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Egyptian Regional Human Rights Authority
Report of Findings
10-110-9026
Chester Mental Health Center
August 24, 2010

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 250 male recipients. The specific allegations are as follows:

1. A recipient at Chester Mental Health Center has not been provided with adequate care and services.
2. The recipient's property was confiscated and destroyed.
3. The recipient's request for his medical records has not been addressed.

Statutes

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-102 (a), 5/2-104, 5/2-201) and the Mental Health and Developmental Disabilities Act (Act) (740 ILCS 110/4).

Section 5/2-102 (a) of the 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."

Section 5/2-104 of the Code states, "Every recipient who resides in a mental health or developmental disabilities facility shall be permitted to receive, possess and use personal property and shall be provided with a reasonable amount of storage space therefor, except in the circumstances and under the conditions provided in this Section. (a) Possession and use of certain classes of property may be restricted by the facility director when necessary to protect the recipient or others from harm, provided that notice of such restriction shall be given to all recipients upon admission. (b) The professional responsible for overseeing the implementation of a recipient's services plan may, with the approval of the facility director, restrict the right to property when necessary to protect such recipient or others from harm. (c) When a recipient is

discharged from the mental health or developmental disabilities facility, all of his lawful personal property which is in the custody of the facility shall be returned to him."

Section 5/2-201 of the Code states, "Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to (1) the recipient and, if the recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice; (3) the facility director; (4) the Guardianship and Advocacy Commission, or the agency designated in 'An Act in relation to the protection and advocacy of rights of persons with developmental disabilities and amending the Acts therein named' approved September 20, 1985, if either is so designated; and (5) the recipient's substitute decision maker, if any. The professional shall be responsible for promptly recording such restriction or use of restraints or seclusion and the reason therefor in the recipient's record."

Section 110/4 of the Act states, "(a) The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof: (1) the parent or guardian of a recipient who is under 12 years of age: (2) the recipient if he is 12 years of age or older; (3) the parent or guardian of a recipient who is at least 12 but under 18 years, if the recipient is informed and does not object or if the therapist does not find that there are compelling reasons for denying the access. The parent or guardian who is denied access by either the recipient or the therapist may petition a court for access to the record. Nothing in this paragraph is intended to prohibit the parent or guardian of a recipient who is at least 12 but under 18 years from requesting and receiving the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed, including medication, if any; (4) the guardian of a recipient who is 18 years or older; (5) an attorney or guardian ad litem who represents a minor 12 years of age or older in any judicial or administrative proceedings, provided that the court or administrative officer has entered an order granting the attorney this right: or (6) an agent appointed under a recipient's power of attorney for health care or property, when the power of attorney authorizes the access.

Investigation Information

Allegation 1: A recipient at Chester Mental Health Center has not been provided with adequate care and services. To investigate the allegation, the HRA Investigation Team (Team), consisting of two 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 the facility's Training Coordinator. The recipient's clinical chart was reviewed with his written authorization.

I... Interviews:

A...Recipient:

During the site visit, the recipient informed the Team that he experienced a seizure shortly after he was admitted to the facility. He stated staff handled him in a "rough manner" when he had a seizure. The recipient did not provide the name of the staff members involved or list any witnesses to the event.

B...Training Coordinator:

During the site visit, the Team spoke with the facility Training Coordinator concerning the allegation. The Training Coordinator related that he was not aware of any information pertinent to the allegation. However, with the recipient's written authorization, he provided the Team with requested documentation from the recipient's clinical record.

II ...Clinical Chart Review:

A: Treatment Plan Reviews (TPRs):

Documentation in a 09/02/09 TPR indicated that the recipient was adjudicated Unfit to Stand Trial (UST) on 08/03/09 and admitted to Chester Mental Health Center on 08/25/09. His diagnoses were listed as follows: AXIS I: R/O (Rule Out) Bipolar Disorder with psychiatric features vs. Schizoaffective Disorder Bipolar Type vs. Schizophrenia Paranoid Type, non-compliance; AXIS II: Deferred; AXIS III: Seizure Disorder, H/O (History of) a stroke in 2001; and AXIS IV: H/O Incarceration, non-compliance, poor insight and judgment, UST. The record indicated that the recipient refused to take any medications.

Problem areas listed in the 09/02/09 TPR included the recipient's legal status of being UST and his psychotic symptoms. The TPR contained goals for the recipient to achieve fitness and to reduce his psychotic symptoms.

The recipient's 09/15/09 21-day TPR added a seizure disorder as an additional problem area. A goal for the recipient to manage and minimize seizure episodes and to prevent injury in the event of a seizurewas incorporated in the TPR. Objectives were listed as follows: 1) Nursing staff will administer medication, encourage and monitor compliance and report any medication side effects and seizure activity; 2) Nurses and physicians will monitor medication protocol including serum blood levels of prescribed medications; 3) All seizure activity will be recorded; 4) Psychiatrists, therapists, nurses and STAs will assure safety of the recipient in the event of a seizure. He will not be restrained but protected, especially his head, from hard, sharp objects; and 5) A nurse will educate the recipient regarding his current anticonvulsant medication including the name, dosage, time, schedule, side effects, labs, and importance of taking the medication. The medication prescribed for seizure control was listed as Dilantin 400 mg at bedtime. A facility nurse recorded that the recipient had experienced one seizure since his admission.

Documentation in 10/13/09, 11/10/09, 12/08/09 and 01/05/10 TPRS indicated that the recipient had not experienced any seizures during the reporting periods. However, the recipient continued to be listed on the seizure precaution list so that staff could be alerted to any seizure activity and document any occurrences.

B: Progress Notes:

The Authority reviewed Progress Notes from the date of the recipient's admission on 08/25/09 through 02/22/10. According to a 09/04/09 Progress Note completed by a Registered Nurse (RN), security staff and a peer reported that the recipient had lowered himself to the floor. Upon arrival to review the situation, the RN found the recipient was lying on the floor on his right side. When the RN asked the recipient if he needed assistance to get up, he was able to ambulate unaided to a nearby chair. The RN recorded that the recipient was not disoriented or incontinent of urine; nor had he sustained any type of injury. He was able to state his name and that he did have seizure activity. Documentation indicated that the nurse notified a facility physician who ordered that a Dilantin level be completed in the AM. The RN recorded that staff were alerted to monitor the recipient for any type of seizure activity and to contact a facility physician if a seizure occurred. Documentation in the progress notes indicated that the prescribed monitoring was conducted as ordered by the RN.

Documentation in a 09/28/09 Progress Note completed by an RN indicated that the recipient had refused to have labs. Another RN recorded that an STA had notified the RN that the recipient had alleged that he was "picked up roughly after a seizure." When the RN spoke with the recipient he denied encountering any problems or having any injury, and he declined to be seen by a facility physician.

Documentation indicated that Dilantin levels were obtained on 09/05/09, 09/15/09 and 01/19/10. The record indicated that the recipient refused lab work on 09/28/09. Dilantin levels were within normal limits. There was no documentation to indicate that the recipient had experienced bruising.

Summary of Allegation 1

According to the recipient, facility staff did not provide adequate care when he experienced a seizure shortly after his admission to the facility. Documentation in the recipient's clinical chart indicated that the recipient was admitted to the facility on 08/25/09 and experienced a seizure on 09/04/09. When an RN was notified by staff that the recipient was on the floor, the RN went to the recipient to assess the situation. Documentation indicated that the RN found the recipient lying on his side; however, he was able to ambulate to a nearby chair without assistance and did not experience any disorientation or incontinence. The record indicated that the RN contacted a facility physician and alerted staff to monitor the recipient for any additional seizure activity. Documentation indicated that a goal was added to the recipient's TPR to manage and minimize seizure episodes and to prevent injuries in the event of a seizure. The record indicated that labs were periodically obtained to monitor the level of the seizure medication, Dilantin. When the recipient reported that he was handled in a rough manner during

a seizure, documentation indicated that an RN spoke with the recipient who stated that he did not receive an injury and declined to be seen by physician.

Conclusion of Allegation 1

Based on the information obtained, the allegation that the recipient did not receive adequate care is unsubstantiated. No recommendations are issued.

Allegation 2: The recipient's property was confiscated and destroyed. To investigate the allegation, the Team spoke with the recipient and the Training Coordinator. The Authority reviewed information from the recipient's clinical chart and the Patient's Handbook (Handbook).

I... Interviews:

A: Recipient:

The recipient informed the Team that a package of commercially wrapped non-perishable food items was sent to him via the mail. He stated that when the package was received, facility staff considered the items contraband and destroyed them. The recipient informed the Team that the items were allowable due to the manner in which they were packaged and should have been stored in the commissary and given to him during commissary periods. He stated after the items were destroyed, staff offered to replace them with items from the commissary; however, he refused the replacement because the items that were sent to him were of better quality than the items in the commissary. He stated that after his refusal to accept the commissary items, the facility offered him money for the cost of the items that were destroyed. He related that he felt that extra compensation should be allowed and informed facility staff that he would accept three times the value of the items that were destroyed.

The recipient stated that he also has a [NAME] t-shirt valued at $200, which can not be found in his property. The recipient informed the Team that the shirt was given to him by a relative for his birthday. He provided a copy of a receipt dated 05/22/09 verifying that he had the shirt while he was incarcerated in a county jail. The recipient stated that he had also requested compensation for the shirt: however, the facility has not honored his request.

In a follow-up letter to the Authority, the recipient stated that he had requested payment of $3600.00 for the commissary items and the [Name] t-shirt., and if that amount was not received he would proceed with legal action in small claims court.

B...Training Coordinator

The Training Coordinator informed the Team that when the recipient received a package it was opened in the recipient's presence. He stated that when the staff member learned that the package contained food items, the package was confiscated and the contents destroyed. The Training Coordinator stated that this was a mistake made by the staff member since the items sent to the recipient were non-perishable items in the original packaging, items considered by the facility to be allowable.

The Training Coordinator stated that the facility acknowledged the mistake and offered to replace the items with items from the commissary, and when the recipient refused the replacement he was offered monetary compensation. He informed the Team that the recipient is demanding three times the cost of the items; however, the facility is only willing to compensate for the value of the items destroyed.

The Training Coordinator stated that the recipient has expressed some concerns regarding a celebrity t-shirt that he believes that the facility has lost. He stated that there is no record in his property inventory regarding the recipient having the shirt when he was admitted to the facility. He stated that a search was made through the recipient's property and in property storage without locating the item. Since there is no record of the item, the facility has not offered to compensate the recipient for the item.

II: Clinical Chart Review:

The Authority reviewed the following TPRs: 09/02/09, 09/15/09, 10/13/09, 11/10/09, 12/08/09, and 01/05/10. Documentation indicated that the recipient remained fixated on his rights being violated and lawsuits that he wants to file. However, the Authority did not observe any documentation pertinent to the allegation. Documentation in the 01/05/10 TPR indicated that the treatment team had assessed that the recipient to be fit to stand trial.

When Progress Notes from the time of the recipient's admission on 08/25/09 until 2/19/10 were reviewed, the Authority did not detect any documentation regarding the recipient's property issues or any record to indicate that the recipient required a specialized diet. Nor did the recipient's property inventory include documentation that the recipient had the t-shirt when the inventory was completed at the time of admission.

III...Handbook:

The Authority reviewed the Handbook, which is given to recipients upon admission to the facility. General guidelines, a description of the hospital, programs and services offered information about bringing or sending items to recipients, etc. are included in the Handbook. Documentation regarding sending food to the facility is as follows, "To ensure good physical and mental health for our patients, visitors should only bring caffeine free drinks and food items with limited amounts of sugar. No food or other items may be taken back to the unit by the patient; therefore, the amount of food brought by a visitor should be limited and must be consumed during the visit or taken out by the visitors at the conclusion of the visit. To ensure a safe living environment, no metal or glass items may be given to the patients. Only a reasonable amount of food items should be sent to the hospital in order to prevent problems with insects and spoilage. For medical reasons, patient's dietary needs will be considered and diets will be strictly adhered to."

Additional documentation indicated that that no perishable food item should be sent to the recipient from home since there is no way to guarantee the safety of these items. Any non-

perishable food items sent from home must fit with any special diet the recipient may be on, be in the original package and be subject to inspection.

Summary of Allegation 2

According to the recipient whose rights were alleged to have been violated, when he received a package via mail that contained numerous non-perishable food items that were commercially wrapped, the items were confiscated and destroyed. The Training Coordinator acknowledged that the staff person who destroyed the items made a mistake when he considered the approved items as contraband. The Training Coordinator, as well as the recipient, related that the facility had offered to compensate the recipient for his loss. Initially, the recipient was offered substituted commissary items and when he refused, monetary compensation equal to the value of the destroyed items was offered. However, the recipient refused the offer and informed facility staff that he would accept three times the worth of the destroyed items, plus reimbursement for an expensive t-shirt that he believed was sent from the jail to the facility. The recipient provided documentation from the jail to verify that he had t-shirt while he was incarcerated; however, the Authority did not observe any documentation to indicate that the item was inventoried when the recipient was admitted to the facility. The recipient documented in a letter to the Authority that he had requested $3600 compensation for the items, and would seek legal action if the facility did not comply. The HRA's review of the recipient's clinical chart did not reveal any documentation pertinent to the matter.

Conclusion

Based on interviews with the recipient and the Training Coordinator, the Authority substantiates that the recipient's property was confiscated and destroyed. However, both of the individuals interviewed indicated that compensation was offered after the facility was made aware that the approved items were destroyed. It is also noted that the facility attempted to locate the recipient's t-shirt; however, there was no record to indicate that the shirt arrived with the recipient when he was admitted. Although the allegation is substantiated, the Authority notes that the facility acted in good faith by offering a fair compensation and recommends the following:

1. The facility should continue to offer fair compensation to the recipient for the value of the items destroyed.

Comment and Suggestion.

Interviews from both sides of the issue indicated that there was a problem regarding the items sent to the recipient via mail and a resolution was sought when the items were destroyed. However, the HRA did not observe any documentation in Progress Notes or the recipient's TPRs pertinent to the allegation or the facility's attempt at resolution. The following suggestion is issued:

1. Significant issues and attempts to resolve those issues should be documented in a recipient's clinical chart and discussed when the recipient's TPR is conducted.

Allegation 3: The recipient's request for his medical records has not been addressed. To investigate the allegation, the Team spoke with the recipient and reviewed his clinical chart.

I: Interview:

During a site visit at the facility, the recipient informed the Team that he had been able to review his medical records. However, he did not agree with the documentation pertinent to his diagnosed mental illness or previous history of any type of mental health issue.

II: Clinical Chart Review:

The recipient's clinical chart contained statements signed by the recipient that he had received a complete copy of his clinical file on 01/11/10 and an additional copy on 02/11/10.

Summary of Allegation 3:

When the Team spoke with the recipient during a site visit to the facility, he stated that he had received copies of his clinical chart. Documentation in the recipient's clinical chart contained signed statements regarding the recipient's receipt of the requested records in January 2010 and, once more, in February 2010.

Conclusion

Based on the information obtained, the allegation that the recipient did not receive a copy of his medical records is unsubstantiated. No recommendations are issued.

Comment/Suggestion

Per Section 110/4 (c) of the Act, any person entitled access to a record may submit a written statement concerning any disputed information in a recipient's clinical chart.

1. Recipients should be informed of their right to dispute information in their clinical chart in a manner that is understandable to the recipient.