FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY - SPRINGFIELD REGION
REPORT OF FINDINGS

Case #20-050-9010
Andrew McFarland Mental Health Center (MMHC)

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations involving services at Andrew McFarland Mental Health Center. The complaint alleges inadequate safety of a patient and inadequate services per a treatment plan. If found substantiated, the allegations would violate The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102, 112 and 5/3-211).

Complaint Statement

The allegations state that during a female patient's stay, a male peer grabbed her rear end, then the next day he entered her room when he was not wanted. Allegedly the male patient then entered the shower room, where the female patient was, after staff failed to stay and observe. The female patient had to yell for help. The allegations state that the female patient complained about all three incidents, wrote a report about them and was told the allegations would be investigated, but nothing reportedly happened. The allegations state the male peer remained at the facility through the female patient's discharge and he never respected a 10-foot rule that was placed on him. The allegations also state the patient was also supposed to receive Gabapentin as prescribed from a transferring hospital and it was not administered for 10 days; it was started 3 or 4 days before discharge (the patient was at the hospital for two weeks).

Interview with staff (3/27/2020)

Staff began by explaining that the female patient was at the facility under a month, from November 18th until December 2nd. Staff were unaware about the patient being hit on the rear end because she did not tell staff. The male patient was less socially functioning, and he would put himself in positions where he disturbed people, but not one that was sexual. Staff restricted the patient to physically be 10 feet away from the female patient. Staff would redirect him to follow the guidelines. The male peer did go into the shower and stood there while the patient was bathing, and this was because staff left their post. There was an investigation by the Office of Inspector General (OIG). That staff member was retrained and disciplined with counseling due to the substantiated finding by OIG. Staff explained the OIG would have sent something to the

female patient. Staff said they were only aware of the shower and there was no formal complaint about the other issues. Staff said that once they turn over the complaint, the facility must back out of the complaint. Staff said the female patient would have been interviewed for the incident and she would have met with security or OIG.

During the HRA site visit, the facility staff reviewed a note in the record that stated on December 1st the male patient grabbed the rear end of the female patient. She was discharged on December 2nd, so they would not have had time to investigate the situation. According to the documentation, the shower was investigated but the other two allegations were not. Staff did not see anything in the chart outside of the incident on December 1st when she was leaving the next day. Staff said if she would have brought up the issues prior to December 1st, then they would have possibly reviewed a unit transfer if the male patient's behavior was a targeted behavior. They would have talked about multiple options if she would have had concerns over the incident. Also during the interview, staff did not have documentation on why the 10 foot restriction was in place and it was not added to the discharge summary. Staff said that OIG would alert the patient that the issue was being investigated and staff said that hopefully they caught her before she left to let her know they were investigating, but there was a chance that they did not. She could be contacted via phone. Staff stated that they would email the patient with the case being closed and their security would contact her or possibly OIG would contact her.

When a patient is admitted, staff perform a medication reconciliation where they review all the medications and see if they need to continue or discontinue any medications. The staff guessed that the physician may have wanted to see if the patient was managing without the medication. Gabapentin is for nerve pain but also used for anxiety. Originally it was prescribed for shingles and nerve pain. Gabapentine was a routine medication and not a PRN (as needed) medication. The discharge summaries states that the patient told the physician that she was taking the medication at home and that is why it was not given. The hospital starts them on the medication and then McFarland staff receive a hospital medication list; they order what was prescribed at the hospital. The McFarland physician reviews the hospital list. After that, the patient can say that they take additional medication. They physician would try to confirm the additional medication with another physician depending on the medication; however, if the additional medication is just a multivitamin, they would just offer the medication. Staff were not sure what happened in this case. They do not think the medication is for seizures, but they think that it is for nerve pain, which is what the patient told staff.

FINDINGS

On 12/2/19 there is an inpatient psychiatric progress note for the female patient which states that a "male peer grabbed her from behind and entered the shower while she was bathing." It was stated that the peer was put on a 10-foot restriction and they would monitor for further incidents. There is an incident note, stating the incident took place on 11/28/19, and reads "Patient place on a 10 foot restriction due to peer A.M. reporting that patient touched her butt on the way by. Multiple peers witnessed the incident. Patient reported that he touched it on accident and she was in his space after he was there. Patient reminded about keeping his hands to himself and that behavior will not be tolerated and he will be placed on a 10 ft. restriction with peer. Order received for 10 ft restriction x 7 days with peer A.M." The HRA also reviewed a nurse incident note for 12/1/2019 which states: "[Male Peer] told [Staff] that 'the girls' were screaming for [Staff]. [Staff] went to the shower room to see what was going on. [Female Patients] reported

[Male Peer] opened the door and seen both [Female Patients] in the nude. [Staff] redirected [Male Peer] up the hall. Writer went and guarded the shower door until both [Female Patients] finished their showers. [Patient] questioned what was going to happen to [Male Patient]. She stated, 'First he grabs my butt.' 'Then he comes into my room in the middle of the night.' 'Now he's opening the shower room door and seeing me naked.' 'I feel so violated.' Writer voiced she understood pt.'s frustration. [Shift Coordinator] was notified." The patient's discharge summary did indicate that the patient left the facility on 12/2/2019.

Regarding the medication, the HRA reviewed the medication reconciliation form which states that the patient's medication is from the transferring hospital or home and Gabapentin is included on the list and is to be administered with a frequency of "Q80." The last dose was the day the form was completed (11/18/19). The medication is listed as being for "her [patient] neuropic pain/migraines." In reviewing the patient's comprehensive psychiatric evaluation, it also states that the patient was discharged ***from the hospital*** with "gabapentin 900 mg PO TID" [by mouth three times a day] and reads "She also has a history of recurrent shingles on her back with postherpetic neuralgia, for which she is on gabapentin." Other interventions in the evaluation mentioned medications that were discontinued and continued but Gabapentin was not mentioned in this section. The patient's treatment plan had no mention of the Gabapentin. The HRA also reviewed the social worker discharge summary/transition record and the Gabapentin was not mentioned in that document as well. The patient's medical discharge summary reads that the patient has a discharge diagnosis of "Postherpetic neuralgia by history" and "The patient states she was on gabapentin at home for postherpetic neuralgia. She was restarted on the medication. She had no side effects from the medication." According to the comprehensive psychiatric evaluation, the patient was admitted on 11/18/2019. The HRA reviewed a medication order for Gabapentin and the order is for 11/28/2019 and the instructions are for one tablet of 300mg three times a day for day one, two 300mg tablets three times a day for day two, and three 300mg tablets three times a day for day three and beyond. In reviewing the medical administration record, the patient was given 300mg three times a day the first day, 600mg tablets three times a day the second day and 900mg tablets three times a day, the third day and beyond. A nurse incident note for 11/25/2019 documents the patient reporting she injured her thumb playing basketball and in the course of the conversation, she states "'… I thought you said [Physician] was going to see me today about my Gabapentin and thumb?'" The staff writing the note said that patient reacted that it was "… no big deal" and she would see staff later but staff contacted a different physician who examined the thumb.

The facility policy regarding reporting and investigation of unusual incidents states: "It is the policy of McFarland that all allegations of abuse and neglect of individuals served and other incidents as defined in Program Directive 02.01.06.020 shall be reported and investigated in a prompt and procedurally correct manner." The policy defines "Neglect" as "An employee's, agency's or facility's failure to provide adequate medical care, personal care or maintenance, and that as a consequence, causes an individual pain, injury, or emotional distress, results in either an individual's maladaptive behavior or the deterioration of an individual's physical condition or mental condition, or places an individual's health or safety at substantial risk of possible injury, harm, or death." The policy also states that "The Security Department staff is designated as the Required Reporter department … All incidents must be reported to Security within 10 minutes of becoming aware of an incident." The policy also reads "OIG may determine that events and complaints are not reportable incidents by Rule 50. Internal investigation of these events and complaints may still be indicated to assist in identifying underlying or systemic problems.

Therefore, the files of these events/complaints should be kept by the facility administrator. The files will include full documentation of the incident. On a quarterly or as needed basis the incidents will be presented at Leadership Committee by the facility investigator. The Leadership Committee will review the findings of the investigation and consider whether the incidents either alone or in aggregate suggest the need for further investigation or changes in hospital policies, procedures or systems of care." The policy also states, "Security Incident Reports will be completed for any occurrence which is not routine, requires Security assistance or assistance from other units, which may constitute a possible violation of Federal, State or local law; violate a Departmental or hospital rule, order, or regulation; or which may result in public attention."

The HRA also reviewed the facility reconciliation policy, which outlines how medication is reconciliated when a patient is admitted, when the patient is transferred within McFarland, when a patient is sent to a hospital from McFarland and for emergency room visits. The admission part of the policy requires that: "Upon admission, the Registered Nurse will review the list of current medication (prescribed, over-the-counter, alternative, and herbal medication) as identified by the referral documents and the patient/significant other. If the patient and/or family are unable to provide data or are unreliable historians, additional sources of information may be investigated including home medication brought to the hospital and information from previous discharge paperwork." The nurse will then add the medication to an admission medication reconciliation form. The process then requires that "The admitting physician/psychiatrist will review the Medication Reconciliation form and indicate on the form if each medication is to be continued. If discontinued or modified, an explanation will be provided. The physician will order medications on the Physician's Order form (DMHDD44) according to facility and departmental policy. These orders will be faxed to Pharmacy along with a copy of the Admission Medication Reconciliation form. The original of the Medication Reconciliation form will be filed in the physician's order section of the medical record."

The Mental Health and Developmental Disabilities Code states that: "(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" (405 ILCS 5/2-102) and also that patients are to have "Freedom from abuse and neglect. Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect" (405 ILCS 5/2-112).

CONCLUSION

The HRA did not see evidence that a patient wrote a report about incidents but there was evidence that the patient did mention all the incidents to the staff. The staff said there was an OIG investigation on the shower incident, and the incident regarding the patient touching the other patient's backside was dealt with by providing a 10-foot restriction, but the facility said they were not aware of the situation when the patient allegedly entered the other patient's room. Also, staff stated that there was nothing they could do because the other patient was leaving the next day. The HRA reviewed and saw that there was no investigation into the patient entering the female patient's room, but it was documented that the patient made these allegations. The patient was supposed to have a 10-foot restriction from the other patient and the event was never investigated. Even though the female patient was leaving the next day, the male patient who entered the room was still at the facility, which should warrant an investigation so that the patient does not act appropriately with other patients. Nowhere in the policy does it state there is any type of limit or timing protocol on the investigation of unusual instances; in addition, this would

have been inconsistent with meeting the male patient's treatment needs, and possibly neglect by staff, had the patient entered the room while on the 10 foot restriction. Because of the lack of follow-up on a patient's reported safety concern, the complaint is **substantiated** and the HRA recommends that the facility review the incident policy and re-educate staff.

Regarding the medication, the patient was admitted to the facility with Gabapentin that was prescribed from the hospital on 11/18 but, according to the MAR (Medication Administration Report) the medication was not given until 11/28. There is no mention as to why there was such a large gap in providing the medication and there was also no mention of the medication in the treatment plan. The facility policy states that if a medication is discontinued there should be an explanation but the HRA saw no explanation as to why there was such a delay in starting the medication. Besides the inconsistency with policy requirements, the HRA is concerned about the patient's need for pain medication as part of her treatment needs and diagnosis. Because the patient was not provided treatment upon admission, the HRA finds this complaint **substantiated** and asks that the facility staff assure that medications ordered by the hospital are included in the patient's treatment and in a timely manner or any discontinuation be explained in the reconciliation form; the HRA recommends staff be re-trained accordingly.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

JB Pritzker, *Governor*

Illinois Department of Human Services

Grace B. Hou, *Secretary*

McFarland Mental Health Center
901 Southwind Drive • Springfield, IL 62703

November 6, 2020

Tara Dunning, Chair
Human Rights Authority
Illinois Guardianship and Advocacy Commission
#521 Stratton Building
401 S. Spring Street
Springfield, Illinois 62706

Re: #20-050-9010

Ms. Dunning:

This letter is regarding the report of findings on the case number listed above about the substantiated allegation of inadequate safety of a patient and inadequate services.

In regard to the allegation of inadequate safety of a patient, the report outlines the belief of staff neglect for not enforcing the patient's 10-foot restriction and that the incident should have been reported for investigation. It is agreed that staff could benefit from a reminder on when an investigation of abuse or neglect is initiated, and education will be forwarded to all staff. The need to ensure ongoing observation of all patients through staff diligence and regular staff presence on the unit will be enforced. The policy pertaining to 10 foot-restrictions will also be reviewed and updated as needed. All staff will be educated if any procedural changes are made.

In regard to the allegation of inadequate services, it appears the physicians who met with the individual upon her admission, had planned to continue the Gabapentin as it is documented on the Admission Medication Reconciliation. However, the order was not completed. It is believed this was an oversight on his behalf. Education will be provided to all McFarland physicians by our Medical Director regarding the importance of ensuring all orders are completed at the time of admission and coincide with the Admission Medication Reconciliation.

If additional information is needed, please feel free to contact me at the number listed below. Thank you for bringing this concern to our attention.

Sincerely

Sara Broyles, LCSW

Sara Broyles, LCSW, Quality Manager
McFarland Mental Health Center
217-786-6851