FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Chester Mental Health Center
Report of Findings
Case # 22-110-9004

The Egyptian Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission voted to pursue an investigation of Chester Mental Health Center after receiving the following complaints of possible rights violations:

Complaints: Inadequate care and medical treatment

If the allegations are substantiated, they would violate protections under The Mental Health and Disabilities Code (405 ILCS 5/2-102 and 405 ILCS 5/2-211).

Complaint Summary: The complaint alleges the individual broke his toe and the facility staff did not seek medical care for the individual. Allegedly, facility staff taped up the individual's toe and did not transfer the individual to the emergency room. Allegedly, the individual has Crohn's disease, and the facility failed to follow his diet.

Interviews:

Staff stated Chester has an x-ray machine and technician on staff. Most x-rays are done in-house but there may be times when a patient is sent to a local hospital for examination. Staff stated the technician works three days a week on Monday, Wednesday, and Friday. Staff explained the individual injured his toe and was examined by the Chester physician who ordered an x-ray be performed on 7/7/21. Staff stated the x-ray technician did not work on Monday 7/5/21 due to the holiday so 7/7/21 was the first available day for an x-ray. Staff said "it was his little toe and was nondisplaced- traditionally- there is no surgical or other intervention medically needed for a fractured little toe- non weight bearing is not even an indication- just wearing a supportive shoe when up is all the treatment that is normally indicated. Sending someone to the hospital for a broken little toe would be excessive." Staff stated the individual was non-compliant with the doctor's orders of a splint and buddy tape to help with the individual's pain and discomfort. Staff stated the individual demanded to go to a hospital in St. Louis. Staff stated the physician ordered an orthopedic consult due to the individual's continued complaints. The physician ordered x-rays be taken again 6 weeks later to monitor the healing of the toe. However, staff stated the individual was discharged before the x-ray was taken.

Staff explained the individual was on a diet for his medical condition. However, the individual continuously complained about his diet. Staff stated the physician referred the individual for testing to further help with individual. Staff asked the individual what they could do for him, and the individual continuously asked for foods that are known to cause Crohn flare ups.

Policy Review:

Chester Mental Health Center's "Emergency Medical Transfers" policy states "It is the policy of Chester Mental Health Center that in the event of a medical emergency which warrants further medical attention and/or in the event of a Code Blue, a patient, staff member, or visitor will be transferred to the contracting community hospital in a timely and efficient manner. The facility physician or the medical officer of the day (MOD) providing in-house coverage will be responsible for determining the appropriateness of medical transfers. In the absence of a physician, the decision for medical transfer will be made by the shift nursing supervisor/RN II in consultation with a facility physician… the facility physician or the MOD will telephone the emergency room physician to report clinical findings and the reason for the referral. In the absence of a physician, the shift nursing supervisor/RN II will telephone the emergency room physician or nurse…. When a patient is transferred to a general hospital, the nursing supervisor/RN II or designee will notify the Unit Director as soon as practicable…Upon return from a medical hospital admission/ER visit, the patient will be examined by a physician and RN in the medical infirmary. All medical reports sent back with the patient will be reviewed by the RN and physician. Medical orders will be written by the physician and transcribed by the designated RN…".

The HRA reviewed the "Patient Injury Reporting" policy that states "Chester Mental Health Center (CMHC) provides a safe environment in which the risk of injury to patients is minimized. Any injury sustained by a patient will be promptly treated, reported, recorded, and assessed for preventive action according to Program Directive…the RN will detail the cause of injury in the section with the description of the injury. If a staff member other than the RN observes or discovers the injury, he or she must complete in duplicate an Incident Report describing the event. The completed information report(s) shall be submitted to the STA II of the shift for processing according to policy. Medical Evaluations: The decision for off-site emergency medical treatment should be made according to the facility procedure 'Emergency Medical Transfer' (PE.02.03.00.05). Notification of Injury: Upon admission to CMHC, the admitting nurse will inform the patient and guardian (if applicable) of the facility's practice regarding notification of guardians when a patient injury occurs…Review of injuries: At CMHC, the clinical nurse manager is the unit supervising nurse. The nursing director's designee is the daily shift nursing supervisor. After review, the nursing director will route the information from the Injury Report to an individual responsible for inputting the data into the injury data base…".

The "Ordering and Service Modified Diets" policy sates "At Chester Mental Health Center, the dietary manager and registered dietitian shall monitor the planning and serving of all modified diet menus to assure that diets are planned for and served to all patients according to their medical and psychological needs. All modified/special diets must be ordered by a physician. The unit nurse will transcribe the order from IL 462-0047 Physician's Order Form and complete the Diet Prescription. In the event a patient requires immediate dietary considerations, the unit RN will assess the patient with respect to these concerns. If special dietary changes are determined to be appropriate, the RN will contact the physician and obtain a written/telephone order. The unit nurse will contact the dietary department by phone and email to inform dietary staff of the modified/special diet order. Diet changes or discontinuations are to be phoned and emailed into the dietary department by the unit nurse and a Diet Prescription emailed with appropriate changes. Diet renewals will be submitted to the dietary department by the unit nurse by emailing a CMHS-195. All modified/special diets must be reviewed by a physician at least every 30 days. Any modified/special dietary need that is the result of a patient's personal preference request that is not medically warranted must be referred to the patient's treatment team for consideration and approval prior to a physician ordering the dietary request….".

Chester's "Procedure for Modification of the Regular Menu in Order to Provide Patients with Foods Required on Their Special Diets" states "The cooks tally sheets, patient diet sheets and diet spread sheets which are used by the cooks and support workers. These documents help the staff to provide the required food items and the right amounts for patients on special diets. A daily updated tally list of all current patient diets and special food needs will be kept in the diet office and at the cook's station for meal preparation of meals. Daily a diet menu spread sheet will be placed at the workstations of the cooks and the support workers, as a guide of food

substitutions for special diets. The cooks will be provided with a daily tally sheet, indicate the amount of foods to be prepared differently from the regular menu which will provide special diets ordered for certain patients."

Progress Notes Review:

The HRA reviewed progress notes regarding the individual. The note dated 7/1/21 states "Reviewed dietary recommendations; will perform RAST [allergy] test to determine lactose intolerance and egg allergy, Crohn's disease. Either in remission or don't have the disease. Will seek old records if possible… Pt c/o indigestion and requesting antacid. Antacid 30cc po prn given as requested. Pt reports relief from prn. Prn effective. RAST test for eggs and lactose ordered by [physician]. Lab slip sent to lab. This writer went and spoke with [individual] about signing a release for medical records which he did sign…".

The note dated 7/3/21 states "Patient complained I was playing basketball at the gym and felt a pop, my toe hurts. Patient pointed toward his left great toe. Patient rated his pain at 6/10. This nurse asked patient when his injury occurred. Patient stated he was in the gym at about 2 o'clock when it occurred. Patient had no obvious swelling to his lower leg, ankle, or foot at this time. This nurse instructed patient to sit down near nurse's cage and elevate foot. Patient was offered APAP (Acetaminophen) per order but declined. After patient was seated, patient was instructed to remove his sock and shoe. Patient was assessed. Patient indicated it was the side of his L great toe that was the center of the pain. Patient had no obvious edema, redness, discolorations, bruising, laceration, confusions, or open breaks in his skin. Patient stated that it was tender to palpation. Patient offered Ice pack but refused. Patient wanted to know if he could go to the hospital for an x-ray. Patient was placed on medical call line and was instructed to keep foot elevated and stay off of it as much as possible. Patient was advised against going to the gym or yard until he was seen by practitioner in call line. Patient verbalized understanding."

On 7/4/21 that note states "At 1315 [Physician] assessed patient. New order received cold compresses to L hallux 20 min TID x 24 hrs. Ibuprofen 800mg p.o. Monitor pain, unit restriction. X-rays of L foot on 7/7/21. Ibuprofen 800 mg p.o administered for 8.5/10 pain per order, ice provided per order and applied, will monitor. Injury report addendum completed. C/O pain in the L great toe rated 8 ½ (0-10 pain scale). Pt felt a popping sensation of the L foot yesterday while playing basketball…. At 1425 patient rates pain 7/10, resting in bed. Continued education on keeping foot elevated and ice as prescribed. Will administer acetaminophen as prescribed and discussed."

The note dates 7/5/21 states "Recipient requesting Mylanta for c/o upset stomach. Offered and accepted Mylanta 30mg po. Will monitor."

On 7/7/21 at 0910 hours the note states "X-ray note: Pt matches charge. L foot complete." Another note on 7/7 at 1100 hours states "Reviewed medical records from [hospital]… recommended GI consultation refused… Today reporting repeated toe pain/swelling…". At 1145 hours the note states "Pt seen, and records reviewed by [physician]. Orders received for meals on unit, buddy tape toe, soft splint for fx toe." At 1510 hours the note states "Order received from [physician] for ortho consult. Referral, hospital summary and med req completed. Pt requesting pain meds and to go to the hosp. Education on toe fx completed. Informed pt he currently gets acetaminophen 650mg po and he insists on more pain RX (prescription). [Physician] notified. Pt also informed of ortho consult. He replied oh ok, thank you. Awaiting order for pain RX from [physician]."

The note dated 7/8/21 at 1130 hours states "Social Worker Note: Staff met with [Individual] about his dietary complaints. He informed us that we contradict his diet needs over and over but when asked what we can do to accommodate, he stated his needs are not being met and he is still having issues. We discussed other concerns about his complaints which he states that all we can do as patients is make complaints because staff do nothing. [Individual] understands roles of all staff and is aware of complex actions/results of various disciplines inside and outside of the facility." Another note 1115 hours states "Unit director met with [Individual] and [staff] to discuss his Crohn's disease, dietary complaints and how we can further help him. It was reiterated that he has

seen the dietician and physian multiple times and he has been placed on a specific diet to help prevent Crohn's flare up. [Individual] has refused testing including blood-test and scope which would help to meet his needs and better diagnose his medical condition. [Individual] stated that he will continue to write HR [human rights] complaints. It was reiterated that staff are aware of his allergies to milk and eggs. He was encouraged to talk to staff when he has flare ups and discussed how dietary is trying to accommodate by increasing protein. He was repeatedly asked how staff can help him and he continued to state that he wants specific food such as French fries or chicken that are known to trigger flare up with Crohn's." At 1200 hours the notes states "Pt refused soft ankle brace, offer of ice and instructions to elevate foot. He refused to allow this writer to examine foot. Education and counseling attempted, pt walked away."

A note dated 7/12/21 states "Pt c/o L gr toe pain 3/10. States I need Motrin. Phone order received from [physician] for ibuprofen 800mg po prn x 7 days. Pt offered and accepted ibuprofen 800mg prn at this time. Pt refuses to apply soft brace as ordered, refuses to elevate, and refuses to allow nurse to buddy tape. No changes in gait or ambulation difficulties."

A review of the note on 7/14/21 states "Patient c/o not getting enough juice at meals. This writer called for clarification, spoke with [staff] in kitchen…. dietician stated two juices is enough. This writer attempted to speak with patient about complaints, patient refused to speak to writer…".

On 7/25 the note states "Orders received per [physian] to add double protein to current diet."

There were notes almost daily where the individual requested ibuprofen for the pain in his toe.

Records Review:

A review of the individual's treatment plan dated 7/7/21 states "[Individual] was found unfit to stand trial…on the charge of retail theft, unlawful possession of a weapon by a felon, residential burglary, and unlawful possession of a motor vehicle… According to [physician] dated 10/22/20, it was his opinion [Individual] was unfit to stand trial in [county] because at the time of the interview [Individual] came to the interview reluctantly. He ignored attempts at introductions and immediately in an assertive manner wanted to know if I was from [another agency]. He made a number of complaints that someone was messing with his head and something about a report about working…The nature of the assessment and the limits of confidentiality could not be explained to him, and he did not give verbal consent for the evaluation or to release information to the court, to his attorney, or the States Attorney…It is this writer's opinion that [Individual] is incompetent to stand trial at this time. It is likely he can be restored to competency in the stator limit of one year with appropriate treatment." Under chronic medical problems the treatment plan states, "Hypertension and Irregular bowel pattern". On 7/7/21 the treatment plan states "He hurt toe playing in gym. He had an Xray today, which confirmed fracture…[Individual] took fitness test on 5/11 and received 75%. Since then, he continues to refuse to take the fitness test again. He is able to identify the roles of all the different staff within the facility along with articulate rational goal-oriented thoughts of his numerous complaints about needs and wants…The treatment team feels that he is fit and is recommending him as so to the court." Under the goal for irregular bowl patter the treatment plan states "Patient will notify staff with any s/s (signs/symptoms) of irregular bowel pattern. Recipient will be able to have bowel movements on a regular basis with minimal medication intervention. Bowel elimination will be monitored in bowl elimination clinic. Patient will comply with doctor's orders, lab work, medication administration and education. Nursing will assess patient, provide education, and administer medication per doctor's orders. Nursing will monitor and record bowel movements BID [twice per day], give medications as ordered. Nursing will monitor/encourage adequate fluid intake and good nutritional intake. Patient has dicyclomine 10mg po TID [three times per day] ordered at this time. Patient compliant with medication prescribed to control irregular bowel patter. Pt has Crohn's disease and is on a special diet. Patient constantly wanting diet changed. Continues to use Mylanta numerous times for indigestion….".

The HRA reviewed the "Discharge Summary/Transition Record-Physician" which states "Reason for inpatient admission: According to jail progress notes, it has been reported that [Individual] is very delusional and paranoid. He has told [officers] that he is the mayor of the jail. He has made several verbal threats toward the correctional officers. He had to be subdued with a taser. He is currently being housed in segregation because he can't get along with his peers. [Individual] is only allowed sack meals because he used his meal tray as a weapon. The sergeant reported that [Individual] has been in and out of jail numerous times, but his presentation of symptoms are more acute now, versus previous jail stays. Principal diagnosis at discharge: delusional disorder and antisocial personality disorder. Medical diagnoses: Hypertension; Crohn's disease…Mental status at the time of discharge: He is at his baseline... Problems active at the time of discharge: acute toe fracture, Crohn's, hypertension, COPD, stable and under the care of medical provider. Discharge medications and the amounts given: Seroquel 100mg QHS [every night], Lorazepam 1mg BID and 2mg QHS. Special medication instructions: Lactose intolerant, double meat, increased calorie. No fluid milk may have other dairy products, cheese in place of eggs for breakfast, no apples. Two juices in place of fluid milk, no vegetable as side dishes." The discharge summary was signed by the physician on 8/6/2021.

The HRA reviewed the "Discharge Summary/Transition Record- Social Worker" that indicated the individual had no "appointment for medical condition requiring follow-up after discharge". The instructions provided to the individual was "medication instructions" and "managing your mental illness".

A review of x-ray results for the individual dated 7/7/2021 states "There is an acute obliquely oriented fracture involving the first proximal phalanx, extending to involve the distal articular surface. There is no significant displacement or angulation. No other fractures are seen. Joint spaces appear preserved. No destructive osseous process identified."

The HRA reviewed a memo regarding the individual's medical appointment. The memo states "Please authorize necessary security and transportation for the following: Recipient [Individual] unit C has been scheduled for an Ortho Consult [physician and facility name] on 9/2/21 at 0900." Furthermore, there was a note that states "cancelled on 8/3/21 at 0906 due to pt leaving our facility".

The HRA reviewed a referral report for the individual dated 7/6/21 that states "See 6/30/21 response to referral and request for medical review to determine if pt has Crohn's disease and allergies to lactose and eggs. 7/1 orders for RAST test to r/o (rule out) lactose intolerance and egg allergy. Medical records have been requested."

The Medication orders for the individual were reviewed. On 7/4/21, the individual was given an order for "cold compresses to L hallux 20 min D x 24 hours. Urgent Ibuprofen 800mg p.o now for pain pc. Unit restrictions, X-ray of L foot on 7/7/21." On 7/1 the order states "RAST test to r/o lactose intolerance and egg allergy." On 7/7 the order states "Ibuprofen 400mg p.o 3 days and food. Phalanx left foot. Request orthopedic consult. Meals on the unit. Buddy tape and soft splint." The order on 7/14 states "May have dry cereal when served, increase calorie diet, not drinkable milk (may have other dairy products). No apples, mayo, cheese in place of egg, 2 juices in place of milk, no veggie burger-cheese sandwich in its place. Meals on the unit. Buddy tape left fracture toe and soft splint." On 7/21 the orders state "Repeat x-ray in 6 days… Ibuprofen 400mg p.o.q 80 prn for toe pain x 7days."

A review of an injury report for the individual dated 7/3/21 states "Patient had no noticeable edema, redness, abrasions, lacerations, or confusions. I was playing basketball and I felt something pop. Elevation, rest. Refused po meds. Placed on medical call line." There was an addendum to the injury report on 7/4/21 that states "Pt c/o (complained of) L great toe pain. I was playing basketball and I heard a pop. Pt seen by [physician]- 1x dose ibuprofen 800mg administered, ice pack applied, x-ray ordered for 7/7/21. Mild to moderately tender to palpation…-x-ray of L foot to be done 7/7/21 to r/o fx (fracture)."

Conclusion:

Complaint 1. Inadequate care and medical treatment

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) states "(a) 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."

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-211) states "A medical or dental emergency exists when delay for the purpose of obtaining consent would endanger the life or adversely and substantially affect the health of a recipient of services. When a medical or dental emergency exists, if a physician or licensed dentist who examines a recipient determines that the recipient is not capable of giving informed consent, essential medical or dental procedures may be performed without consent. No physician nor licensed dentist shall be liable for a non-negligent good faith determination that a medical or dental emergency exists or a non-negligent good faith determination that the recipient is not capable of giving informed consent."

It is documented in the individual's records that the individual is diagnosed with Crohn's disease as well as lactose and egg allergies. The individual was receiving a specific diet to help with his medical condition. However, the individual was not happy with his diet and requested changes to his diet on multiple occasions. According to the progress note "…He was repeatedly asked how staff can help him and he continued to state that he wants specific food such as French fries or chicken that are known to trigger flare ups with Crohn's." The individual injured his toe on 7/3/2021 and informed the nurse. The individual requested to go to the Emergency Room and have an x-ray done however that was not done. The next day, the individual was examined by Chester's physician who ordered an x-ray. On 7/7/21 the individual received the x-ray, and it was determined the individual had fractured his toe. The individual was in pain from his fractured toe which is documented in the progress notes. The day of the injury the individual reported pain to be a 6 out of 10 but the next day the individual reported the pain to be an 8 ½ out of 10. Staff stated Chester has an x-ray machine and technician on staff. However, the individual did not receive an x-ray until 4 days after injuring his toe. Staff stated 7/7/21 was the next day the x-ray technician worked due to the holiday on 7/5/21. Staff stated taking an individual to the hospital for a broken toe is "excessive". The HRA is concerned that staff believe seeking medical treatment for a broken bone is excessive especially when the individual made many complaints about pain and discomfort. Additionally, staff waited 4 days to x-ray a suspected broken bone when an x-ray could have been performed in a timelier manner if the individual had been taken to a hospital to seek medical treatment. The individual was scheduled for an orthopedic consult in September 2021, but Chester canceled that appointment since the individual was discharged in August 2021. The HRA found no evidence that Chester notified the receiving facility of the individual's need for an orthopedic consult. Therefore, the Egyptian Human Rights Authority concludes that the consumer's rights were violated specific to treatment of the fractured toe versus care for the Crohn's Disease; therefore, the complaint of inhumane care is **substantiated.**

The Human Rights Authority makes the following **recommendations**:

1. **Chester Mental Health Center ensure all information including any referrals for consultations or medical appointments are provided to the receiving faculties to ensure consumers are getting the services they need.**

2. **Chester Mental Health Center follow The Code (405 ILCS 5/2-102) by ensuring all consumers are provided with adequate and humane care.**

3. **Chester Mental Health Center follow The Code (405 ILCS 5/2-211) by ensuring all consumers are receiving medical treatment in a timely matter. If there is a suspected broken bone, seeking medical treatment at a hospital should not be considered excessive. An update to the "Emergency Medical Transfer" policy to include the definition of a medical emergency per The Code (405 ILCS 5/2-211) would provide clear guidance for staff when deciding if there is a medical emergency or not. Provide the HRA with the updated policy.**

4. **Chester Mental Health Center re-train staff on The Code (405 ILCS 5/2/102 and 405 ILCS 5/2-211) and provide evidence of the training to the HRA.**

The individual's orthopedic consult was canceled by Chester due to the individual's discharge to another facility. However, the individual still needed the consult. The HRA **strongly suggests** Chester not cancel appointments for recipients when being discharged.