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Egyptian Regional Human Rights Authority
Report of Findings
20-110-9007
Chester Mental Health Center
May 28, 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:

1. **A recipient is receiving inadequate medical treatment.**
2. **A recipient experienced negative interactions with staff.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5 et al.) and facility policies. Chester Mental Health Center (Chester) 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 the recipient, reviewed the recipient's record, with consent, and examined pertinent policies and mandates.

I. Interviews:

A. Guardian: It was explained that the recipient was evaluated and found fit on 8/9/19 but, despite the psychiatrist's testimony, a judge still found the recipient unfit and ordered him to be admitted to Chester. A request was put in to have another psychiatrist evaluate him. The recipient was transferred in the meantime to Chester, and the second physician who evaluated the recipient also found him fit and indicated a report would be forthcoming. When the recipient arrived at Chester an issue arose because he was wearing a towel on his head due to severe burn scars. When asked to remove it, the recipient explained what it was for and an argument ensued with staff, but eventually the recipient complied with removing the towel. At that point, 5 STAs (Security Therapy Aides) were in his room and one staff reportedly grabbed the recipient from behind, choked him and threw him on the bed. The recipient was placed in restraints and realized he could not speak. He asked the nurse to press on his tracheal area, so he could speak, and swallow and the nurse reportedly said, "no that's not my job." The guardian was not contacted about the incident and learned of it when the recipient telephoned her. The Office of Inspector General was also contacted to investigate abuse/neglect allegations regarding this incident. During a visit with the recipient at Chester, the guardian noticed he could barely swallow the food she had brought him, and his bottom lip would shake. The recipient reported his neck was sore and it hurt when he swallowed. The recipient had 2 prior tracheotomies, so this was concerning to the guardian. She requested that the facility send him to a specialist to be

evaluated. She was told they would put in a request for the recipient to see the facility physician and he would have to make a referral to a specialist if necessary.

Another concern was that the recipient allegedly did not receive his seizure medication as prescribed while he was a patient at Chester. A nurse contacted the guardian requesting approval for a psychotropic medication increase, but the guardian refused to consent as he had been stable on his current regimen. The guardian was concerned about what medication the recipient was being given because a copy of a medication consent form was sent to her for signature and it was noted that verbal consent was obtained, but the guardian stated she did not give consent for the increase. She contacted the social worker and conveyed this to her. The second psychiatrist who evaluated the recipient also reported that he was fit to stand trial. The guardian had spoken to the forensic coordinator who stated once the order to be released was received, they would transport him back to jail to stand trial. The recipient was at Chester for approximately 2 weeks.

B. Recipient: The recipient reported that he is on Zyprexa, Dilantin, Depakote, Lamictal and Topamax. Since arriving at the facility, he has been given Zyprexa and Dilantin in the morning and then all 5 medications at night. His community physician prescribed him to have all 5 in the morning and all 5 in the evening, so he did not feel he was getting the appropriate amount of his medication. He had not had any seizures while at the facility. The recipient confirmed that staff choked him upon admission because he did not want to take off the towel he wore on his head. He tried to explain to staff why he wore it, but they would not listen and insisted he remove it, so he did as they asked but they reportedly choked him and put him in restraints anyway and stated to him "what you gotta say now?" At the time of our meeting, he had been found fit and was waiting for transport back to the jail.

II. Clinical Chart Review:

A. Treatment Plan Reviews (TPRs): The 72-hour TPR was reviewed since the recipient was transferred after approximately 2 weeks. The discussion section documented that he had signed a consent to take medication and also signed a release of information for the facility to communicate with his guardian, even though it was noted in the reason for admission section that he had a guardian. It was documented that the recipient was holding his throat and when asked if something was wrong, he reported that during the restraint episode the day prior, his neck was injured. He asked the psychiatrist a few questions regarding the timing of his seizure medication. It was noted that the psychiatrist "adjusted his medication." The TPR also documented that the recipient *"required FLR [full leather restraints] upon admission to the facility. Since that time, he has been compliant. He signed consent for medication and has been compliant with his medication thus far."*

B. Case Notes: The infirmary admission note stated at 11:25 a.m. the recipient was cooperative on admission. A nursing note at 1:25 p.m. stated that during the intake process, the recipient refused to take a towel off his head, became verbally aggressive, took a fighting stance and attempted to attack staff. The recipient was placed in a physical hold and continued to "violently fight and resist" and was placed in restraints. He was released 2 hours later. An hour later he met with his therapist and it was documented that he *"was cooperative and articulate"* during this meeting. A nursing note the following day, at 12:10 p.m., stated that the nursing staff was

advised of the abuse allegation per treatment team. An assessment and an injury report were completed, and the Office of Inspector General (OIG) was notified. A new order for a soft diet was documented 10 minutes later. On 8/15/19 a nursing note documented a new order from the psychiatrist to increase Topamax to 200 mg twice daily, there is no reason documented. A nursing note on 8/17/19 stated that the recipient *"accused nurse of attempting to administer his meds incorrectly as he did not feel they were the correct meds or doses. He wanted his bedtime meds this am as he states this is what his physician ordered. Was threatening to call his mom on this writer and tell his mom he was being given the wrong medication. Nurse showed him the MAR [Medical Administration Record] with physician orders and took multiple attempts for him to take his medications."* Another nursing note later that day documented that the nurse spoke with the recipient's guardian who voiced concerns about the recipient's difficulty swallowing. The nurse observed him eat but noted no difficulty and documented that when the recipient *"noticed he was being watched [he] kept swallowing hard and pressing on old trach site."* The note continued to say that the guardian complained that his lower lip was quivering and stated that he was taking the wrong medicine and was over-sedated. The nurse noted that the recipient was *"alert visiting with visitors/eating."* The nurse documented that she gave the guardian the medication list and explained what each was for. The guardian was reassured that the recipient would be placed on the physician's line to re-evaluate difficulty in swallowing and her concerns about scarring from previous tracheotomies. A note on 8/18/19 documented the recipient ate pizza and pasta during his visit with guardian. He did not complain of neck pain or difficulty swallowing. The recipient spoke to the nurse again on 8/19/19 asking about his medication and was *"very concerned if nursing staff is keeping track of his medication…repeatedly asking what medication is ordered for am, after answering/telling him what medication is ordered for am x 3 he was agreeable to take am meds. Pt[patient] following module rules and staff direction for most part at this time."* The therapist also spoke with the guardian on this date and documented that the guardian felt the STA and accompanying nurse were "inappropriate and degrading." The therapist reported this to another staff (title not listed.) A therapist note on 8/19/19 also documented concern expressed by the guardian over the recipient's snacks and guardian was informed of the recipient remaining on the soft diet. The recipient was asked if he should remain on the soft diet and he stated he still needed it due to his difficulty swallowing. The guardian inquired about the Otolaryngologists (ENT) referral that was addressed with nursing staff on 8/11/19. The physician saw the recipient on 8/20/19 and placed a new order to discontinue the soft diet. On 8/22/19 a therapist note documented a conversation with the recipient's guardian regarding a medication increase, but the guardian was informed he is still on the same dose he was on 8/19/19 when they spoke. The recipient was discharged on 8/27/19.

C. Medication Orders: An order on 8/14/19 was for Olanzapine 15 mg at hour of sleep and Divalproex 1500 mg at hour of sleep. On 8/15/19 there was an order for Topamax two 100 mg pills twice daily. On 8/14/19 an order for Phenytoin 300 mg in the morning and 100 mg at hour of sleep. A medication verification/reconciliation dated 8/14/19 was also reviewed which showed some discrepancy to the orders. The Order for Divalproex shows 1000 mg which was marked over to indicate 1500 mg while the medication verification signed by the registered nurse and APN (Advanced Practice Nurse) showed 500 mg to be given twice daily. Also, the Order for Dilantin instructs 300 mg to be given in the morning and 100 mg to be given in the evening. However, the medication verification showed 200 mg to be given in the evening and 100 mg to be given in the morning.

The MAR documented 15 mg of Olanzapine being given daily at hour of sleep daily, Divalproex 1500 mg given at hour of sleep, Phenytoin 300 mg being given in the morning and 100 mg given at hour of sleep daily, Topamax 200 mg being given twice daily, morning and at hour of sleep. The discharge summary and medication reconciliation form for transfer both documented these medications and dosages at time of discharge/transfer.

There was a consent form for medication that was signed by the recipient for Olanzapine "up to 30 mg/day" and Divalproex "up to 4500 mg /day." On one side of the form there was a hand-written note that documented *"verbal consent obtained from [guardian] 1330 8/14/19."* Another note above the guardian signature line stated *"REFUSED TO SIGN."*

D. Outside records:

Jail medication records: The records from the jail prior to the recipient's admission to Chester documented that he was given Olanzapine 15 mg daily, Divalproex 1000 mg daily (500 mg in the morning and 500 mg in the evening), Phenytoin 300 mg daily (200 mg in the morning, 100 mg in the evening), Topamax 200 mg daily (100 mg in the morning, 100 mg in the evening), and Lamictal 400 mg daily (200 mg in the morning, and 200 mg in the evening)

A Neurologist note dated 9/3/19 discussed current treatment and plan for seizure control. It was documented that he was *"on Dilantin 100 mg TID [3 times/day] and was on a high dose during mental hospitalization and developed Dilantin toxicity with tremors and shakes in his hands and body. His Dilantin levels were 34.0 mcg on 8/28/19. Will repeat levels today."* The lab results showed that on 8/30/19 his Total Dilantin level was 34.6 mcg (high) and on 9/3/19 was 24.0 mcg (high). According to *Drugs.com*, therapeutic levels range from 10-20 mcg. 20-30 mcg results in mild toxicity-nystagmus (involuntary eye movement), mild ataxia (lack of muscle control i.e. difficulty with speech, eye movement and swallowing), 30-40 mcg results in moderate toxicity-ataxia being prominent and levels greater than 40 mcg results in severe toxicity-ataxia, consciousness, and encephalopathy (damage or disease that affects the brain can cause altered mental state, confusion, muscle twitching, trouble swallowing, dementia, seizures etc.)

Primary Care Physician: The visit notes dated 8/30/19 stated that the recipient was seen for a sore throat after being choked. It was documented that he had been on a soft food diet due to trouble with swallowing and sore throat after being choked by a security guard. He exhibited neck tightness and soreness. The recipient stated there were claims of charging the guards made against him; he stated that was incorrect. He also exhibited mild dysphagia and requested to see an ENT and have a laryngoscopy.

Physical Therapy Notes: The recipient saw a physical therapist on 9/17/19. The notes documented that it was reported that the injury occurred while at Chester during the admission process when STAs "choked and body slammed" the recipient. It was reported that the recipient was experiencing neck pain, decreased range of motion and was placed on a soft food diet due to difficulty swallowing. The diagnosis was acute strain of neck muscle and trauma of soft tissue of neck. The treatment prescribed was twice a week for six weeks. Improvement was documented by an increased extension from 25 to 32; increased left arm rotation from 46 to 64

and increased right rotation from 36 to 65. The recipient reported feeling "looser" in his shoulders but still voiced some discomfort in his anterior neck at the conclusion of treatment.

Otolaryngologist (ENT) specialist: The recipient was seen by an ENT physician on 9/19/19 where he had a Laryngoscopy procedure because of the difficulty swallowing (dysphagia). A small healing hematoma was discovered in the left posterior vocal cord. *"Significant glottic erythema"* [significant redness in the larynx that consists of the vocal cords] was also discovered upon examination. A follow up appointment was recommended for four weeks later and they would consider conducting a swallow study at that time if problems persist.

Community Psychiatrist Notes: The visit notes from September 2019 were reviewed. The recipient saw the psychiatrist approximately 14 days after discharge from Chester. The notes documented that it was reported that the recipient *"reports that he was strangled by 1 of the security guards and they slammed him in to a bed and restrained him…when he was in the hospital he was perhaps toxic on Dilantin. Apparently had a pretty high level in which showing symptoms."* The psychiatrist increased Olanzapine to 20 mg and Depakote to 500 in the morning and 1000 in the evening and ordered a check on his levels following the increase.

Office of Inspector General Report: The OIG conducted an investigation on an allegation that 5 STAs grabbed the recipient by the neck and choked him. This incident occurred approximately an hour after he was admitted to the facility when staff asked him to remove a towel he had wrapped around his head. It was documented that the recipient was angry that they wanted his towel and "took a step toward staff" at which time the STA "grabbed him in a choke hold." He was then "thrown onto the bed" by the STA, placed in handcuffs and placed in restraints. The OIG report documented that other staff involved in the physical hold and restraint episode "provided a consistent and corroborated account indicating no abuse occurred." There was no video to review due to technical difficulties with the hard drive crashing. The Security Chief had reviewed the video prior to the crash and wrote a statement indicating no abuse was observed. A review of the injury report revealed that during a medical examination there was no redness or swelling noted to the recipient's neck, however he did report tenderness and pain so minor first aid was administered. The allegation was unsubstantiated.

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."*

EC.04.09.00.08 Code of Conduct policy states "*At Chester Mental Health Center (CMHC) we strive to promote the welfare of those with whom we have contact and to prevent mental or physical harm. All patients, employees and visitors shall be treated with dignity, respect and courtesy. The rights, views, and positions of all, will be respected regardless of their job title. This will be upheld via a code of conduct which is a set of rules which outline the responsibilities of / or proper practices for an individual or organization. Chester Mental Health Center has zero tolerance for workplace violence and intimidating and disruptive behaviors…*

Unacceptable Employee Conduct. Chester Mental Health Center has zero tolerance for intimidating and disruptive behavior, and behaviors that undermine the culture of safety. These behaviors include but are not limited to: On Duty Conduct-

- *Harassment (verbal or physical conduct that denigrates or shows hostility or aversion toward an individual) - this includes: epithets, slurs, teasing, ridicule, making someone the brunt of pranks or practical jokes, negative stereotyping, threatening, intimidating, bullying, or hostile acts, racial jokes, stalking, malicious or mischievous gossip, written or graphic material showing hostility or aversion toward a group or individual.*
- *Improper Language - this includes vulgar, profane or loud/disruptive language.*
- *Threats- this includes direct, indirect and/or conditional threats of bodily harm. They may be electronic, written or verbal.*
- *Physical aggression- this includes aggression toward patients, visitors, other staff and property.*
- *Unsafe work practices or behavior which may harm the staff member or others…"*

PE 01.01.01.01 Admission of New Patients policy states *"All new admissions are admitted through the Infirmary. Upon admission, a new patient will be:*

A. Uncuffed (if applicable)

B. Searched

C. Temporarily assigned to a room until the Infirmary nurses and Security Therapy Aides can initiate the admission process.

Any personal items brought with the patient will be secured by unit staff until the STA staff has an opportunity to examine and inventory the property…

All legal and clinical files brought with the patient will be placed in the file cabinet in the Infirmary conference room… Medical records staff will be responsible for removing the files from the Infirmary.

Patient will be asked to undress and shower…Privacy shall be provided to the patient…

The Admitting Nurse will…

E. Confiscate any medications and list type, number of pills or pertinent information and forward the medication to the pharmacy. After 4:30 p.m. or on weekends and holidays, the medication will be turned in to the nursing shift supervisor for storage in the Documed [sic] Cabinet…The patient is to have an Initial Psychiatric Examination within 24 hours of admission. The psychiatrist will be assigned on rotation by the supervising nurse of the shift. The psychiatrist will be informed by phone, in person, or by a note left on the I.D. badge in the control center.

A. The initial psychiatrist will also complete the Consent to Psychotropic Medication form IL 462-0014, Admission Suicide Assessment CMHC-745, Violence Risk Assessment Tool CMHC-747, the 3-Day Treatment Plan Worksheet CMHC-677, and the Medication Verification/Reconciliation CMHC-732."

TX 02.04.00.02 Use of Psychotropic Medication policy states *"The consent form shall be included in the admission packet and must be completed and signed by the treating psychiatrist and the patient after the initial assessment if medication is prescribed. Prior to prescribing psychotropic medication in non-emergency situations, the treating physician shall ascertain and document whether the individual is capable of giving informed consent. This documentation*

shall be included in the consent form as a statement regarding recipient's capacity to make a reasoned decision about the proposed treatment"

IM.03.01.01.03 Treatment Plan policy requires that the facility *"shall ensure that each individual is receiving active treatment to address problem areas which precipitated hospitalization. Treatment planning is an ongoing process in which problems, goals, objectives and interventions are identified and monitored. The multi-disciplinary treatment planning process is to be documented upon admission and throughout a patient's stay via assessments, treatment plan, treatment plan reviews, progress notes and other documentation…*
Treatment Plan Participation and Treatment Oversight:

Each person attending the treatment plan review will sign in with signature and title on the Treatment Plan/Review Attendance Record (CMHC-811f). Additionally, the Treating Psychiatrist will be listed as the person responsible for ensuring prescribed treatment is appropriate and occurs as specified. This will be validated by the Treating Psychiatrists signing the Treatment Plan. It is the responsibility of all disciplines to participate in the development of a multidisciplinary treatment plan..."

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… 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. A qualified professional shall be responsible for overseeing the implementation of such plan…"*

The Code (405 ILCS 5/2-112) guarantees freedom from abuse and neglect. "*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."

Conclusion

The first allegation was inadequate medical treatment due to the recipient's medication not being administered as prescribed. This was based on the dosage of medication and times of day that the medication was administered while the recipient was briefly at Chester. After reviewing jail medication logs and comparing them to the medication logs at Chester, it was discovered that the Olanzapine remained the same as did Topamax. However, Divalproex was increased by 500 mg at Chester and the dosage times were changed also. In jail, he was given 500 mg in the morning and 500 mg in the evening; At Chester, he was given 1500 mg at the hour of sleep. Phenytoin was also increased by 100 mg at Chester. In jail, the recipient received 200 mg in the morning and 100 mg in the evening. At Chester, he was given 300 mg in the morning and 100 in the evening. Finally, Lamictal was discontinued at Chester. In jail, the recipient was receiving 400 mg - 200 mg of Lamictal in the morning and 200 mg in the evening. These changes began on the date of admission. Also, the HRA found discrepancies between the nursing verification/reconciliation dated 8/14/19 and the Orders dated the same date. Although there were discrepancies found, the MAR showed that medication was given as prescribed on the Orders by the Chester physician, however there was no reason documented for why the medications were increased or why the time of day medications were given were adjusted from what he was taking upon admission. Also, the HRA found documentation from a community physician immediately following discharge showing that the recipient's labs showed Dilantin toxicity. Therefore, the allegation is **substantiated. The HRA makes the following recommendations:**

1. **To ensure adequate care and treatment as guaranteed by the Mental Health and Developmental Disabilities Code, the medical staff should be retrained on proper documentation of medication and documenting why changes or adjustments are made. Provide increased oversight to ensure the medication reconciliation form has accurate information and is consistent with orders.**

2. **Medical staff should ensure that labs are being drawn when medication changes are implemented to ensure no toxicity occurs and to help in determining when adjustments need to be made.**

3. **Even though the recipient had a guardian, he was given the consent for medication to sign. Staff should be retrained on the Mental Health and Developmental Disabilities Code requirements for guardian involvement and consent for psychotropic medications (405 ILCS 5/2-102).**

4. **Revise the policy *TX 02.04.00.02 Use of Psychotropic Medication* to include directives for when the patient has a guardian to give consent for psychotropic medications to ensure compliance with 405 ILCS 5/2-102.**

The second allegation was negative staff interactions based on a restraint episode that occurred during admission. The admissions policy states that personal property will be secured by unit staff until the STA staff have an opportunity to examine and inventory the property. The incoming recipient must also shower, so the request to take the towel from the recipient's head would have been a reasonable one and aligns with policy. There was documentation that the recipient was aggressive when asked to comply with this request, although the recipient denies this allegation. That incident resulted in a restraint episode during which the allegation of abuse by choking allegedly occurred. In the OIG report it was documented that the security camera footage was unable to be retrieved due to the hard drive crashing, but it was noted that the Security Chief had reviewed the video prior to the crash and wrote a statement indicating no abuse was observed. A nursing note the day after admission stated that the nursing staff was advised of the abuse allegation per the treatment team. An assessment and an injury report were completed, and OIG was notified. A new order for a soft diet was documented 10 minutes later due to difficulty swallowing. This was effective 8/15/19 and was discontinued on 8/21/19. The community psychiatrist that examined the recipient immediately upon discharge also documented reports of abuse. The neurologist who examined the recipient immediately following discharge, also documented that labs drawn just after discharge confirmed Dilantin toxicity at the moderate level which can result in severe toxicity-ataxia, consciousness, and encephalopathy (damage or disease that affects the brain can cause altered mental state, confusion, muscle twitching, trouble swallowing, dementia, seizures etc.). It is hard to determine from the record if the trouble swallowing was a result of abuse by choking, Dilantin toxicity or for some other reason. Therefore, this allegation is **unsubstantiated**. The HRA makes the following suggestions:

1. Case notes documented that the recipient was cooperative during the admission process, but a nursing note entered two hours later documented aggressive behavior during intake towards staff resulting in a restraint episode. The recipient's account of the admission process remained consistent even after discharge while the case notes seemed contradictory. If the recipient was indeed cooperative during the process, it is reasonable to assume that if staff had explained why the towel must be removed, the recipient may have been cooperative in complying with the request. The documentation for the remainer of his stay at Chester showed cooperative and non-aggressive behavior from the recipient. There was also a documented concern from the guardian about how she was treated by a therapist and STA during a visit. Staff should be retrained on the Code of Conduct policy and be reminded that all patients, employees and visitors should be treated with dignity, respect and courtesy especially during intake process when an individual might have trouble adjusting to new rules and a new environment.

2. A nursing note three days after admission documented that the *recipient "accused nurse of attempting to administer his meds incorrectly as he did not feel they were the correct meds or doses. He wanted his bedtime meds this am as he states this is what his physician ordered. Was threatening to call his mom on this writer and tell his mom he was being given the wrong medication. Nurse showed him the MAR with physician orders and took multiple attempts for him to take his medications*." Another note documented that the recipient's guardian also voiced concern over medication that same day and dosages and reason for medication were reviewed with her. The recipient again voiced concerns over medication two days later on 8/19/19. There were no notes

stating this issue was ever brought to a psychiatrist's or physician's attention. The HRA suggests that nursing staff should be more open and understanding to questions by patients regarding medications rather than viewing it as a threat or as a patient being difficult or accusatory. If the issue cannot be resolved directly, then consider a referral to a physician for review and discussion with the patient and guardian.