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Egyptian Regional Human Rights Authority
Report of Findings
Case #11-110-9047
Chester Mental Health Center

The Egyptian Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning Chester Mental Health Center:

1. Recipients are placed in full leather restraints when they are not needed, but used as a means to trigger the pursuit of court-ordered medications.
2. Recipients are served food and beverage items that have outdated expiration dates.
3. Recipients are required to wear clothing that is in poor condition.
4. Housekeeping conditions are poor.
5. Air filters are not routinely changed.
6. The facility's internal process for investigating allegations of abuse is inadequate.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-100 et seq.).

Chester Mental Health Center is a secure, inpatient mental health facility operated by the Illinois Department of Human Services. The facility has 240 beds. Approximately half of service recipients receive forensic services upon court referral after having been found either unfit to stand trial or not guilty by reason of insanity.

To investigate the allegations, an HRA team interviewed facility staff, interviewed recipients, examined the facility commissary, examined the laundry area, toured facility units, and reviewed pertinent policies. The complaint was general in nature and did not indicate specific recipients who were subjected to the complaint issues.

Complaint Statement:
According to the complaint, the application of full leather restraints is recommended as a prerequisite for the pursuit of court-ordered medication and the use of the restraints is encouraged by facility psychiatrists, even if the restraints are not required. The complaint also indicated that recipients are "…often given expired food, drinks, and snacks. They are also forced to wear clothing and shoes in the poorest of conditions….Housekeeping services have been severely neglected in a pathetic attempt to save money and the air quality is so poor, as a direct result of a complete failure to routinely change the filters." Furthermore, the complaint contends that the internal mechanism for reviewing abuse and neglect complaints is inadequate. Additional complaints regarding abusive behaviors and comments, particularly regarding the

designated, internal investigators, as well as concerns regarding neglect were reported to the Illinois Department of Human Services' Office of Inspector General (OIG).

FINDINGS

Staff interviews:

According to the Chair of the facility's internal human rights committee, there is no prerequisite that full leather restraints be applied as a condition for the pursuit of court-ordered medication; court-ordered medication is pursued based on Mental Health Code requirements as per the Chair. The Chair also explained that there is a clear internal complaint mechanism for handling complaints of abuse and neglect involving identified internal investigators. In addition, as Chair of the internal human rights committee, he also receives and evaluates complaints. The Chair reported that he reviews all complaints that he receives and ensures that abuse and neglect complaints are pursued by investigators. With regard to housekeeping and air filter changes, the Chair reported that there is established protocol for cleaning units and changing filters. The HRA also inquired about facility food; the Chair reported that a change in the menus occurred in the Spring upon the dietician's recommendation. The Chair stated that the calorie count on the menus was decreased due to recipient weight gains. Recipients were informed of the menu change through unit meetings.

The HRA team met with commissary staff regarding the food and drinks available for resident consumption. Staff reported that commissary products are rotated on a regular basis either by staff who do the purchasing or by the vendors who deliver the items. Staff also indicated that if a recipient obtained a stale or outdated item, it would be replaced.

The HRA team interviewed staff who oversee recipient clothing care. There are 4 staff who handle recipient clothing. There is a one day turn around for laundry and the facility maintains a supply of state-issued clothing should a recipient have an inadequate supply of clothing or have clothing in disrepair. Staff utilize a computer database to document recipient clothing sizes. The facility also maintains a sewing machine to repair clothing although a recipient may need to make staff aware of clothing in need of repair.

The HRA interviewed a facility administrator regarding the food. She reported that menus have changed although special diets continue. She stated that most food items are purchased bi-weekly although there are some items that are purchased in advance. A computer program tracks food purchases. Later contacts were made with the facility dietary manager and dietician. The dietician confirmed that a change occurred in the menus beginning in April of 2011. The dietician stated that the dietary system had been in place since the 1980s and needed a review. She indicated that, based on the review, it was discovered that daily menus totaled to more than 3,000 calories, and, as a result, recipients were routinely gaining weight. As part of the system overhaul, menus became computerized and recipes were standardized which may have had an impact on portion size. She reported that current daily calories total 2400 to 2600 calories. Individual dietary reviews and special diets continue, including opportunities for increased

calories should a recipient be losing weight. One primary difference between prior menus and the current menu is that recipients receive only one slice of bread with each meal instead of the two slices previously received as per the dietician. To prepare for the change, the dietician and dietary staff began notifying unit staff and the quality assurance department in January of 2011 before the change was to occur in April; the dietician provided staff with a specific description of the change and the reasons for it. The dietician reported that a dietary meeting is held every quarter to review food issues and includes a variety of facility staff such as STAs, nurses, the Quality Assurance Department and physicians. The dietary manager reported that food is ordered on a close timetable and the facility never orders more than it needs, particularly with bakery products. The bakery delivers twice per week and does not use preservatives. Food is checked when it arrives and before it is served. No expired food is served and no moldy food is served, unless it is missed. Food comes out of storage for serving using the first in, first out method. Still, if, on a rare occasion, an item served has mold on it, a recipient can bring it to an STA's attention for a replacement; there are several STAs in the dining room during mealtimes. The dietary manager concluded by stating he recently submitted a report to the facility quality assurance department indicating that most recipients are still gaining weight.

The HRA interviewed an administrator who oversees the facility housekeeping. Although the housekeeping staff numbers are down due to attrition, there are 19 housekeepers who clean the facility. The majority of housekeepers work first shift and complete certain tasks on a daily basis such as cleaning restrooms, emptying trash and vacuuming. Other tasks, such as cleaning windows and waxing floors are done less frequently. Three housekeepers work the second shift and clean non-patient areas such as the offices, halls, and rehabilitation area. Some recipient rooms are cleaned daily and others less frequently depending on need and the recipient's ability and interest in keeping his room clean; a unit manager provides housekeeping staff with a list of recipients who might need daily housekeeping assistance and a list of those who need less assistance. However, if a recipient or unit staff person identifies a housekeeping need on the unit, the housekeeping staff are notified; housekeepers carry pagers to ensure accessibility. The housekeeping department maintains an extensive manual to address housekeeping protocol but a checklist is the tool most frequently used to track housekeeping tasks. In addition, A composition book is used to document more specifics regarding daily housekeeping needs and issues.

The HRA spoke to the staff person who oversees maintenance regarding air filter changes. She reported that air filters are changed monthly unless there is a need to change one more frequently. The facility has a computerized maintenance schedule that produces work orders; the work orders, including air filter changes, are printed weekly.

Recipient Interviews:

Over the course of two visits to the facility, the HRA interviewed 15 different recipients about the various complaint issues. Of the 15 recipients, only two indicated that they had been restrained and had also been receiving court-ordered medication. The remaining recipients provided a variety of responses regarding their use of medication: some stated that they did not take medications; others reported that they took medications voluntarily; and some stated that they received court-ordered medication but had not experienced restraint application.

With regard to facility food, 6 recipients reported that they had no problems with the food, 3 reported that the food was terrible and of poor quality, 3 indicated that they did not get enough food, and 3 reported receiving outdated food (e.g. sour milk, moldy donut). One recipient who was known to the HRA team appeared to have lost weight.

On the clothing issue, all recipients who met with the HRA team were observed wearing appropriate clothing in good repair with the exception of one recipient whose shoes were falling apart; this was brought to the attention of human rights committee Chair who indicated new shoes would be purchased. Recipients indicated that, for the most part, there were no clothing problems. Three recipients indicated occasional problems with missing clothing. Another two recipients indicated that the state-issued clothing is not always in good repair. And, one recipient stated that he had a past problem with a zipper and buttons not being replaced.

The HRA team inquired about the cleanliness of units and rooms. All but three recipients indicated that their rooms and units were clean or reasonably clean. One recipient stated that the unit he is on smells dirty but the unit is cleaned when there is an investigation. Another recipient stated that the toilets are not always cleaned. And, a third recipient stated that the ventilation filters are dusty.

In follow-up visits with recipients, some indicated that complaints of abuse had resulted in contact from the OIG investigators.

Facility Tour:

The HRA team toured various areas of the facility. The HRA examined food items available in the commissary and found no outdated items. The HRA observed the laundry and clothing storage area which was very organized; personal clothing was sorted by bin and labeled by recipient name. A sewing machine was available for repairs. And, there was a large assortment of state-issued clothing sorted by size. Staff reported that clothing is moved to the laundry area by unit, sorted by unit, washed by unit and then delivered by unit. Staff also indicated that inventories are completed in the laundry area.

Over the course of two visits, the HRA team toured two different units and observed general unit areas as well as individual recipient rooms. The HRA found that all areas observed appeared to be clean. During the tours, the HRA team found a resident rights statement posted along with information about how to file a complaint.

Document Reviews:

The HRA team reviewed the facility complaint form that allows recipients to document complaint details and any witnesses; the form indicates that, once completed, it will be forward to the facility human rights committee and the quality assessment/improvement office.

The HRA reviewed menus prior to the calorie count change and then menus after the calorie count change in response to concerns voiced that there is not enough food. The menus appear very similar in offerings with a few exceptions. The new menus specify that skim milk will be served. And, with the prior menus there appeared to be more food items offered, but only on some days, as compared to current menus. Calorie counts for the current menus appear to range

from 2,500 calories per day to 3,200 calories per day with a daily average of about 2,700 calories.

The HRA examined the United States Department of Agriculture's (USDA) 2010 dietary guidelines on the USDA website. Recommended calories for men who are moderately active are listed as follows: for ages 19 - 30, 2600 to 2800 calories per day; for ages 31 - 50, 2400 to 2600 calories per day; and for age 51+, 2200 to 2400 calories per day. The recommended calorie count is approximately 200 calories less per day by age group for sedentary individuals and about 200 calories more per day by age group for more active persons.

With regard to air filters, the HRA examined work orders for changing air filters dating back to June 1, 2011. The HRA saw evidence of air filters being checked and changed at various locations in the facility on the following dates: 06-15-11, 07-25-11, 08-22-11, 09-13-11, 09-21-11, 09-23-11, and 09-26-11.

Policy Reviews:

The HRA examined policies pertinent to the investigation. The HRA first examined the employee code of conduct which emphasizes a zero tolerance for such behaviors as harassment, inappropriate language, threats, and/or physical aggression. Employees who are witnesses to such behavior are to report it immediately to a supervisor and complete an incident report which is forwarded to the hospital administrator by the supervisor.

The facility's procedure for "Reporting and Investigating Incidents and/or Allegations" lists the types of incidents to report, which include physical abuse, sexual abuse, unauthorized social interaction, retaining recipient personal belongings, substance abuse, improper financial transactions and retaliation. All such incidents are to be reported immediately to the facility director and an incident report is to be included. Reports are not to be screened. For other "occurrences" as determined by the "facility investigator," internal reporting forms are completed and sent to the facility director. "Immediately upon becoming aware of an incident, but no later than the end of the next calendar day after the incident was discovered, the Facility Director or designee is to report incidents of suspected employee mistreatment of a patient, sexual abuse, patient death or serious patient injury to the IDPH Long Term Care/Nursing Home Hotline….The Facility Director or designee is to report within four hours by telephone to OIG all incidents which are allegations of abuse or neglect, improper employee conduct, or death." The procedure states that the Illinois State Police are to be contacted immediately if evidence suggests that a crime (e.g. sexual assault, homicide or other felony) has been committed. The Director or designee are to preserve evidence and ensure the safety of patients, employees and property. If the facility investigates, the investigation is to be completed in a timely manner and by a person specifically trained to investigate. Investigation status reports are required if an investigation is not completed in 60 days with status reports every 30 days thereafter. If another patient is the perpetrator, he is to be evaluated by the clinical coordinator for further therapy and treatment needs. Investigation results along with any corrective measures are to be submitted to the OIG. If the OIG substantiates an abuse complaint, a response is to be submitted within 30 days. Other requirements state that "The Facility Director will designate a liaison for communications with appropriate reporting and investigating entities. The STA [security therapy aide] IV-OIG Liaison will perform this function in the Chester Mental Health Center. In

his absence, another STAQV may assume this role in addition to other designee responsibilities referenced in this directive….When an investigation indicates, based on credible evidence, that an employee is the perpetrator of abuse, the Facility Director will take necessary action to ensure the employee is immediately barred from any further contact with patient, pending the outcome of any further investigation, prosecution or disciplinary action against that employee. In addition, the Facility Director or designee is responsible for promptly notifying OIG of the employee(s) placed on administrative reassignment or administrative leave pending an investigation."

A procedure entitled, "Reporting an Incident to External Agencies," requires the facility OIG liaison or shift supervisor to gather information to complete an OIG Incident Report Form. For incidents of physical, sexual, verbal/psychological abuse, neglect or theft, patient injuries, or theft, the incidents are to be reported by fax or phone to both the Illinois Department of Public Health (IDPH) and to the OIG. Improper employee conduct and property thefts of over $100 are to be reported to the OIG. For deaths other than medically related deaths, the IDPH, the OIG and the Coroner are to be notified. The OIG Liaison will contact the OIG regarding the need to involve the Illinois State Police. Unauthorized absences are to be reported to the State Police, the OIG and local law enforcement.

The facility maintains a policy for tracking incident information and requires the completion of additional forms, including, an Incident Screen Form, a Victim Form, and a Perpetrator form in addition to a form completed by the Unit Director. Forms are held in the case file and disseminated to the facility investigator, hospital administrator, and a secretary for data input.

A policy, entitled, "Stocking Shelves in Rotating Stock In Commissary," requires commissary staff to rotate and replace items using the "first in - first out" method. A procedure is also in place to document withdrawal of funds from recipient accounts to cover commissary expenses. The HRA examined another policy provided by facility staff regarding "care of the storeroom" in the "storekeeper's manual." According to the dietary manager, this policy guides the storage and inventory of food supplies. The policy requires that stock be arranged and maintained using the procedure of "first in, first out." Deliveries are marked or stamped and federal guidelines for shelf life and storage temperatures are referenced.

The HRA examined the facility's unit housekeeping procedure. Daily unit housekeeping activities include emptying the trash, wiping furniture, brushing vents, dusting and mopping floors, cleaning bathrooms, vacuuming carpeting, spot washing the walls, etc. These activities are to occur in both the general use areas of each unit as well as in individual recipient rooms. Weekly activities include vacuuming pool tables; patient rooms are to be spray buffed three times per week. Spot check inspections are done daily, quality control checks are done weekly, and floors are checked for refinishing needs on a monthly basis. A sample checklist of restrooms was provided which includes the daily cleaning of toilets. A checklist of housekeeping tasks for offices and conference rooms was also shared.

Mandates:

The Mental Health and Developmental Disabilities Code (405 ILCS 5/3-102) guarantees the right to adequate and humane care and treatment. Section 5/2-112 guarantees the right of each recipient to be free from abuse and neglect.

According to Section 5/2-108, "Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others." Restraints are only to be used upon written order and the facility director is to review all restraint orders daily and the reasons for their application.

The process for pursuing court-ordered medication requires the completion of a petition after which a hearing is held. Clear and convincing evidence of the following criteria must be met for court-ordered medication:

(A) That the recipient has a serious mental illness or developmental disability.

(B) That because of said mental illness or developmental disability, the recipient currently exhibits any one of the following: (i) deterioration of his or her ability to function, as compared to the recipient's ability to function prior to the current onset of symptoms of the mental illness or disability for which treatment is presently sought, (ii) suffering, or (iii) threatening behavior.

(C) That the illness or disability has existed for a period marked by the continuing presence of the symptoms set forth in item (B) of this subdivision (4) or the repeated episodic occurrence of these symptoms.

(D) That the benefits of the treatment outweigh the harm.

(E) That the recipient lacks the capacity to make a reasoned decision about the treatment.

(F) That other less restrictive services have been explored and found inappropriate.

(G) If the petition seeks authorization for testing and other procedures, that such testing and procedures are essential for the safe and effective administration of the treatment.

The recipient has a right to be present at the hearing, can request a jury trial and have a guardian ad litem appointed. The initial medication order can last for 90 days although the order can be extended after another hearing.

Regulations that govern abuse/neglect reporting (59 Ill. Admin. Code 50/1 et seq.) require that abuse allegations be reported to OIG within 4 hours. Screening of reports and retaliation for reporting are prohibited (59 Ill. Admin. Code 50.20).

According to Section 50.40 of OIG regulations:

1) The Office of Inspector General shall determine whether OIG, or the community agency with OIG's investigative protocol, shall take primary responsibility for investigating the allegation. This determination shall be

based on the nature of the allegation, frequency of allegations and complaints of a comparable type and knowledge of the facility or agency….

5) …OIG may designate primary responsibility for the investigation to the community agency on a case-by-case basis using the OIG investigative protocol. If at any time during the course of the investigation, the community agency requests that OIG assume primary responsibility for the investigation, OIG shall do so.

6) When OIG designates primary responsibility for the investigation to the agency, OIG will provide investigative guidance and be available for assistance and shall retain the right to assume primary responsibility for the investigation at any time….

c) Nothing in this Part precludes a community agency or facility from taking immediate action that may include protecting the individuals from danger or harm, notifying appropriate law enforcement officials, or taking any other administrative action deemed necessary by the community agency or facility, unless otherwise directed by OIG. However, the community agency or facility can take initial investigative steps in keeping with the requirements of Section 50.30(f). The agency shall request approval from OIG prior to conducting its own full investigation.

With regard to conducting investigations, the following regulations, as found in Section 50.50, must be considered:

a) Depending on the nature of the allegation, an investigation shall consist of, but not be limited to, the following procedures whether done by OIG, the community agency or the facility:

1) Ensure that the victim is not in imminent danger;

2) Protect the integrity of the investigation at all times;

3) Secure the scene of the incident;

4) Identify and separate witnesses;

5) Preserve and secure all evidence;

6) Obtain statements from persons involved including victims, alleged perpetrators, and witnesses by face-to-face interviews, in writing, or by telephone; and

7) Obtain copies of pertinent documents relating to the investigation, i.e., progress notes, incident or injury reports, patient or resident records, photographs, etc. ….

c) All investigations shall be conducted in a manner that respects the dignity and human rights of all persons involved.

Section 50.60 addresses investigation reports and states the following:

1) The investigative report shall be submitted to the Inspector General within 60 days from assignment unless there are extenuating circumstances including, but not limited to, the unavailability of witnesses or official documents.

2) Upon receipt of an investigative report, the Inspector General will determine whether to accept the findings. The Inspector General may require additional documentation or further investigation by the community agency or may determine that further investigation by OIG is warranted….

5) Finalizing investigative reports and notifications to community agencies and facilities….

B) Cases investigated by community agencies. After determining the finding, the Inspector General shall notify the community agency that the finding was accepted, or if additional information is required to complete the investigation.

C) The community agency or facility shall submit a written response as described in Section 50.80.

6) After determining the finding in all cases, the Inspector General shall notify the complainant, the individual who was allegedly abused, neglected or financially exploited or his or her legal guardian (if applicable), and the person alleged to have committed the offense. The notice shall identify the outcome of the investigation and include a statement of the right to request clarification or reconsideration of the finding. In substantiated cases, the Inspector General shall provide the perpetrator with a redacted copy of the investigative report.

CONCLUSIONS

Complaint #1: Recipients are placed in full leather restraints when they are not needed, but used as a means to trigger the pursuit of court-ordered medications.

Staff stated that the Code requirements, rather than incidents of restraint application, dictate the pursuit of court-ordered medication. Only 2 recipients interviewed indicated that they had experienced both court ordered medication and restraint application and neither mentioned that restraints had been inappropriately applied. Other recipients reported receiving court-ordered

medication with no history of restraint application. The Code identifies specific criteria to be met to pursue court-ordered medication.

Based on the inclusive recipient interviews, the HRA does not substantiate the allegation. However, the HRA does suggest periodic quality checks of restraint episodes by the facility quality committee and/or behavior management committee to review facility restraint use, documented need and any patterns.

Complaint #2: Recipients are served food and beverage items that have outdated expiration dates.

Staff reported biweekly purchases of food, with some limited items being purchased in advance, and a computer program that tracks food purchases. The HRA found no outdated food in its review of the commissary items and a policy is in place to rotate commissary food items.

The HRA spoke to the facility dietician and kitchen manager about food rotation and dietary changes. The dietary changes and rationale were confirmed with the dietician. Food rotation and purchasing practices appeared consistent with attempts to serve food that is not stale, outdated or moldy. If a recipient receives moldy or sour food, there is a means to request a substitute via the STAs in the dining room although it is unclear if recipients are aware of this. Dietary changes were reported to unit staff well in advance of the change and it was thought that the information trickled down to recipients; quarterly dietary meetings are held with staff to discuss food related issues. The facility maintains written procedures for storing and maintaining food stock using federal guidelines related to shelf life and temperature storage.

Of the 15 recipients interviewed, 2 indicated a problem with sour tasting beverages and one stated he received a moldy donut. A few recipients also stated that they did not receive enough food to which staff reported that a menu change occurred in the Spring due to recipient weight gains. An HRA review of the menus indicated some minor menu changes with calorie counts that appeared to meet dietary recommendations of the USDA. The majority of recipients did not report problems with stale, sour or outdated food items.

The Mental Health Code guarantees the right to adequate and humane services.

Two individuals indicated sour drinks but it is difficult to determine whether this was due to outdated beverages, improper storage or even a recipient's taste. A moldy donut would be of concern; however, this type of complaint was voiced by only one of the 15 individuals interviewed and it would be difficult for mold to exist on only one item given the typical packaging of large amounts of institutional food. However, the facility staff indicated that this could occur but attempts are made to check food before it is served and bakery items are delivered twice per week to help ensure freshness. The agency maintains policies to rotate food. **While the HRA does not discount the claim, it cannot substantiate given the available information.** The HRA does take this opportunity to suggest that the facility ensure recipients know that if a food items seems stale or sour, they can request a replacement through STAs in the dining room. The HRA also suggests that the facility consider including a recipient representative in the quarterly dietary meetings.

Complaint #3: Recipients are required to wear clothing that is in poor condition.
In interviews with recipients, the HRA found that recipient clothing appeared to be in decent repair except for the recipient with the worn shoes. Recipients, for the most part, reported no problems with clothing being in disrepair; some recipients indicated problems with missing clothing. During a tour of the laundry room, the HRA interviewed laundry staff who reported that repairs are done if known and the laundry facility was found to have a sewing machine for repairs, a well-stocked supply of state-issued clothing should a recipient's clothing become worn and an organized system for washing and returning clothing.

The Mental Health Code guarantees the right to adequate services.

Based on the evidence, the HRA does not substantiate the complaint but suggests that the facility ensure that recipients are aware that they can request clothing repairs.

Complaint #4: Housekeeping conditions are poor.
During the Authority's investigation, one recipient reported problems with odors on the unit and another recipient indicated problems with toilets not being cleaned; most recipients reported that the cleanliness of the units was fine. On the days of the HRA team's tours and on the units observed, the HRA found no evidence that the units were unclean. Again, the Code guarantees the right to adequate care and services. **Based on the evidence, the HRA does not substantiate the allegation.**

Complaint #5: Air filters are not routinely changed.
One recipient interviewed by the HRA indicated that there were problems with ventilation on the units. The HRA examined work orders that documented the checking and changing of air filters on a routine basis consistent with the Code's requirement for adequate and humane care and treatment. **Therefore, the complaint is not substantiated.**

Complaint #6: The facility's internal process for investigating allegations of abuse is inadequate.
The HRA examined policies and procedures associated with the facility's internal mechanism for reporting and investigating abuse allegations. The system is detailed and appears to mirror most requirements of the OIG regulations with one exception. The facility's procedure for "Reporting and Investigating Incidents and/or Allegations" includes the following statement: "Immediately upon becoming aware of an incident, but no later than the end of the next calendar day after the incident was discovered, the Facility Director or designee is to report incidents of suspected employee mistreatment of a patient, sexual abuse, patient death or serious patient injury to the IDPH Long Term Care/Nursing Home Hotline." The reference to the "end of the next calendar day" time frame appears inconsistent with the four hour requirement listed in the OIG requirements although the 4 hour requirement is mentioned later in the same policy. The HRA contends that this statement could be misleading to facility staff. In spite of the statement, the HRA team did receive confirmation from recipients interviewed who had previously made abuse allegations that an OIG investigator had met with them.

Due to the statement that appears inconsistent with the OIG requirements and the potential confusion the statement could cause, the HRA substantiates the allegation only with regard to the one policy statement and recommends the following:

Remove the reference to "the end of the next calendar day" in the facility's procedures for reporting and investigating incidences and/or allegations.