FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
13-110-9009
Chester Mental Health Center

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 provides services for approximately 240 recipients serving both forensics and civil commitments. The specific allegations are as follows:

A Security Therapy Aide (STA) assaulted a recipient. Staff are disrespectful to recipients. Unit conditions are unsanitary.

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2).

Statutes

The Mental Health and Developmental Disabilities Code (405 ILCS 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."

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

Investigation Information

To investigate the allegation, the HRA Investigation Team (Team), consisting of two members, the HRA Coordinator and the HRA Director conducted a site visit. During the visit, the Team spoke with the Recipient whose rights were alleged to have been violated and toured the facility to observe living conditions. The housekeeping coordinator also produced the housekeeping schedule and list of duties to be completed each shift. With the Recipient's written authorizations, copies of information from the Recipient's clinical chart were reviewed by the Authority. Facility Policies relevant to the complaints were also reviewed.

I. Interviews:

A. Recipient 1: The Recipient informed the Team that on or about August 29, 2012, another recipient gave him a chicken patty which is not allowed. An STA who observed this confronted him and told him to move, throw away his entire tray and leave the chow hall. As the recipient was leaving the STA vigorously and forcefully pushed him in the back which almost caused him to flip over. The recipient stated he has a bad leg so he walks slowly. The recipient also stated that he overheard a staff member use "unprefisional attitude when saying racial terms and prejudice words and meaning against patient (recipient 2)" [sic]. The recipient also said the living conditions are unsanitary because of the patients' urine and bowel movements and no one is there to clean it on a shift by shift basis.

B. Recipient 2: When questioned, recipient 2 reported to the Team that staff address him as "boy" and do or say things to provoke him to lash out such as saying he will never get out of Chester and calling him explicit names. However, he could not recall the specific incident that recipient 1 reported to be able to elaborate to the Team what racial terms and prejudice words were said or which staff member might have said these things.

II. Clinical Chart Review:

A...Progress Notes: A nursing note dated 8/16/12 at 6:30 pm stated that the recipient was loud and had been brought back from the dining room upset over the diet and wanting double portions. He was yelling loudly and threatening staff. He was offered and accepted PRN medication. A nursing note at 7:10 pm stated he was still loud but the recipient "alleges he feels better after being given the PRN."

A STA note dated 8/16/12 at 6:15 pm, recorded as a late entry in progress notes, states the recipient stole food off the tray of a peer after eating all of his food. When staff asked him to put the peer's food back, he spit on it and proceeded to eat more of the peer's food. The recipient was escorted back to the unit. The recipient was threatening staff and stated he would continue this type of behavior "just next time he won't get caught". He was given a PRN and placed in the quiet room with the door unlocked and allowed to calm down.

The Team found no documentation of difficulty escorting the recipient back to his unit. There was no documentation stating that the recipient had complained of being pushed by staff until an 8/31/12 nursing note at 7:05 am which said the writer was notified by the RN that a STA IV was informed that the recipient stated he was pushed in the back while in the dining room by staff on 8/16/12. It also stated that an injury report had been completed, the recipient was examined and no injury was noted. The recipient denied complaints of pain and a doctor would be notified. There was a doctor's note dated 8/31/12 but the handwriting was hard to read. It appeared to say that an injury report was filled out and stated "note as per injury report". A nursing note on 8/31/12 at 10:35 am stated the recipient was seen by the doctor for "alleged abuse. No apparent injury was noted. Recipient denies any complaints or injuries."

B. OIG Report: An OIG report was filed regarding the 8/16/12 allegation. The outcome of that investigation was "unfounded". The OIG report referenced the same case notes as documented above and stated "the failure of [recipient] to report the incident in a timely manner denied the investigator the ability to collect timely evidence to support or contradict the allegation. These

factors lessened the credibility of [recipient] and established that no credible evidence was present to support the allegation." It was also noted in the report that this STA as well as another STA who wrote a staff informational report documenting the incident at the time of occurrence had corroborative accounts of the incident, denying any abuse to the recipient.

III…Facility Tour:

The Team took a tour of the facility to observe the living conditions. The Team observed the day room, stem area, showers, hallways, patient rooms as well as restraint and seclusion rooms. During the tour no odor was noted on the modules. The shower stalls appeared clean and sanitary with no mold or odor. Although the Team did note the lack of dry storage space for clothing in the showering rooms and was told that often patients put their clothing just outside the shower door in the hallway to keep them dry while showering. The day rooms were clean and free of odor and dust, the floors looked clean. The patient rooms appeared neat and clean with no odor and the toilets and sinks in the room were clean. The restraint and seclusion rooms also appeared clean.

IV...Facility Policies:

A. Chester Policy RI 01.01.02.01 Patient Rights states: "Each patient admitted to Chester Mental health Center shall be treated with respect and shall be ensured of all rights under Sections 2-100 to 2-111 of the Mental Health and Developmental Disabilities Code. Restrictions of rights and corresponding rationale shall be properly documented in the patient's clinical records.

B. Chester Policy RI .05.00.00.01 Code of Ethics states: "It is expected that all Chester Mental Health Center employees will serve as ethical role models for each other and for patients being served. Every employee, at every level of the organization, must continually evaluate the potential outcomes of the decisions he/she makes since action or inaction may affect the well-being of others. The employee must accept responsibility for any consequence resulting from his/her behavior."

"Chester Mental Health Center employees will act to safeguard and perpetuate the rights and interests of patients. Employees shall act as advocates for patients and strive to promote their well being. Employees will speak out to promote the rights, interests, and prerogatives of patients…will provide care with respect for patients' background, gender, religion and heritage. Every task performed by a Chester Mental Health Center employee must have, as its ultimate goal, to serve in a positive way, those patients in our care."

"Every employee of Chester Mental Health Center shall be expected to commit to the following principles: …To respect the similarities and differences among people arising from differences among their cultural, ethnic, religious, and personal backgrounds."

C. Chester Housekeeping Schedule: Per the housekeeping coordinator, there are two shifts in housekeeping services 7:00 am to 3:00 pm and 3:00 pm to 11:00 pm. The Team was provided with a housekeeping schedule showing that each day during first shift, Unit A has 2-3 staff; Unit

B has 1-2 staff; Unit C has 1-2 staff and the infirmary has 1 staff. Second shift has 3-4 staff scheduled each day with the exception of Wednesdays when there are 2 staff members. There are also 4 staff members listed as "relief".

According to a memo dated December 21, 2012 regarding how much time it takes to clean one module, it would take 1 staff 12 hours 2 staff 6 hours 4 staff 3 hours and 6 staff 2 hours. These are conservative estimates with no extra time allowed for patient movement which requires the housekeeping cart to be taken to a secure area, restocking the housekeeping cart, staff breaks or cleaning modules that would require more attention than others. It is also noted that the minimum side which has more restrooms would require extra time. The duties listed are dusting, wiping down walls, sweeping, mopping floors, scrubbing the toilet and sink and disinfecting patient rooms; dusting furniture, sweeping, mopping and vacuuming halls and day rooms; wiping down floors and walls in the showers and disinfecting; dusting and mopping the nurse's station; cleaning the toilet, sink, mopping floor and disinfecting the staff restroom; dusting mopping and removing trash from the offices and dusting, vacuuming, wiping counters, removing trash cleaning and restocking restrooms in the stem area.

Conclusion

Based on review of the recipient's clinical chart, the recipient waited 15 days before reporting the alleged incident. The lack of timely reporting by the recipient made it hard for the physician and OIG investigator to find any injuries that might have been present immediately following the alleged incident and therefore the allegation that a STA assaulted a recipient could not be substantiated.

Facility policies require all staff to treat the recipients with respect and to act as positive ethical role models and to act as advocates for all recipients. Although the recipient made an allegation that a staff member was using racial slurs and acting inappropriately to another recipient, no specific staff could be named. The other recipient that this allegation involved did say staff talk to him in a disrespectful manner; he didn't recall this specific incident and could not give the team a specific staff person's name. Therefore, the allegation that staff members are disrespectful to recipients could not be substantiated.

Based on a review of the housekeeping schedule, list of duties and the number of staff on each shift along with the estimate of how much time it takes staff to clean each module, there appears to be adequate staff on each shift to be able to accomplish the duties assigned. During a tour of the facility, the Team did not observe any unsanitary living conditions. Therefore, the allegation that unit conditions are unsanitary is unsubstantiated. No suggestions are made.