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Egyptian Regional Human Rights Authority
Report of Findings
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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 240 recipients. The specific allegation is as follows:

> A recipient at Chester Mental Health Center has not received adequate care for a medical condition.

Statutes

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

Section 5/2-102 (a) 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 being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan."

Section 5/1-101.2 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."

Investigation Information

To investigate the allegation, the HRA Investigation Team (Team), consisting of two Members and the HRA Coordinator (Coordinator), conducted a site visit to the facility. During the visit, the Team spoke with the recipient whose rights were alleged to have been violated and the Chairman (Chairman) of the facility's Human Rights Committee. With the recipient's written authorization, the Authority reviewed copies of information from his clinical chart.

I...Interviews:

A...Recipient:

During the site visit, the recipient informed the Team that he continues to experience a urinary tract infection that facility medical staff members refuse to treat appropriately. He stated that he has seen blood in his urine; however, medical staff informed him that testing does not indicate that an infection is present.

According to the recipient, in 2006 he was sent to urologist for additional testing when he reported a similar problem. However, the medical procedures conducted did not reveal an infection or any type of urinary tract disorder.

The recipient stated that he informed the medical staff that "When I was on the streets in 1972, I got a venereal disease and a urinary tract infection, which was treated to an antibiotic, Wycillian. I need Wycillian."

B...Chairman:

According to the Chairman, the facility's Human Rights Committee has not received any complaints relevant to the issue presented by the HRA.

II....Clinical Chart Review:

A...Treatment Plan Reviews (TPRs):

According to a 02/01/11 TPR, the recipient was admitted to the facility on 12/12/03 from a correctional facility. The recipient's Legal Status was listed as Involuntary. According to a mental health evaluation from the transferring correctional facility, "the recipient suffers from a mental illness manifested by paranoid beliefs about the intentions of the correctional staff, his food being poisoned, and the presence of urinary tract infections caused by a sexually transmitted disease that has not been detected by medical staff while in DOC."

Recordings in the 02/01/11 TPR indicated that during the recipient's treatment time at the facility, his aggression has stabilized, but his insight into his mental illness and need for medication have remained poor. Documentation indicated that the recipient remains paranoid and continues to have a fixed delusion regarding a sexually transmitted disease and the need for

"one million milligrams" of an antibiotic. However, regular testing has not indicated an evidence of the suspected illness.

The recipient's diagnoses were listed as follows: AXIS I: Schizophrenia, Paranoid Type, Chronic; AXIS II: Antisocial Personality Disorder; AXIS III: H/O (History Of) Syphilis, H/O Seizure Disorder Secondary to TBI (Traumatic Brain Injury); AXIS IV: Moderate stressors-chronic illness; legal problems.

The recipient's strengths were listed as follows: 1) He is able to perform his ADLs (Activities of Daily Living); 2) He is able to communicate his needs; and 3) He is of average intelligence.

His problem was listed as psychotic symptoms. The TPR contained a goal for the recipient to be free of displaying aggressive sexually inappropriate behaviors toward others. An additional goal for the recipient to reduce psychotic symptoms, which consist of a fixed delusion that he has a sexually transmitted disease (syphilis), demands Penicillin shots and exhibits psychotic symptoms such as becoming agitated when his request for Penicillin is not granted. A target date of 12/11 was listed on both goals.

According to additional documentation, the recipient has been institutionalized in the Department of Corrections and/or in a psychiatric hospital, except for very brief periods, since 1970 related to behavior secondary to psychosis. Symptoms of the psychosis include paranoia, grandiose delusions, as well as a fixed delusional belief that he has a constant urinary tract infection and needs daily doses of antibiotics, despite repeated negative and normal laboratory studies. The record indicated that when the recipient is informed of the negative findings, he relates that he believes that the findings are being altered by facility medical staff.

The recipient's current medication were listed as follows: Risperidone 8 mg BID (twice daily) for psychosis, Lamotrigine (Lamictal) 200 mg PO (by mouth) every HS (bedtime) for mood swings; Lorazepam 1 mg PO BID for anxiety/akathisia; Benztropine 1 mg BID for EPS (Extrapyramidal Symptoms), and Lorazepam 2 mg PO every 4 hours PRN (when needed) for agitation /psychosis.

A facility psychiatrist indicated in a 02/01/11 progress report to the recipient's treatment team that the recipient continues to demand antibiotics despite negative result for syphilis. A Registered Nurse (RN) recorded the recipient "continues to request Wycillen more and more." The recipient's therapist indicated that "[NAME] has exhibited continued delusional verbalization, including somatic delusions and grandiose, religious beliefs. He maintains he is suffering from syphilis. He also states he is a central figure in the Old Testament."

Documentation in a 02/28/11 TPR indicated that on 02/02/11 the recipient was granted permission to have an independent evaluation. However, when the psychiatrist attempted to conduct the evaluation on 02/09/11 the recipient refused to meet with him, even after three attempts were made.

Documentation by a staff psychiatrist indicated that the recipient's fixed somatic delusions persist. His therapist recorded that the recipient continues to possess delusional beliefs involving somatic themes and has limited insight into the irrational nature of these beliefs.

According to recordings in a 03/29/11 TPR, during the reporting period the recipient's aggression had stabilized, but his insight into his mental illness remained poor. Documentation in a 04/26/11 TPR indicated that the recipient complained that he had not been receiving treatment for a sexually transmitted disease. The record indicated that a facility physician reviewed recent examinations/testing and explained to the recipient that he does not have or require treatment for a sexually transmitted disease. Upon hearing the physician's comments, the recipient became quite hostile and left the meeting.

Additional documentation in the 04/26/11 TPR indicated that the recipient had refused medical treatment during the reporting period. On 04/03/11, he refused to allow a nurse to listen to his bowel sounds, and he refused to provide a urine sample on 04/19/11. A facility psychiatrist recorded that the recipient remains delusional believing that he has an undetected infection that requires antibiotics.

According to a 05/24/11 TPR, the recipient's psychotropic medications remained the same as listed in the 02/01/11 TPR, as well as subsequent TPRs listed in this report. An RN recorded that the recipient remains on crush and observe status (crushing the recipient's medication and observe him taking the medication). However, he had several refusals during the reporting period. A facility psychiatrist recorded that the recipient's fixed somatic delusions persist. However, he does possess some insight. He believes that the medications prescribed calms him. The recipient's therapist documented that the recipient continues to believe that he is a central figure in the Old Testament, and he continues to possess delusional beliefs involving somatic themes.

B...Progress Notes

Progress Notes from 01/25/11 through 07/10/11 were reviewed to investigate the allegation.

According to a 01/25/11 medical progress note, the recipient had complained that his testicles hurt, his throat was sore, and it hurt when he urinated. Documentation indicated that a facility physician ordered Loratadine, an antihistamine, and pseudoephedrine, a decongestant, and gave instructions for the recipient to gargle with salt water. Additionally, the physician ordered a CBC (Complete Blood Count), a throat culture, UA (urinalysis) and a C& S (Urine Culture and Sensitivity). Documentation in a 01/27/11 progress note indicated that the CBC which was drawn on 01/26/11 was within normal limits.

Documentation in a 02/03/11 progress note indicated that the recipient continued to complain about having a cough and congestion and had requested to see a facility physician. Documentation in a 02/04/11 physician's medical progress note indicated that the recipient stated that he was having headaches and blood drainage from his nose. The recipient was diagnosed as having acute sinusitis and Amoxicillian, an antibiotic, was prescribed for a 10 day period. When

the recipient was seen by the Physician on 02/14/11, Levoquin, another antibiotic, was prescribed for a 10 day period due to the continued sinusitis

Documentation in a 03/22/11 progress note completed by an RN indicated the recipient had complained of dizziness and intermittent chest pains. The RN documented that a facility physician was notified and the recipient was transferred to the facility infirmary in a wheelchair.

Documentation in a 03/22/11 medical progress note completed by a facility physician indicated that the recipient stated that he had been having sharp pains under his heart and had been dizzy. The physician recorded that the recipient stated that pains were severe enough to wake him from his sleep. The physician ordered an immediate testing such as an EKG, cardiac enzymes, and Troponin, to determine if the recipient was having a heart attack. Serial cardiac enzyme testing was ordered after the initial test was conducted. Medical staff members were instructed to send the recipient to the community emergency room if the recipient condition deteriorated.

A 03/23/11 progress note indicated that the recipient stated that he was feeling "ok" and all of his test result did not indicate any problems. Recordings in a physician's note on 03/24/11 at 9 AM indicated that the recipient's serial cardiac enzymes and Troponin were within normal limits, his EKG was normal, and a physical examination did not reveal any problems. Documentation indicated that the recipient was released from the infirmary on 03/24/11 at 9:10 AM.

In a 04/07/11 progress note completed at 8:30 AM, an RN recorded that the recipient had complained of having blood in his urine. She documented that a facility physician would be notified regarding the recipient's complaint. Documentation in an additional 04/02/11 progress note indicated that the recipient had written an order to collect the recipient's urine for a urine analysis and a C&S due to the recipient's complaints of blood in urine and frequent urination. According to documentation when the recipient was approached to obtain the urine sample he refused to comply, and stated, "You know I need Wycillian right?"

A physician documented in a 04/19/11 medical note that the recipient had reported painful, blood urination. However, he had refused to provide a urine specimen for an analysis and culture. The physician recorded that the recipient stated, "All I need is two shots of Wycillin to fix my infection;" An RN documented in a 04/22/11 progress note indicated that a urinalysis had been completed from a specimen obtained on 04/20/11. All findings were within normal limits.

Documentation in a the recipient's therapist 04/26/11 progress note indicated that the therapist spoke with the recipient about his frequent request to see a facility physician, yet when medical procedures were prescribed the recipient refused to comply. The therapist recorded that when an attempt was made to discuss the matter with the recipient he became angry and left the room.

Documentation in a 05/15/11 medical progress note completed for a facility physician related that the recipient continued to complain about having blood in his urine. The physician

recorded that the recipient stated that he had given an urine specimen in April, but was not treated: therefore, he refused to given another.

An RN recorded in a 05/16/11 progress note that the recipient asked if the RN had received new orders for him to have Wycillin. The RN documented that the recipient stated if the physician truly understood the situation then she would write the orders because "He has called and placed junctions against all of us and he was going to come out on top because he was Jesus Christ Super Star."

Documentation in a 06/22/11 progress note completed by an RN indicated that the recipient discussed his need for being allowed to receive Wycillin, and stated that he "only needed two shots to totally heal".

.C...Physician's Orders and Laboratory Findings

The HRA observed Physician's Orders for the following: 1) 04/07/11...UA and C&S; 2) 04/19/11...UA and C&S and 05/06/11...UA. Laboratory reports dated 04/07/11, 04/20/11 and 05/06/11 indicated all findings to be within normal range.

Summary

The recipient whose rights were alleged to have been violated informed the Team that he has a urinary tract infection that facility medical staff members have not adequately treated. He stated that he has informed staff of prior successful treatment; however the physician will not prescribe the medication needed to resolve his problem. Documentation throughout the recipient's clinical chart indicated that the recipient has complained about having blood in his urine and experiencing pain when urinating. The record indicated that when the recipient registered these complaints, he was examined by a facility physician, and the physician ordered appropriate testing. On some occasions the recipient agreed to provide a urinalysis; however, at other times he declined. The HRA review of the laboratory findings indicated that findings were within the normal range. Additional documentation in the recipient's TPRs and Progress Notes revealed that the recipient has a fixed somatic delusion regarding having a urinary tract infection.

Conclusion

Based on the information obtained, the allegation that a recipient at Chester Mental Health Center has not received adequate care for a medical condition is unsubstantiated. No recommendations are issued.

Suggestions

1. Medical Staff should carefully review the recipient's medications to determine if changes are warranted to deal with the recipient's continued fixed delusion.