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Egyptian Regional Human Rights Authority
Report of Findings
20-110-9001
Chester Mental Health Center
March 22, 2021

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.

Recipients were inappropriately discharged.
The facility failed to communicate with guardians.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2 et al.) and facility policies. Chester Mental Health Center is a state-operated mental health facility serving approximately 280 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 staff, reviewed records and examined pertinent policies and mandates.

Complaint Statement

The complaint alleges that one recipient was denied re-admission to the facility due to a feeding tube being placed during a hospital stay, a second recipient was discharged into a nursing home with several Illinois Department of Public Health (IDPH) violations without guardian involvement and a third was transferred to another state operated mental health facility without guardian involvement.

I. Clinical Chart Review:

Recipient 1: The Office of State Guardian (OSG) was appointed temporary guardian of the recipient in 2019 as there was no known family members to provide care and per the Order appointing a temporary guardian of the person, *"medical conditions and ability to manage the care of his person are quickly declining. Respondent needs immediate help to make decisions regarding his psychiatric and medical treatment that serves his best interest."* Case notes indicated the recipient was transferred to a local hospital in late March 2019 for difficulty swallowing and choking following surgery two days prior for a fractured neck. He was transferred the following day to a larger hospital where an NG [nasogastric feeding] tube was placed. A case note on 4/15/19 indicated that the recipient was doing well, but the NG tube remained. The facility spoke with the hospital discharge planner and discussed long term skilled care facility options. A more permanent feeding/medication administration tube [PEG Tube] was

placed on 4/23/19. A state guardian was appointed shortly thereafter. There were ongoing discussions between the hospital and facility regarding the recipient's status and placement throughout the month of May. On 5/22/19 a progress note documented a telephone conference with the hospital, state guardian and treatment team to discuss long-term treatment options and the medical care he would require. A case note dated 5/26/19 documented the plan was to discharge the recipient the following week to a nursing home. The recipient was transferred on 5/29/19 to a long-term skilled nursing facility.

The 4/23/19 Treatment Plan Review (TPR) documented the above medical chronology and that the recipient would need 1:1 Nursing Care 24 hours a day. He would also need physical and speech therapy. It was documented that the facility was in the process of obtaining an emergency state guardian to assist with placement and that multiple referrals had been sent out to nursing home facilities that could meet his needs. A guardian had not yet been appointed, therefore there was no guardian involved in this TPR. The treatment team agreed that Chester Mental Health Center was "not an appropriate placement for him due to medical injury he sustained when he slipped and injured neck requiring surgery." The discharge plan documented the team exploring placement in a skilled nursing facility *"until his medical condition has stabilized."* The need for mental health services section documented that the treatment team's opinion was that the recipient needed inpatient treatment in the Department of Human Services and remained subject to involuntary admission *"due to his impaired impulse control and inability to care for his own basic needs. At this time, [recipient's] medical condition is becoming the overarching clinical issue, he continues to meet criteria for involuntary commitment to DHS, not only for behavioral issues, but largely due to his physical/medical decline and his inability to care for himself."*

<u>Recipient 2:</u> A utilization review dated 8/3/17 documented that the recipient *"continues to present as a significant behavior problem. He frequently requires restraints due to aggressive and unpredictable behaviors. He is difficult to redirect and has limited comprehension, is incoherent and impulsive...stays up the majority of the night yelling and kicking his door, goes into peers' rooms and takes their property, attacks staff spontaneously, throws urine soaked objects at peers, floods his room and engages in property destruction."* A Clinical Neuropsychologist was contacted to conduct a special review. The recommendation was that when the recipient is ready for transfer/discharge, that he be placed in a nursing home with a locked dementia unit for violent patients with co-morbid diagnosis. At that time the recipient was on 1:1 observation due to high fall risk and deep vein thrombosis (DVT). A TPR dated 9/25/18 documented that the recipient was *"unable to engage in any discussion regarding his treatment and has not been since this writer took his case over on 8/8/18. He does not appear to comprehend much of what staff or this writer says to him. He lacks the ability to care for his day to day basic needs without significant assistance. There has been no change in his mental status since being placed on this writer's caseload."* An interim treatment plan dated 10/11/18 documented that the nursing home had agreed to admit the recipient *"when his Thiem Date expires after November 16th 2018."* A Social Worker note dated 10/9/18 documented that the treatment team met with the recipient and a nursing home to determine if the recipient would be a good candidate. The treatment team believed he would be better served at a nursing home due to his *"multiple medical conditions that will only worsen with time, not get better."* The nursing home staff agreed to place the recipient after a state appointed guardian is in place. Another

utilization review dated 11/15/18 documented that the treatment team was working with a nursing home for placement of the recipient. He had been interviewed, assessed and accepted for placement. The treatment team was awaiting state guardian appointment, so he could be "transported immediately." It was noted that he was doing well on his current medication regime and had not been aggressive or restrained since transferring to the unit a year prior. The OSG was appointed temporary guardian of the person for this recipient in late 2018 based on an emergency petition that was filed. The Court found that he *"was a person in immediate need of guardianship and assistance in making and communicating responsible decisions concerning the care of his person to avoid further deterioration of his body."* The social worker's transfer note dated 12/5/18 at 2:08 pm documented that the social worker spoke to the nursing home supervisor *"to provide continuity of care and discharge planning."* All medical and psychological information was provided to the nursing home supervisor at that time and his Veteran's Administration Hospital paperwork was also transported with the recipient. There was no documentation that the newly appointed state guardian was contacted prior to transporting the recipient to the nursing home.

<u>Recipient 3:</u> The recipient was admitted in December 2016 from another state operated facility as an emergency admission. There were several case notes in 2019 documenting the recipient's falls and that his OSG guardian was notified by leaving voice mail messages. The recipient was examined by a physician in early April for frequent falls, the guardian was notified of the plan of care and new orders. A nursing note dated 5/20/19 documented new orders for a change in psychotropic medication and to discontinue another. There were no case notes reflecting that the guardian was consulted or notified of the change or gave consent for the medication change. A social worker note on 5/22/19 documented that the recipient signed his 60-day voluntary admission paperwork *"acknowledging understanding of his legal rights."* There was no documentation that the guardian was involved in this decision. A therapist "late entry" note dated 6/21/19 documented that the therapist met with the recipient to discuss transfer and discharge summary. The recipient *"verbalized readiness to leave and go to a nursing home. Patient was encouraged to take his medication, listen to staff and use his coping skills. [recipient] acknowledged understanding…Due to patient's cognitive deficits extent of awareness is unknown."*

The 5/21/19 TPR stated that once criteria for transfer has been met, the recipient would transfer to a less secure facility or long-term care residential unit. It was noted that a specific plan for aftercare would be developed at that time. The discharge plan section stated that the recipient is unable to live on his own or care for himself and that he would need to be housed in a nursing home with placement assistance. Guardian participation in the TPR meeting was not documented and there was no guardian's signature present on the signature page. The 6/18/19 TPR documented that the recipient had been recommended for transfer to a less-secure facility. However, the discharge plan stated he would need to be housed in a nursing home with placement assistance. There was no documentation that the guardian participated or provided feedback for this meeting and no guardian signature on any documentation; the recipient did sign the form. On 6/24/19 the recipient was transferred to the state operated facility that he was initially transferred to Chester from. The discharge summary documented that notification of discharge/transfer was given to the recipient but the box next to guardian notification was not checked. The comprehensive summary section stated that the recipient had an OSG Guardian.

This section also documented previous placements in both nursing homes and state operated facilities.

The guardian denied receiving notification from Chester when the recipient was transferred to the less secure state operated facility and stated that the receiving facility provided notification to him after the transfer had been completed. The recipient was transferred approximately 6 weeks later from the less secure facility to a nursing home in the community.

Facility Policies

Facility policy IM .03.01.01.03 Treatment Plan states that monthly treatment plan *"is to be completed…a minimum of every 30 days beginning at the 21-day review and filed in the chart within 7 working days. A copy of the Treatment Plan/Review Attendance Record (CMHC-811f) is placed in the medical record as verification of the meeting and a placeholder until the final plan is entered into the record... Change of Condition: An Interim Treatment Plan Review… is to be completed whenever a patient experiences a change in condition that precludes participation in the previously prescribed treatment intervention or requires new interventions. Some (but not limited to) include: medical issues arise or decompensate, special observation, increase in examples aggressive behavior, assessment completed/received with additional problem areas, e.g. elopement. Section II will be completed when all members of the treatment team meet at the earliest opportunity. This will be reported to the Nurse Supervisor each shift and in the morning Clinical Meeting… 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.

E. The patient is given a daily schedule of assigned groups and activities based on the interventions assigned in the treatment plan.

F. A copy of the Treatment Plan/Review Attendance Record (CMHC-811f), for the treatment plan is placed in the record on the day the meeting.

G. Treatment Plan/Review plan documents are typed and filed in the chart within the required time frame.

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.

I. Individuals are encouraged to involve their family or support system to participate in treatment planning.

J. If a patient is transferred to another unit within the hospital, the treatment plan must be reviewed by the receiving treatment team and updated with current interventions, staff names, etc. within 72 hours of the transfer"

Facility Policy RI.01.02.01.01 Processing Guardianships states *"When it is determined by the treatment team that guardianship assistance is required, referral is sent to the Office of the Assistant Facility Director. The Assistant Facility Director shall coordinate the filing of all*

documents needed for guardianship appointments. Each guardianship appointment is reviewed annually by the treatment team to assess the need for continuation or modification."

A policy was obtained from another state operated mental health facility regarding triaging potential admissions due to medical condition (AID.060). This policy includes directives from the Illinois Department of Mental Health (DMH) *"It is the policy of [facility] to treat patients who meet eligibility requirements specifically for psychiatric needs. Patients suffering from complicated physical and/or medical conditions must be identified in order to find proper placement elsewhere…The below list includes relative contraindications for admission to a DMH Hospital. Exceptions may be made based on specific clinical circumstances. Final decisions for admission are made by the DMH Hospital's Medical Director or designee after close case review and consultation with the referring physician."* This list of contraindications for admission includes Feeding tubes or N/G tubes.

Statutes

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-100) states that *"No recipient of services shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the receipt of such services. A person with a known or suspected mental illness or developmental disability shall not be denied mental health or developmental services because of age, sex, race, religious belief, ethnic origin, marital status, physical or mental disability or criminal record unrelated to present dangerousness."*

Section 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 physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment… If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2-107 or 2-107.1 or (ii) pursuant to a power of attorney for health care under the Powers of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act…If the recipient is under guardianship and the guardian is authorized to consent to the administration of electroconvulsive therapy or psychotropic medication pursuant to subsection (c) of Section 2-107.1 of this Code, the physician shall advise the guardian in writing of the side effects and risks of the treatment, alternatives to the proposed treatment, and the risks and benefits of the treatment."*

Section 3-400 states that *"Any person 16 or older, including a person adjudicated a person with a disability, may be admitted to a mental health facility as a voluntary recipient for treatment of a mental illness upon the filing of an application with the facility director of the facility if the facility director determines and documents in the recipient's medical record that the person (1) is clinically suitable for admission as a voluntary recipient and (2) has the capacity to consent to voluntary admission. For purposes of consenting to voluntary admission, a person has the capacity to consent to voluntary admission if, in the professional judgment of the facility director or his or her designee, the person is able to understand that:*

(1) He or she is being admitted to a mental health facility.

(2) He or she may request discharge at any time. The request must be in writing, and discharge is not automatic.

(3) Within 5 business days after receipt of the written request for discharge, the facility must either discharge the person or initiate commitment proceedings."

Section 3-902 provides that *"The facility director may at any time discharge an informal, voluntary, or minor recipient who is clinically suitable for discharge…When the facility director determines that discharge is appropriate for a recipient pursuant to this Section or Section 3-403 he or she shall notify the state's attorney of the county in which the recipient resided immediately prior to his admission to a mental health facility and the state's attorney of the county where the last petition for commitment was filed at least 48 hours prior to the discharge when either state's attorney has requested in writing such notification on that individual recipient or when the facility director regards a recipient as a continuing threat to the peace and safety of the community. Upon receipt of such notice, the state's attorney may take any court action or notify such peace officers that he deems appropriate. When the facility director determines that discharge is appropriate for a recipient pursuant to this Section or Section 3-403, he or she shall notify the person whose petition pursuant to Section 3-701 resulted in the current hospitalization of the recipient's discharge at least 48 hours prior to the discharge, if the petitioner has requested in writing such notification on that individual recipient."*

The Illinois Administrative Code (59 IL ADC 125.10) states the following in regard to DHS discharge/linkage/aftercare for recipients *"The intent of this Part is to define and describe the role of the Department of Human Services once the decision has been made by direct service personnel that a recipient is a candidate for discharge from a State-operated facility. A person shall not remain in a State-operated facility after it has been clinically and professionally determined that therapeutic services as defined within the Mental Health and Developmental Disabilities Code [405 ILCS 5] are no longer needed by the recipient. Adequate discharge planning, linkage and aftercare within an appropriate setting with individualized follow-up services will be provided for each recipient. Recipients will not be discharged from State-operated facilities without assurance that linkage will occur, unless the recipient refuses individualized follow-up services."*

Section 125.90 states that *"a) A recipient age 18 or over is presumed legally competent. A recipient is considered incompetent upon the filing of a petition with the court where the court adjudges a recipient to be a disabled person. At the time of the hearing a guardian may be appointed. (See Sections 11a-2 and 11a-3 of the Probate Act of 1975 [755 ILCS 5/11a-2 and 11a-3]) b) Guardianship is ordered only to the extent necessitated by the recipient's actual mental, physical and adaptive limitations. c) A guardian may be appointed for a recipient, if, because of disability, there is a lack of sufficient understanding or capacity to make or communicate responsible decisions concerning personal care. A guardian may be appointed for the estate of a disabled recipient, if, because of disability, the recipient is unable to manage an estate or financial affairs."*

The Probate Act (755 ILCS 5/11a-3) states this about the power to appoint a guardian*" (a) Upon the filing of a petition by a reputable person or by the alleged person with a disability himself or on its own motion, the court may adjudge a person to be a person with a disability, but only if it has been demonstrated by clear and convincing evidence that the person is a person with a disability as defined in Section 11a-2. If the court adjudges a person to be a person with a disability, the court may appoint (1) a guardian of his person, if it has been demonstrated by clear and convincing evidence that because of his disability he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning the care of his person, or (2) a guardian of his estate, if it has been demonstrated by clear and convincing evidence that*

because of his disability he is unable to manage his estate or financial affairs, or (3) a guardian of his person and of his estate.
(b) Guardianship shall be utilized only as is necessary to promote the well-being of the person with a disability, to protect him from neglect, exploitation, or abuse, and to encourage development of his maximum self-reliance and independence. Guardianship shall be ordered only to the extent necessitated by the individual's actual mental, physical and adaptive limitations."
Section 5/11a-17 guarantees that *"(d) A guardian acting as a surrogate decision maker under the Health Care Surrogate Act shall have all the rights of a surrogate under that Act without court order including the right to make medical treatment decisions...*

Conclusion

The complaint alleged discharge and/or admission issues for three recipients. The allegation regarding the first recipient was that he was inappropriately denied re-admission to the facility due to a feeding tube being placed during a hospital stay. The HRA reviewed a DMH directive from another state operated mental health facility's policy which lists a feeding tube as a contraindication for admission to a state operated facility. A state guardian was appointed in the Spring of 2019. The progress notes documented that the social worker at Chester was working with the state appointed guardian and hospital social worker to provide the recipient with the long-term medical care he will require. The DMH policy listing feeding tubes as a contraindication to admission to a state operated mental health facility along with documented concerns in the TPR and case notes regarding the facility's ability to care for the recipient and his medical condition, which appeared to exceed mental health needs, provides sufficient rationale as to why alternative placement was sought for this recipient. Therefore, this allegation is **unsubstantiated.**

Recipient 2 was reportedly discharged into a nursing home without guardian involvement. The treatment team at the facility had determined that he would be better served at a nursing home due to his *"multiple medical conditions that will only worsen with time, not get better."* The facility had been in communication with a nursing home that was willing to accept the recipient once a legal guardian had been appointed. The facility petitioned for the Office of State Guardian (OSG) to be appointed as the recipient had no family able to act as his legal guardian. The Court appointed the OSG and records document that the recipient was transferred to the nursing home shortly after appointment. There was no documentation indicating that the newly appointed guardian was contacted or consulted regarding the most appropriate placement for the recipient. Rather, the recipient was simply transferred immediately to the nursing home, once a guardian was appointed. The Mental Health and Developmental Disabilities Code requires guardian involvement in treatment planning (405 ILCS 5/2-102). The facility policy (IM 03.01.01.03) also states that it is the responsibility of the therapist to notify the guardian of all scheduled meetings, document in a progress note and mail a copy of the treatment plan to the guardian and the Probate Act states that a guardian has the right to make medical decisions. This allegation is **substantiated.**

Recipient 3 was reportedly transferred to another state operated mental health facility without guardian involvement or notification. The case notes documented that the therapist met with the recipient to discuss transfer and discharge summary. It was also noted that the recipient verbalized understanding. The same note also acknowledged that "due to patient's cognitive deficits extent of awareness is unknown" The HRA found no documentation that the guardian was consulted regarding the voluntary reaffirmation. A nursing note documented new orders for

a change in psychotropic medication. There were no case notes reflecting that the guardian was consulted, notified or gave consent for the psychotropic medication change. The June TPR documented that the recipient had been recommended for transfer to a less-secure facility. However, the discharge plan stated he would need to be housed in a nursing home with placement assistance. There was no documentation that the guardian participated or provided feedback for this meeting and no guardian signature was present on the form. Finally, the discharge summary documented that notification of discharge/transfer was given to the recipient but the box next to guardian notification was not checked. Due to lack of documentation that the guardian was notified or involved in treatment plan meetings, the absence of a guardian's signature on the TPR, and lack of documentation that the guardian was consulted or notified of the recipient's transfer or psychotropic medication changes, the allegation of lack of guardian communication is **substantiated**.

The HRA makes the following **recommendations:**

1. **The therapists and treatment team staff should be retrained on the Mental Health Code requirements for guardian involvement in treatment planning (405 ILCS 5/2-102) including notification of treatment plan meetings to allow guardian participation and facility policy (IM 03.01.01.03). Provide the HRA with documentation of training completion.**

2. **The 9/25/18 TPR documented that recipient 2 was unable to care for his daily basic needs and was unable to engage in any discussion regarding his treatment. An interim treatment plan dated 10/11/18 also noted that his Thiem date was expiring 11/16/18. Since it was well documented that the recipient was unable to participate in treatment planning or care for his daily basic needs, treatment planning from admission should have included discussions of guardian appointment. At the very least, this should have occurred prior to his Thiem date expiration and discharge planning. The Mental Health Code requires a decisional capacity statement (405 ILCS 5/2-102) regarding treatment including psychotropic medications. If the recipient does not have capacity, the facility must consider other measures including the need for a surrogate decision maker before administering treatment (59 IL ADC 125.90). When it is suspected that a recipient lacks capacity to make informed decisions on his own behalf, the treatment team should petition the court for possible guardianship appointment as allowed in the Illinois Administrative Code (125.90) and the Probate Act (755 ILCS 5/11a-3).**

3. **Although recipient 3 had a court appointed guardian, the recipient signed his 60-day voluntary admission paperwork *"acknowledging understanding of his legal rights."* However, a therapist's note in the chart also documented on another issue that *"due to patient's cognitive deficits the extent of his awareness is unknown."* The Code requirements for an individual to sign for voluntary admission to a facility includes having the capacity to consent to the admission. Staff should be retrained on these requirements in the Code (405 ILCS 5/3-400) and should contact guardians when readmission paperwork is required. This also allows participation of the**

guardian in treatment planning, which includes placement decisions as also required by the Code (405 ILCS 5/2-102).

The HRA offers the following suggestion:

1. The HRA reviewed a DMH directive which lists a feeding tube as a contraindication for admission to a state operated facility. The HRA suggests that Chester review its admissions policy and consider revising it to include this and other possible contraindications for admission.