked to attend activities and sometimes he will participate and other times he does not. Less stimulation is typically better for his maladaptive behaviors, when overstimulated he would inflict "serious injury" on others. He was first placed in the infirmary due to a serious head injury he received from a peer on the regular unit. Due to his regression following the head injury, the facility had tried to place him in a nursing home but it had been difficult to find one willing to accept him because he was too violent. At the time of this report guardianship was being pursued for this recipient to assist him with decisions and future needs. The recipient had recently been moved to a regular unit when the infirmary closed and was doing well at the time of the HRA interview. His therapist stated that he was attending more off unit activities although he observed more than he participated. The recipient had required less PRN medication since moving from the infirmary to the regular unit going from 20 per month in the infirmary to 13 over two months on the regular unit. According to the therapist, the recipient's barriers to transfer are his aggressive behaviors which make him a danger to others and difficult to place in a less secure facility. The separation criteria in his TPR is listed as *"must exhibit: an ability to inhibit any significant impulses to engage in aggressive behaviors of violence or sexually inappropriate behaviors for at least 3 months; a genuine desire for transfer; be cooperative in his adjustment as exhibited by his statements, the taking of any medications deemed as essential, the participation in activities on/off the unit, and the making of reasonable plans."* The HRA found no documentation of sexually inappropriate behaviors; the recipient did not communicate if he had a desire for transfer, although it was documented that he had done well and had shown "good adjustment" since being transferred to the regular unit from the infirmary on 8/30/17; and, his PRN medication had decreased since the move. The therapist also stated he was attending more activities but observed more than he participated. The only criterion that has possibly not been met is the aggressive behaviors. According to the December TPR, the recipient had 4 episodes of restraint use for the year 2017. The TPR stated that he must have no more than 3 episodes of aggression and less than 10 PRNs in a month. The recipient had met the PRN criteria since moving to the regular unit. However, there was still documentation of the recipient yelling and/or slamming doors; this occurred approximately 4 times in October 2017 which were the last case notes reviewed by the HRA. There was no behavior intervention plan in place to address his aggressive behaviors. The treatment plan was to have the therapist meet with him to discuss instances of aggression towards others from the previous week as well as the difference between right and wrong. The STAs are to monitor the recipient for signs and symptoms of agitation before he becomes aggressive. STAs are to then notify nursing for a PRN to be given. The therapist was using talk therapy to address his aggressive behaviors and there was documentation that the facility was exploring other placements but was having difficulty due to the recipient's aggressiveness. This allegation is **unsubstantiated**. The HRA offers the following suggestion.

1. The treatment team should consider alternatives that might be helpful in addressing the recipient's aggressive behavior other than PRN medication and consider holding a utilization review.