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Egyptian Regional Human Rights Authority
Report of Findings
07-110-9017
Chester Mental Health Center
April 28, 2009

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Chester Mental Health Center, a state-operated mental health facility located in Chester. The facility, which is the most restrictive mental health center in the state, provides services for approximately 300 male residents. The specific allegation is as follows:

Recipients at Chester Mental Health Center have not been provided with adequate care.

Statutes

If substantiated, the allegation would be a violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102 and 5/1-101.2). The Administrative Code (59 Ill. Admin. Code 112.30 (3)) is also pertinent to the allegation.

Section 5/2-102 (a) of the Mental Health Code 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 provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided."

Section 5/1-101.2 defines adequate care and services as "…services reasonably calculated to result in a significant improvement of the condition of a recipient of services confined in an inpatient mental health facility so that he or she may be released or services reasonable calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others."

The Administrative Code's Section 112.30 (3) states, "On completion of the comprehensive diagnostic examinations, a treatment plan for any medical and dental services shall be established as part of the recipient's individualized services plan."

Complaint Information

According to a complaint received at the Egyptian Regional HRA several recipients at the facility had become ill due to fecal impactions, and possibly some of the recipients had died as a result of the problem. It was alleged that the facility's failure to appropriately recognize that constipation is a side effect of many of the medications used to treat mental illness may have been a contributing factor in the recipients having the impactions.

Investigation Information

To investigate the allegation, the Investigation Team (Team) conducted two site visits at the facility. During the initial visit the Team, consisting of two members and the HRA Coordinator (Coordinator), spoke with six recipients and the Chairman (Chairman) of the facility's Human Rights Committee concerning the allegation. When the second visit was conducted the Team spoke with the facility Administrator (Administrator) and the Chairman. The Authority reviewed the masked records of three recipients who died while hospitalized at the facility and the facility's policy pertinent to the allegation. February 2009 Daily BM (bowel movement) Monitoring Forms for three recipients were reviewed with the recipients' written authorization. The Coordinator spoke with a Department of Human Services, Office of Inspector General (OIG) Representative, and the Authority members reviewed OIG Reports of Findings pertinent to the deaths. The Authority also reviewed 2006 and 2007 OIG Annual Reports and the Illinois Department of Human Services Policy and Program Directive (PPD) pertinent to effective treatment planning.

I…Interviews…Initial Visit

Chairperson:

During the initial visit to the facility, the Team met with the Chairman about the HRA's request for masked records (records with personally identifiably information deleted). The Team requested the records of recipients who had been transferred from the facility to a community hospital for the period July 1, 2005 through February 1, 2007. The Chairman stated that he would speak with the Hospital Administrator (Administrator) regarding the HRA's request. After the request was made, a follow up letter was sent to the Administrator on October 23, 2007 outlining the request.

Recipients:

As a part of the investigation process, the Team spoke with six recipients. According to Recipient A, he experienced some stomach problems that required hospitalization in the facility

infirmary for a period of time. He stated that the illness prevented him from eating; however, he did not express any problems with constipation.

Recipient B stated that although he had not experienced any problems with constipation, he was aware of several recipients who had become very ill due to impactions. He stated that some of the recipients required hospitalization in a community hospital.

Recipient C informed the Team that he had experienced constipation or problems with his stomach that required treatment at an area hospital. However, he was not aware of the diagnosis of his illness. He informed that Team that after his return to the facility after being hospitalized he has been required to drink prune juice and to take Metamucil on a daily basis. He stated that staff members frequently ask him whether he has a bowel movement.

Recipient D stated that a recipient on the unit where he resides was sent to a community hospital after he became ill from eating something that caused an allergic reaction. He stated that two additional recipients, a fifty year old and a recipient in his twenties, were sent to the hospital due to problems with their bowels. He informed the Team that he had not personally experienced any problems; however, he was asked on a daily basis about his bowel elimination.

Recipient E stated that he is required to take prune juice and a "pill" so that he can "go to the bathroom". He stated that staff informed him that if he did not take the "pill" medical staff would have to perform a rectal exam.

Recipient F informed the Team that after several recipients became seriously ill due to stomach problems and serious constipation, the facility instituted a bowel monitoring procedure. He stated that recipients are given prune juice and laxatives, as well as enemas and rectal exams as a part of the procedure. Recipient F stated that he believed that the medications that are prescribed for the recipients' mental illnesses have caused the problem.

Interviews…Second Visit

Chairman

When the information that was requested in the initial visit was not received, the Team conducted a second visit. During the visit, the Chairman stated that all information pertinent to the case would have to be obtained from the facility Administrator.

Administrator

When the Team spoke with the Administrator, she stated that due to the broadness of HRA's request for the masked records, abiding by the request would create an undue hardship for the facility. She stated that numerous recipients had been sent to the hospital for various reasons during the time period listed in the request.

As a result of the Administrator's concerns, the Team asked that the facility provide masked records for any recipient who had died while residing at the facility for the period of July

1, 2005 through January 28, 2008. The following items were requested: Master Treatment Plans, Monthly Treatment Plan Reviews (TPRs), Nursing Notes, Physician Notes and Medication Administration Records (MARS) for three months prior to each recipient's death. The Team also requested copies of any facility policy pertinent to the complaint. A follow up letter was sent to the Administrator on January 28, 2008 outlining the HRA's revised request.

I…Record Review:

The Authority reviewed the masked records for three recipients who died during the period targeted by the HRA's request. The recipients are referred to as Recipient 1, Recipient 2, and Recipient 3 in this report.

Recipient 1:

A: Treatment Plan Reviews (TPRs)

According to documentation obtained, Recipient 1, a 49-year-old individual, was admitted to the facility on 09/26/2000 from a less restrictive state-operated mental health facility. The recipient had been discharged from Chester Mental Health Center to the transferring facility on 01/05/2000. He was returned to Chester Mental Health Center after he exhibited violent behavior at the less restrictive facility. The recipient's record indicated that he had been consistently institutionalized most of his adult life, amassing over 70 admissions to various mental health facilities.

A 01/18/05 TPR indicated that the recipient had the following diagnoses: AXIS I: Bipolar Disorder, Manic with Psychotic Features and History of Poly Substance Abuse; AXIS II: Deferred; AXIS III: Essential Hypertension, History of Thyrotoxicosis with Radioactive Iodine Treatment:, Hypothyroidism, Adult Onset Non-Insulting Diabetes Mellitus (by history) ; and AXIS IV: Psychosocial Stressors (Anticipated Placement and Chronic Mental Illness).

Documentation indicated that the recipient had goals of service that included the following: 1) To be free from any episodes of aggressive and violent behaviors towards others, 2) To be cooperative in taking medications for his mental and physical problems and 3) to have his manic symptoms of irritability, demanding behaviors, grandiosity, paranoia, and aggression under control. Medications prescribed to assist him in reaching the above goals were listed as: 1) Olanzapine 10 mg BID (to control psychosis, manic behaviors and aggression), 2) Quetiapine 400 mg in the AM and at bedtime (to control psychosis, manic symptoms and aggression), 3) Lorazepam 2 mg every six hours as need (to control agitation), 4) Topiramate 100 mg twice daily (AM and PM) (for mood instability and to control aggression), 5) Clonazepam 2 mg four times daily (to decrease and control anxiety, agitation and mood instability) and 6) Lithium 300 mg twice daily (to decrease and control mood instability and aggression).

Additional goals dealing with health care issues included the following: 1) to be within his Ideal Body Weight (IBW) (161-184) and 2) to maintain health dentition by having an annual dental exam.

The recipient's Psychosocial Treatment Services goals included the following: 1) The recipient will effectively curb his anger and frustrations when difficult situations occur as evidenced by no incidents of assaultive behaviors, verbal threats, information reports, seclusion and restraints. 2) The Recipient will be able to develop an understanding of his mental illness as evidenced by reduction and/or elimination of threats and/or verbal accusations toward other patients.

Additional goals included attending, participating and appropriately interacting in leisure opportunities, programming, educational and vocational activities. Documentation indicated that the recipient also had a goal to maintain consistent contact with his family in order to build and/or strengthen his social support system.

In the Extent To Which Benefiting From Treatment Section of the TPR, documentation indicated that the recipient had exhibited significant inappropriate behaviors since his return to the facility. He continued to be loud, demanding and abrasive on a daily basis. His ideas of persecution remained, and his manic features required constant attention from staff in spite of the many medication adjustments.

Documentation in the recipient's 02/14/09 TPR indicated that the Olanzapine was discontinued on 01/26/05 because of an elevation of his serum amylase. Haloperidol was prescribed on 01/29/05 to assist the recipient in controlling paranoia, aggression and manic behaviors. According to documentation, the recipient had not experienced any episodes of aggression toward staff during the reporting period. However, he had continued his disruptive, agitated behaviors of yelling, screaming, and cursing at others.

According to documentation in the recipient's 03/15/05, 04/12/05, 05/10/05, 06/07/05, 07/14/05, 08/02/05, 08/30/05, and 10/25/05 TPRs, there were no changes in the recipient's psychotropic medication regime. There was no documentation in any of the TPRs to indicate that the recipient had problems with bowel elimination. The primary focus in all of the TPRs was to formulate goals to assist the recipient in obtaining control of his aggressive behaviors and psychotic symptoms.

B…Progress Notes:

According to documentation in a Medical Note on 08/01/05, Recipient 1 was diagnosed with severe chronic constipation. A colonoscopy had been scheduled for 07/15/05; however, the procedure could not be completed because there had been inadequate bowel preparation. The record indicated that when the recipient refused to have more aggressive bowel preparation, the physician ordered Lactulose, a laxative, to be given daily and glycerin suppositories to be inserted rectally every other day to deal with the bowel evacuation.

Documentation in a 08/17/05 Progress Note indicated that staff had reported that the recipient continued to dig at his anus with his fingers.

According to a 09/08/05 note, the recipient had refused the Lactulose syrup for constipation without giving a reason for his refusal.

In a 09/13/05 Note, a physician documented that the recipient reported that he was having daily bowel movements, some small and some large. He ordered that Lactulose and glycerin suppositories be continued. Additional documentation indicated that the recipient refused Lactulose stating that he didn't need the medication.

A Security Therapy Aide (STA) documented in a 10/12/05 progress note that the recipient had feces under his fingernails and on his hands after he had inserted suppositories. The STA recorded that this practice had become a health hazard for the recipient, as well as others.

In a 12:20 PM Progress Note on 11/10/05, documentation indicated that the recipient came to the nurses' station and said, "I'm blind, I'm blind." The nurse recorded that the recipient was staring vacantly and his speech was garbled. The record indicated that a nursing supervisor was contacted in order that further assessment might be conducted. Additional documentation indicated that the recipient had a bowel movement in his clothes, and staff members washed him and applied clean clothing.

A nurse recorded at 12:30 PM on 11/10/05 that an attempt had been made to obtain the recipient's blood pressure after he ambulated to his bedroom and laid on the bed. However, no audible or palpable pulse could be obtained in either arm, and the recipient had a "pale cast in his face, hands and feet". The nurse documented that the recipient's abdomen was distended and firm to touch with no audible bowel sounds; however, he denied having any pain. After the examination, the nurse supervisor called a facility physician.

Documentation indicated that the facility physician ordered the nurse to have the recipient be transported via a stretcher to the facility infirmary for immediate treatment at 12:35 PM on 11/10/05, and the physician examined the recipient in the infirmary at 12:37 PM. At that time the physician ordered the recipient be transported by ambulance to a community hospital. When the ambulance arrived at the facility at 12:45 PM., the recipient was examined, and an IV started. Documentation indicated that the recipient denied having any pain or discomfort.

Documentation indicated that the recipient arrived at the community hospital emergency room for further evaluation at 1 PM. At 2:30 PM, upon returning from having x-rays, the recipient went into respiratory arrest. When resuscitation efforts failed, he expired at 3:19 PM.

C…Medication Records.

According to Medication Administration Records (MARS) and Medication Orders, on 08/02/05, a facility physician ordered Lactulose syrup daily and a glycerin suppository every other day to assist the recipient in having a bowel movement. Documentation indicated that the recipient did not consistently take the prescribed medication. On 10/13/05, the facility physician discontinued the use of all suppositories after a STA reported that the recipient had fecal matter under his nails after inserting the suppositories. When the suppositories were discontinued the

physician ordered that Docusate Sodium be given twice daily and Magnesium Citrate once weekly for the recipient's chronic constipation.

D. Additional Information:

The documentation provided no indication that the recipient's bowel movements had been monitored and recorded.

Recipient 2:

A…Treatment Plan Reviews:

According to documentation in a 01/11/06 TPR, the 25- year-old recipient was admitted to the facility on 01/09/06 from a less restrictive state-operated mental health facility. The recipient's record indicated that he had a history of Illinois Department of Human Services admissions dating back to 1997 with four previous admissions to Chester Mental Health Center. The recipient's diagnoses were listed as Schizophrenia, Paranoid Type and Schizoaffective Disorder, Bipolar Type. At the time of admission, his medications were listed as Risperidone 2 mg twice daily (for psychosis) and Lorazepam 1 mg twice daily (for anxiety). His strengths were listed as follows: 1) good physical health, 2) ability to independently complete ADL's (activities of daily living) and 3) the ability to voice needs and concerns. His problems were listed as 1) psychotic symptoms, which included hallucinations, delusions and perceptual problems, and 2) aggression toward others. The TPR contained goals for the recipient's psychotic symptoms to be reduced and for him to be free of aggressive behaviors toward others.

In a 02/02/06 TPR, documentation indicated that Risperidone was increased from 2 mg to 4 mg at bedtime; however, the AM dosage was continued at 2 mg. The recipient's individual treatment goals continued to focus on his psychotic symptoms and aggressive behaviors.

Documentation in the 03/01/06 TPR indicated that Risperidone was discontinued and Seroquel for psychosis and Depakote for mood stabilization were commenced. In a 03/29/06 TPR, a facility psychiatrist reported that he had noticed a partial positive response since the change in medications. Goals to reduce the recipient's psychotic symptoms and aggressive behaviors continued to be priority in the recipient's treatment.

According to a 04/26/06 TPR, the recipient was doing much better after the change in medication; however, Lorazepam was added to his medication regime. Documentation indicated that the recipient had not required seclusion, restraints, or emergency medications during the reporting period.

The recipient's 05/25/06 and 06/22/06 TPRs indicated that the recipient's goals continued to be focused on his psychotic symptoms and aggressive behaviors. According to documentation in the 06/22/06 TPR, the treatment team determined that the recipient was doing very well and a transfer to a less restrictive setting would be considered within two weeks. During both reviews, documentation indicated the recipient had good health.

In a 07/20/06 TPR, the recipient's record indicated that a facility psychiatrist stated that he did not believe the recipient was ready for transfer at the time of the meeting. However, the treatment team would continue to monitor his progress, and if he continued to do well, a transfer recommendation would be submitted. It was recorded that the recipient continued to have good health.

During its review of the recipient's TPRs from January through July 2006, the HRA found no documentation to indicate the recipient had complained of having constipation or any problems with his stomach.

B… Progress Notes:

The Authority reviewed Progress Notes from April 2006 through August 2006. There was no indication that the recipient had voiced any physical complaints until 08/10/06. The recipient's Therapist recorded in a 9 AM Progress Note on 08/11/06 that the recipient had come to her on 08/10/06 stating that his stomach was hurting and he felt very faint. The Therapist noted that the recipient looked very pale. The Therapist contacted a nurse, and when the nurse examined the recipient she contacted a facility physician. The Therapist recorded that the recipient was taken to medical diagnostics at the facility and later transferred to a community hospital. The Therapist documented that she had contacted the recipient's family member after being informed that the recipient was going to have exploratory surgery on 08/11/06.

A Registered Nurse (RN) recorded in a 08/10/06 Progress Note that the recipient had complained that he hurt in the lower part of his stomach; however, he denied having any nausea, vomiting or diarrhea. The RN documented that the recipient was noted to be very pale, his eyes were red, and his bowel sounds were hypoactive.

A facility physician recorded in a 2:50 PM 08/10/06 Progress Note that he had been called to see the recipient. He documented that the recipient was extremely pale and complained of abdominal pain. He noted that the recipient reported that he had a small bowel movement in the morning. The physician recorded the following findings: 1) hypoactive bowel sounds, 2) hard mass in the abdomen, and 3) sinus tachycardia. The physician documented that he had notified the emergency room staff at an area community hospital so that the recipient could be transferred to the hospital.

An additional 08/10/09 note recorded that the facility physician had ordered an EKG at 3:30 PM with instructions that the test be conducted immediately.

In a 3 PM Progress Note on 08/11/06, the recipient's therapist recorded, "The Treatment Team was notified that [NAME] went into cardiac arrest at the hospital while on the operating table. He was pronounced dead this afternoon…"

The HRA did not observe any documentation in the Progress Notes that specified that the recipient had complained about constipation or any other illness prior to 08/10/06. Nor did documentation reveal that the recipient was specifically asked about his bowel movements.

C…Medication Records;

The HRA did not detect any documentation in the MARS and Medication Orders to indicate that the recipient was receiving any type of medication to alleviate constipation or to act as a bulking agent to prevent constipation.

Recipient 3

According to documentation in the recipient's chart, the 35-year-old was admitted to the facility in June 1994 after being found Unfit to Stand Trial (UST). When he returned to court in August 1994 his status was changed to Not Guilty by Reason of Insanity (NGRI). The record indicated that as a result of a gunshot wound to the head in 1991, the recipient was left with poor muscle control, poor eye coordination and speech impairment. Additional information indicated that the recipient had a history of a laparotomy due to an abdominal gunshot wound. His admitting diagnoses were listed as follows: AXIS I: Organic Mental Disorder, AXIS II: No diagnosis and AXIS III: Status Post-Brain Injury (to the left side of the brain) and Spastic Hemiparesis. At the time of admission, the recipient's medications were listed as follows: Stelazine 2 mg, Tegretol 200 mg twice daily and Klonopin 0.5 mg.

The HRA reviewed the recipient's TPRs from February 1995 through March 2006. Documentation in his May 1995 TPR indicated that he had begun to exercise vigorously and was involved in body building. In a July 1995 TPR, the record indicated that staff found the recipient in the bathroom forcing himself to throw up his meal as a means to control his weight. The recipient's weight was recorded as 200 lbs and his IBW was listed as 164-178. Additional documentation indicated that the recipient was referred to the facility dietician. Documentation in an October 1995 TPR indicated that the recipient had been treated for a minor injury that he received while he was exercising in his room. The physician also examined the recipient, twice biopsied a penile lesion and treated him for a scratch of his left lip that he received during a fight with another recipient.

According to a July 1996 TPR, the recipient received a laceration to his upper lip and a scratch on his right eye when he fought with another recipient. The laceration on the lip required sutures. The record indicated that the recipient complained of eye pain; however, he refused treatment.

The record indicated that the recipient fell in the shower in February 2007; however, he did not receive any injuries. In June 1997, he complained of having a sore throat, but refused treatment. In October 1997, he received an antibiotic ointment for an abrasion on his penis. Documentation in a December 1997 TPR indicated that the recipient had denied any physical problems, sleep issues, or bladder and bowel difficulties.

Documentation in a May 1998 TPR indicated that the recipient had four teeth extracted, and in the June 1998 TPR the record denoted that the recipient had pulled one of his teeth. In the September 1998 TPR, documentation indicated that recipient was hoarse and had a temperature, sustained an injury to his wrist and had an additional dental extraction. In the December 1998 TPR the record indicated the recipient had denied having any bowel, bladder, or sleep problems.

In a January 1999 TPR, the record indicated that the recipient broke a tooth and experienced a fall that required two sutures to his right eyebrow. During February and April 1999, the recipient had dental extractions. In a July 1999 TPR it was recorded that the recipient burned his index finger with a cigarette. In September 1999 when the recipient complained of a severe headache, he saw a facility physician. A follow up was ordered; however, the recipient refused to see the physician. In November 1999, the recipient had a loose toenail and a splinter removed from his thigh. The record indicated that in December 1999, the recipient became very concerned about dying and felt that the Treatment Team could tell him when his demise would occur. Staff members reassured him that he was in good physical health.

In February 2000, the record indicated that the recipient remained concerned about dying despite being assured that his health was good. There were no recordings of any illness, injuries, or dental problems the remainder of 2000, as well as 2001.

The record indicated that in June 2002, the recipient had another dental extraction, and it was recommended that he consider dentures. In December 2002, the record indicated that the recipient was not eating well. However, in February 2003, he became obsessed with eating.

Documentation in a February 2004 TPR indicated that the recipient was encouraged to get dentures, but he continued to refuse. The record indicated that he obtained an abrasion to his knuckles when he punched at a window screen. In July 2004, a dietician documented in the TPR that she recommended that a facility physician speak with the recipient and recommend a high fiber/low fat diet in order that he might lose weight. In the September 2004, the recipient's diagnoses were listed as follows: AXIS I: Personality change due to a gun shot injury and Central Nervous System (CNS) damage, History of Poly-Substance Abuse; AXIS II: Personality Disorder, (Antisocial); AXIS III Post Brain Injury (left frontal lobe), (CT Scan 04/06 and 04/02/04 shows bullet lodged in left temporal lobe), Right Spastic Hemiparesis, Dysarthic Speech, Strabsmis, Enuresis, Neurogenic Bladder, and Obesity; AXIS IV: NGRI with Theim Date 12/10/08.

According to a March 2005 TPR, the recipient had complained of headaches and in April 2005 staff reported that he was losing his balance. In the recipient's May 2005, documentation indicated that the recipient had refused an evaluation to address headaches and loss of balance. In November 2005, the record indicated that when the recipient complained of chest pains, an EKG was completed. The results of the EKG denoted no abnormalities.

During review of the TPRS, it was noted that medications to assist the recipient with psychosis and aggression were adjusted throughout his hospitalization. Medication adjustments were made in November 1995, March 1996, June 1996, April 1997, July 2000, November 2001, June 2002, January 2004, February 2004, May 2004, July 2004, October 2004, March 2005, and June 2005.

In the recipient's January 2005 TPR, the following medications he had been taking and their side effects were listed as follows: 1) Divalproex…(side effects) increased appetite, nausea, vomiting, increased weight, decreased weight, dyspepsia, cramps, constipation, decreased T3 and

T4 (hypothyroidism); 2) Risperidone…(side effects) increased appetite, increased weight, obesity dyspepsia, abdominal pain, constipation, diarrhea, nausea, vomiting, abdominal pain, headache, water intoxication, and decreased hemoglobin/hematocrit; 3) Dyphenhydramine…(side effects) anorexia, dry mouth and throat, epigastria pain and constipation.

Documentation throughout the recipient's TPR indicated that he was above his IBW, and he would at times be obsessed about exercising, refraining from eating, and exhibiting some purging behaviors to address his weight issue. While at other times, he could not get enough to eat and refused to exercise. The HRA did not observe any documentation that indicated that the recipient had experienced any problems with constipation. On several occasions, documentation indicated that the recipient denied having any problems with elimination. However, the HRA did not observe any documentation indicating that his bowel movements had been monitored.

Progress Notes:

According to a 11/14/05 Progress Note, a facility physician was contacted when the recipient complained of chest pain that radiated to the left side. When an EKG was completed, it was noted that there were no changes from the previous EKG. When the physician spoke with the recipient, he denied having any chest or arm pain.

Documentation in a 03/12/06 Progress Note indicated that the recipient had been recommended for transfer.

In an 8:10 PM Progress Note on 03/26/06, a facility physician documented that the recipient was noted to be in respiratory distress. The physician recorded the following: 1) breathing moderately labored in a sitting position, 2) bilateral scattered wheezing, 3) heart rate 160, 4) blood pressure 160/100, 5) abdomen distended, 6) absent bowel sounds, and 6) no history of cardiopulmonary disease. Oxygen was administered, and the physician ordered that the recipient be transferred by ambulance to the community hospital.

In a 11:45 PM Progress Note, documentation indicated that an emergency room nurse at the community hospital notified the facility that the recipient had "coded" at 11:20 PM and was pronounced dead at 11:40 PM

Medication Records:

The HRA reviewed Medication Orders and MARS from October 2005 until the recipient's death on 03/26/06. A facility physician ordered that oxygen be administered, and the recipient be transferred to a community hospital emergency room by ambulance on 03/26/06. The diagnosis listed on the Medication Order to transport the recipient to the hospital listed the recipient as having a possible bowel obstruction. The Authority did not observe any documentation in the Medication Orders or the MARS that indicated medication had been prescribed for constipation or as a bulking agent to prevent constipation.

III…OIG Investigation Information:

The Coordinator spoke to an OIG Representative concerning the allegation, and the Authority reviewed OIG Annual Reports for 2006 and 2007 and OIG Reports of Findings for the three recipients who died while residing at the facility.

A…OIG Annual Reports

According to the 2006 OIG Annual Report to the Governor, two deaths had occurred at the facility during the year with one of the death investigations completed when the Report was issued. Documentation in the Report indicated that there were fifty-one deaths of individuals receiving services in state facilities or deaths of recipients who were recently discharged from the facilities. The leading causes of death were listed as heart disease and pneumonia, followed by cancer, sepsis and renal disease. No abuse or neglect was found in any of the deaths, but three of the deaths were notable. According to the Report, a coroner's jury reviewed a death at a facility from a bowel obstruction. The individual had adhesions from a previous surgery for a gunshot wound. The coroner's jury decided the manner of death was "undetermined." The OIG made several recommendations for the facility to assess bowel elimination of all of the facility recipients.

In a 2007 OIG Annual Report to the Governor, one death was reported at the facility; however, two death investigations had been completed during the year. Documentation indicated that of the eleven deaths that were reported in DHS psychiatric hospitals, two of the deaths were from bowel obstructions.

B…OIG Reports of Findings

Recipient 1:

Documentation indicated that the OIG received a report of the death of Recipient 1 on 11/10/ 2005 at a community hospital. The synopsis of the findings indicated that it was the opinion of the pathologist who performed the autopsy that Recipient 1's death was the result of an adynamic ileus (bowel obstruction) caused by a massive fecal impaction. Documentation indicted that the OIG had a surgeon in a major city review the case and rendered his opinion about the medical care that Recipient 1 had received. According to the surgeon's report there was not a direct connection between Recipient 1's death and his constipation. Documentation indicated that the surgeon stated that he believed the care rendered by the physicians at the facility was acceptable.

However, the OIG recommended that since constipation is not uncommon in institutionalized individuals, especially individuals receiving multiple medications, the medical and nursing staff should develop a system to identify and monitor individuals. Additionally, the OIG recommended that follow up discussion of difficult medical problems occur during treatment team meetings in order to facilitate compliance.

Recipient 2:

According to the OIG Report of Findings, Recipient 2 was taken to surgery to explore his abdomen with the thought that his abdominal pain held the key to his multiple problems. Documentation indicated that the recipient arrested before surgery and could not be revived. He was pronounced dead at 1:51 PM on August 11, 2006. The autopsy findings indicated that the cause of his death was from a mechanical obstruction of the large bowel, due to massive fecal impaction caused by the use of anti-cholinergic drug use. The manner of death was classified as natural.

Documentation in the OIG Report of Findings indicated that the recipient's treatment plan, progress notes and nursing assessments recorded that the recipient generally made his complaints of not feeling well and having pain known to staff. There was no documented evidence that the recipient had complained about having problems with constipation. However, there were no recordings that indicated staff had specifically asked about his bowel elimination. The recipient's record indicated that the physician at the community hospital was unclear as to the etiology of the recipient's pain and attempted to stabilize his cardiac condition prior to exploratory surgery but he expired on the surgery table. The OIG's investigation did not find that the facility was neglectful in the recipient's care.

Recipient 3:

According to an OIG Report of Findings, on March 26, 2006 at approximately 8 PM, while a STA staff member was making rounds, the a 35-year-old recipient was found to be having difficulty breathing. He was also having problems with shivering and was cold to touch. The STA noted that the recipient's abdomen was enlarged. When medical staff was contacted, a nurse and physician examined the recipient. The physician ordered that the recipient be sent via ambulance to a community hospital emergency room for further evaluation. Documentation indicated that the recipient coded at the hospital was pronounced dead at 9:40 PM on March 26, 2006. Autopsy findings indicated that the cause of death was from a mechanical obstruction of the bowel, due to intra-abdominal adhesions that resulted from laparotomy when the recipient received a gunshot wound to the abdomen. Contributing causes included the use of neuroleptic drugs for psychiatric problems, which resulted constipation.

The OIG's review of the recipient's TPR, Progress Notes, Medical History and Nursing Assessments did not give any indication that the recipient's bowel elimination was assessed or monitored, nor that he had complained of constipation. After reviewing the evidence, the OIG concluded that the facility had not been neglectful in the recipient's treatment.

Conversely, it was recommended that a bowel elimination assessment be completed on all recipients at the facility. The assessment should include the individual's medical history, any surgery, current medication, use of laxatives and stool softeners, diet, fluid intake, activity level, normal elimination pattern, any pain with defection, and other important medical information. The assessments should be reviewed by the individual's physician with recommendations made for treatment.

Documentation indicated that when a death inquest was conducted, the Coroner's Jury indicated an undetermined finding.

C…Interview with the OIG

When the Coordinator met with an OIG Representative, the Representative stated that all death investigations are conducted by a specific OIG Investigator with medical expertise. He assured the Coordinator that the OIG had investigated the deaths at the facility, recommendations were made and policies were changed. However, the Representative did not provide any specific information about the investigations.

Facility Policy/Procedure:

A… Bowel Elimination Assessment and Monitoring Procedure

The Policy Statement in the Procedure is listed as, "It is recognized that patients with chronic mental illness are at increased risk for constipation and many psychotropic medications are anti-cholinergic and therefore increase these risk factors (i.e. Clozaril, Benzatropine, and Artane) In addition to psychotropic medication, other medications used to treat mental illness, such as alpha blockers and antispasmodics (i.e. Oxybutin, Terazosin) can also increase risk of constipation. Measures are therefore useful in assessment, monitoring and preventing constipation and its potential adverse sequela such as impaction."

The Procedure is listed as follows: "1) Upon completing a patient's initial medical and nursing history and physical examination, an initial bowel elimination assessment, documented on form CHMC 717 will be completed collaboratively by the admitting nurse and physician. Documentation will include an initial intervention plan if indicated from the assessment. 2) Nursing staff will ask each patient twice daily if he had a bowel movement that day. Frequency and size of bowel movements will be documented on form CHMC-432. Whenever a significant problem is identified and in any case whenever a patient has gone three or more consecutive days without a bowel movement, the nurse will notify the primary care physician/MOD, and a nursing note will be entered in the patient's chart. 3) When notified of a significant bowel problem or of the patient's going three or more consecutive days without a bowel movement, the physician will asses the problem and order appropriate measures."

Documentation indicated that the Procedure was revised on 08/15/06, 09/08/06, 02/11/08 and reviewed on 03/15/07. The Authority was unable to determine when the Procedure was initially formulated.

Daily Bowel Monitoring Forms CHMC-432 (Forms)

With written authorization, the HRA reviewed the February 2009 Forms for three recent recipients. According to documentation for Recipient A and Recipient B, each recipient had been monitored daily in the PM. However, on 02/15/09, there was no documentation to indicate that Recipient A had been asked if he had a bowel movement in the AM. Nor, was there documentation regarding Recipient B's bowel elimination being monitored in the AM on

02/16/09. Documentation indicated that the Recipient C's bowel movements were monitored every morning. However staff failed to document any observations on the evenings of 02/02/09, 02/11/09, 02/12/09 and 02/17/09. In the comments section, there was consistent documentation that indicated that the Recipient C had refused to drink prune juice as an aid to prevent constipation. All the recipients had received an initial assessment per the facility's policy and procedure. There was one occasion during the month of February when Recipient C did not have a bowel movement for three days. Documentation indicated that he was examined by a physician and found to have a soft abdomen and active bowel sounds. Biscodyl, a laxative, was prescribed and he refused the offered prune juice. The record indicated that Recipient C had a bowel movement the day after the examination.

Illinois Department of Human Services PPD

The Authority reviewed the PPD entitled, "Principles and Requirement of Treatment Planning in Mental Health Facilities." The Policy Statement is as follows: "Each individual is entitled to receive the highest quality of care and treatment that can be provided within any Office of Mental Health (OMH) facility. Treatment that is of high quality must be effective (i.e. result in improvement or prevent deterioration), efficient (i.e. achieve results as rapidly as possible), and appropriate (i.e. meet generally accepted standards of practice). Effective, efficient, and appropriate treatment is unlikely to occur in the absence of a thoughtful treatment plan for assessing, prioritizing, and addressing the individual's problems and needs and utilizing the individual's strengths and assets. The development of a quality treatment plan requires clinically competent staff who work collaboratively with the individual in the treatment planning process. This PPD is intended to reinforce a quality treatment planning process that results in measurable positive outcomes for the individuals served and the optimal use of staff resources. It is the policy of the Office of Mental health that staff shall adhere to the explicit requirement of this PPD and shall incorporate the underlying principles and values into their clinical practices."

Summary

During the investigation, the HRA spoke with six recipients concerning the allegation. Four recipients stated that they had not experienced any problems with constipation. However, five of the six interviewed related that they were aware of individuals who had experienced some significant problems with constipation and impactions. Four of the recipients informed that Team that the facility had begun to consistently monitor recipients for any signs of constipation and to offer prune juice, bulking agents, and other treatments for the problem

The masked records that were provided to the HRA indicated that three recipients died during the period of 11/10/05 to 08/11/06. According to the autopsy reports for Recipient 1, his death was a result of a bowel obstruction caused by a fecal impaction. The Autopsy Report for Recipient 2 listed his cause of death as a mechanical obstruction of the large bowel, due to a massive fecal impaction caused by the use of anti-cholinergic drug use. The Autopsy Findings for Recipient 3 listed a mechanical obstruction of the bowel, due to intra-abdominal adhesions that resulted from a laparotomy when the recipient received a gunshot wound to the abdomen. The recipient's use of neuroleptic drugs to treat his psychiatric problems were listed as contributing factors to his death. When a Coroner's jury investigated Recipient 3's death, an

undetermined finding was indicated. All three autopsies noted that medications may have contributed to constipation/impactions.

Documentation indicated that when the OIG investigated each of the deaths, the facility was not cited for inadequate care. However, the OIG issued recommendations for the facility medical and nursing staff to develop a system to identify and monitor recipients for constipation and to have follow-up discussions of difficult medical problems during recipients' treatment plan meetings. The OIG also recommended that a bowel assessment be completed on every recipient at the facility.

The facility has a Bowel Elimination Assessment and Monitoring Procedure; however, it was difficult for HRA to determine when the procedure was initially implemented. Documentation indicated the first review of an existing policy was conducted on 08/15/06. The Procedure mandates that nursing staff ask each patient twice daily if he has had a bowel movement that day. The frequency and size of the bowel movement is to be documented on a Daily Bowel Monitoring Form.

When the HRA reviewed February 2009 Daily Bowel Monitoring Forms for three recent recipients, documentation indicated that Recipient A was not asked if he had a bowel movement in the AM on 02/15/09 and Recipient B was not asked in the AM of 02/16/09. Recipient C's records indicated that staff failed to document any observations in the PM on 02/02/09, 02/11/09, 02/12/09, and 02/17/09.

Conclusion

Although it was unclear to the HRA what policy/procedure was in place at the time of the deaths for the three deceased recipient records reviewed, it was clear that all three died from impactions, all three were prescribed psychotropic medications and all three had no documented monitoring of bowel movements. One of the deceased recipients had a documented history of constipation resulting in prescribed medications and treatments which he sometimes refused. He also had a history of digging behaviors; however, neither the constipation nor the digging behaviors were addressed in the recipient's treatment plan and there was no documented monitoring of the recipient's bowel movements. Another recipient had a documented problem with eating, a history of stomach problems and a documented transfer order to a hospital that questioned the existence of a bowel impaction; the recipient's treatment plan addressed the stomach issues, but there was no treatment plan documentation of constipation problems.

More recent recipient records lacked regular documentation of bowel movements.

The HRA acknowledges that the OIG did not have neglect findings in any of the facility deaths. However, from a rights perspective, HRA has more latitude in defining "adequate care" versus the mores stringent OIG guidelines for identifying "neglect".

Due to the lack of TPR goals and monitoring of a deceased recipient who had a documented history of constipation and monitoring gaps for three more recent recipients, the HRA substantiates the allegation that the facility did not provide adequate care and makes the following recommendations:

1. Ensure that services are provided pursuant to individual treatment plans as required in the Mental Health Code. When medical care or services are warranted, ensure that recipient medical needs are addressed in treatment plans as per Administrative Code requirements (59 Ill. Admin. Code 112).

2. Ensure that assessments of bowel elimination are completed for recipients upon admission as per policy and as part of the required annual physical exams.

3. Ensure that the monitoring of bowel elimination is completed and documented as per facility policy.