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Egyptian Regional Human Rights Authority
Report of Findings
Chester Mental Health Center
08-110-9034
September 30, 2008

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

> Chester Mental Health Center staff failed to protect a recipient from being harmed by another recipient.

Statutes

If substantiated, the allegation would be a violation of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-102 and 405 ILCS 5/2-112). Sections 5/1-101.2 and 5/1-117.1 are also pertinent to the allegation.

Section 5/2-102 states, "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan."

Section 5/2-112 states, "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect."

Section 5/101.2 states, "'Adequate and humane care and services' means 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 reasonably 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."

Section 5/1-117.1 states, "'Neglect' means the failure to provide adequate medical or personal care or maintenance to a recipient of services, which failure results in physical or mental injury to a recipient or in the deterioration of a recipient's physical or mental condition.

Investigation Information

To investigate the allegation, the HRA Investigation Team (Team), consisting of three members and the HRA Coordinator (Coordinator), conducted a site visit at the facility. During the visit, the Team spoke with the recipient whose rights were alleged to have been violated and reviewed his clinical record.

Interview with Recipient:

According to the recipient, while he was in the facility dining room another recipient came up to him, gave him a "karate kick" and then bit off the tip of his finger. He informed the Team that the injury required treatment at a community emergency room, and he was required to remain in the facility infirmary for several weeks after the incident. He stated that he could not remember the date that the injury occurred. The recipient denied being involved in any type of altercation with the aggressor when the incident occurred.

The recipient informed the Team that he felt that staff could have done more to intervene on his behalf and could possibly have prevented his injury.

During the visit with the recipient, he removed the bandage from the affected area so that the Team might observe the injured finger. The Team noted that the affected area did not have any redness and appeared to be healing appropriately.

Clinical Chart Review:

The recipient provided written authorization for the Authority to review his clinical chart. His Treatment Plan Reviews (TPRs) and Progress Notes for November 2007, December 2007, and January 2008 were examined. Nursing Re-assessment Summaries for December 2007 and January 2008 were reviewed.

Treatment Plan Reviews:

According to an 11/06/07 TPR, the recipient was admitted to the facility on 07/21/92 from another state-operated mental health facility. The recipient's legal status was listed as Involuntary. His diagnoses were listed as follows: AXIS I: Paranoid Schizophrenia, in remission; AXIS II: Antisocial Personality Disorder; and AXIS II: Diabetes Mellitus, adult onset.

Documentation in the 11/06/07 TPR indicated that the recipient had experienced problems with stabilization of blood sugar levels. There was an objective in the TPR for the recipient to demonstrate an understanding of the importance of proper nutrition, exercise and maintaining an ideal weight. A facility nurse recorded that the recipient had to be frequently redirected when he attempted to take food, which was detrimental to his diabetic condition, from his peers. A Security Therapy Aide (STA) informed the treatment team that the recipient had to be continually observed so that he would not eat items that he should not have. The Authority did not observe any documentation that indicated that the recipient had received an injury during the reporting period.

In a 12/04/07 TPR, documentation indicated that the recipient came to the TPR; however, after the meeting he returned to the infirmary. The record indicated that the recipient was sent to the infirmary after the tip of his finger was bitten off by another recipient. A facility nurse and the recipient's therapist recorded that the injury occurred when there was altercation between the two recipients.

Documentation indicated that the recipient's 01/01/08 TPR was held in the infirmary where he continued to be observed following an injury to his finger. The recipient's therapist reported that there had been no reports of the recipient being involved in any type of inappropriate sexual behavior. However, documentation indicated that he had been in a physical altercation, which resulted in the loss of the tip of his finger.

Progress Notes

On 11/17/07 at 8:10 PM a facility nurse recorded in a Progress Note that a STA had reported that when the recipient placed his right hand into a peer's mouth, the peer bit off the tip of his right middle finger. The nurse recorded that approximately ½ inch of the flesh was found, placed in ice water and sent to the emergency room with the recipient.

A STA recorded at 8:10 PM on 11/17/07 that the tip of the recipient's right index finger was bitten off by another recipient during an altercation between the two individuals. At 8:20 PM, the STA recorded that the patient was sent to the community hospital emergency room for treatment. The tip of the patient's right middle finger was packed in ice, placed in a sterile specimen cup and sent with the patient to the emergency room.

A RN recorded at 10:10 PM on 11/17/07 that a nurse at the community hospital called to report that the recipient would be returning to the facility. According to the documentation, the RN at the community hospital stated that the amputated portion of the recipient's finger was not reattached, and when the area was x-rayed no fractures were found. Additional documentation indicated that the recipient was given a Lidocaine injection in the finger to treat pain during the procedure. Augmentin, an antibiotic, and Darvocet, a pain reliever, were prescribed. The recipient was also given a Tetanus vaccine.

At 11:40 PM on 11/17/07, documentation indicted that the recipient had returned from the community hospital and admitted to the facility infirmary.

According to the record, a RN on each shift examined the recipient's finger, documented the condition of the affected area and listed the treatments that were administered from the date of his admission to the infirmary on 11/17/07 until the recipient returned to Unit B on 12/10/07. Additional recordings indicated that a facility physician examined the recipient daily during his stay in the infirmary.

Nursing Re-assessment Summaries

Documentation in a 12/04/07 Re-assessment Summary indicated that the recipient was involved in an altercation with a peer on 11/17/07. As a result of the dispute, the tip of the

recipient's finger was bitten off by the peer. According to the record, the recipient was sent to a community hospital emergency room for treatment, and when he returned to the facility he was placed in the facility infirmary. At the time of the assessment, the recipient remained in the infirmary.

According to a 01/01/08 Re-assessment Summary, the recipient had spent several weeks in the infirmary after having the tip of his right middle finger bitten off by a peer. The record indicated that the recipient had returned to Unit B on 12/10/07 in stable condition.

Summary

According to the recipient whose rights were alleged to have been violated, another recipient bit off the tip of his finger. The recipient informed the Team that the attack was unprovoked. The recipient informed the Team that he felt that facility staff could have done more to protect him from the recipient. Conversely, documentation in the recipient's TPR and progress notes indicated that the recipient received the injury as a result of an altercation with another recipient. According to a progress note, the injured recipient had placed his hand in the mouth of the aggressor. The record indicated that as soon as the recipient was injured, he was examined by a facility physician who sent him to a community hospital emergency room. When the recipient returned to the facility after receiving treatment at the emergency room, he was placed in the facility infirmary. Documentation indicated that a RN examined the recipient each shift and a physician examined him daily the entire time that he was in the infirmary. The record indicated that when medical staff determined that the area was healed he was returned to a facility unit.

Conclusion

Although the seriousness of the injury caused the Authority concern, there is no evidence to say that facility staff members failed to intervene when the dispute between the two recipients occurred or that the facility failed to provide adequate care as defined by the Code. Therefore, the allegation is unsubstantiated. No recommendations are issued.