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Egyptian Regional Human Rights Authority
Report of Findings
13-110-9013
Chester Mental Health Center
July 5, 2013

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:

1. **Chester Mental Health Center is not honoring a recipient's dietary requests.**

2. **Medications are administered inappropriately for two recipients when crushed and put into food without a Court Order in place and absent an emergency.**

3. **There are inappropriate staff interactions with recipients**.

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… If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment…If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only pursuant to the provisions of Section 2-107 or 2-107.1…"

The Code (405 ILCS 5/2-107) states "An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy.

The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services. (b) Psychotropic medication or electroconvulsive therapy may be administered under this Section for up to 24 hours only if the circumstances leading up to the needs for emergency treatment are set forth in writing in the recipient's record. (c) Administration of medication or electroconvulsive therapy may not be continued unless the need for such treatment is redetermined at least every 24 hours based upon a personal examination of the recipient by a physician or a nurse under the supervision of a physician and the circumstances demonstrating that need are set forth in writing in the recipient's record. (d) Neither psychotropic medication nor electroconvulsive therapy may be administered under this Section for a period in excess of 72 hours, excluding Saturdays, Sundays, and holidays, unless a petition is filed under Section 2-107.1 and the treatment continues to be necessary under subsection (a) of this Section."

The Code (405 ILCS 5/2-107.1) states "Psychotropic medication and electroconvulsive therapy may be administered to the recipient if and only if it has been determined by clear and convincing evidence that all of the following factors are present. In determining whether a person meets the criteria specified in the following paragraphs (A) through (G). (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 Code also (405 ILCS 5/2-201) 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 therefore to:(1) the recipient and, if such 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 under “An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending 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 also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefore in the recipient's record. (b) The facility director shall maintain a file of all notices of restrictions of rights, or the use of restraint or seclusion for the past 3 years. The facility director shall allow the Guardianship and Advocacy Commission, the agency designated by the Governor under Section 1 of 'An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named,' approved September 20, 1985, and the Department to examine and copy such records upon request. Records obtained under this Section shall not be further disclosed except pursuant to written authorization of the recipient under Section 5 of the Mental Health and Developmental Disabilities Confidentiality Act."

Investigation Information:

To investigate the allegations, the HRA Investigation Team (Team), consisting of two members, the HRA Coordinator and the HRA Director, 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 Chairman of the facility's Human Rights Committee (Chairman). 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.

Allegation 1 (involved 1 recipient): Chester Mental Health Center is not honoring a recipient's dietary requests.

I. Interviews:

A. Recipient 1: The Recipient informed the Team that he is receiving a jelly sandwich at night that he states is alcoholic because he feels dizzy after eating it. The recipient says he has made several requests to have peanut butter rather than a jelly sandwich for his evening snack but his requests are not being honored. The Recipient also stated he addressed this in his treatment plan meeting and was told that it was a preference and not a necessity therefore, they could not comply. He also reports feeling dizzy after eating meals. Therefore, he frequently refuses meals except for breakfast and sometimes his evening snack.

B. Chairman: According to the Chairman, Chester Mental Health policy states that all special diets are ordered by a Physician and monitored by the Dietary Manager. Recipients' dietary requests are considered, however, and reviewed by the Dietician; and approval by a facility Physician is necessary before the diet is implemented.

II. Clinical Chart Review:

A. Treatment Plan Reviews (TPRs):

Recipient 1: The TPR dated 11/19/12 states that the recipient attended and participated in his TPR. According to the TPR, the treatment team has repeatedly discussed his refusal of breakfast and other meals but he continued to voice paranoid ideation about food being rotten or poisoned. During the month of July the recipient continued to show signs of weight loss and further decompensation in his psychiatric symptoms, being increasingly paranoid about food being poisoned or rotten. He refused to be weighed, have vitals taken, blood for lab work drawn

and continued to "not be fit to stand trial due to refusal to take psychotropic medication." The doctor had recommended him as fit to stand trial in June, 2012, but the Forensic Clinical Services evaluator did not concur with the doctor and recommended to the judge that the recipient remain unfit to stand trial. It was not noted in the recipient's TPR that he had made special dietary requests, only that he had been refusing meals. His TPR Lists Problem #1 as unfit to stand trial and ways that will be addressed and Problem #2 as noncompliance with medication and treatments (labs, diagnostic procedures) and how that will be addressed. It does not list any other problems or any ways the team will address his weight loss. The recipient refused to sign the treatment plan.

The TPR dated 1/14/13 states that the recipient attended and participated in his TPR. The next few lines are verbatim from his 11/19/12 TPR regarding him showing signs of weight loss in the month of July, 2012 and that he continued to refuse medication and tests. There was a note that the Court was petitioned for authorized involuntary treatment and that the recipient still refused to take psychotropic medication voluntarily. This TPR listed the same two problems as in his 11/19/12 TPR and the same ways to address these problems in his treatment and has a "C" in the status column which is indicated on the form as meaning "continued."

B. Meal Monitoring:

Daily meal monitoring records for July 17, 2012 through November 4, 2012 show that breakfast was refused daily throughout the month of July and August then beginning August 23rd 100% was eaten most days through November. Lunch varied from 40-100% being eaten and being refused 15 times over the monitoring period. Supper varied from 25-100% being eaten and being refused 9 times over the monitoring period. Snacks were eaten 80-100% and refused 19 times over the monitoring period.

C. Weight Records:

The weight record dated 5/18/11 through 5/1/13 has his initial weight upon admission listed as 198 pounds with a note stating 9 lbs above IBW. Every attempt to obtain a current weight since then has been refused by the recipient. On a second visit to the facility at a later date, the HRA reviewed his weight records again and found that on June 6, 2013 he did allow his weight to be taken and his current weight is 147 pounds which represents a loss of 51 pounds since May, 2011.

D. Medication Orders:

A Medication Verification/Reconciliation form dated 5/18/11 listed no medications and noted "patient refused." Consent to Psychotropic Medication dated 5/19/11 listed Risperdone up to 12 mg per day but states "refused" where patient signature would be. The Psychotropic Medication Refusal form dated 8/19/12 has "yes" circled under emergency meds administered and the doctor's signature is on the form. The same form states that on 8/15/12 a petition for court enforced medication was initiated and that patient did not meet legal criteria stating reason of "other, less restrictive services are more appropriate".

The Medication Administration Record for August 2012 lists the medication of Olanzepine for psychosis and below it states "emergency enforced if refuses Olanzepine PO give IM BID for psychosis". There are initials on two dates where medication was given, but it does not state what form was given.

The Medication Administration Record for November 2012 lists medications of Acetic Acid HC OTIC, Acetaminophen, Milk of Magnesia, Senna/Docusate, Jelly sandwich w/juice at HS. The Jelly sandwich is the only one listed that was given daily the other medications were only given 2-5 times throughout the month. The Team also noted the dates in November were crossed out and December dates were written in as replacements.

D...Referrals and Consultations:

A Physical Exam note dated 5/8/12 lists height as 71" and weight was refused. Labs were refused. Waist circumference was listed as 30".

The annual nutritional/dietary assessment dated 5/21/12 shows that he is on a vegetarian diet, with no weight or lab documentation due to refusal. Nutrition related concerns are listed as constipation, diarrhea, fluid retention and that his appetite is fair. Physical appearance is checked as well nourished. Notes state "pt interview - pt does not want any meat or eggs however, often refuses to go to breakfast as he does not want to get out of bed. Asked pt to be weighed and he refused x2. Annual review- pt refuses to comply with treatment. Refuses to be weighed. Last documented wt was 5/31/11 - 198#. Refuses psych meds. Remains quiet and stays to himself. Diet is vegetarian d/t pt request (provided w/meat free). Unable to determine if pt's needs are met d/t refusing to be weighed and labs. Suggest change diet to meat free, no fish."

According to a Nursing Reassessment Summary dated 6/28/12-7/28/12, the Recipient was referred to the dietician for several written diet "C/Os". The dietician ordered a jelly sandwich bid.

The dietician referral and report dated 7/3/12 shows that the recipient had requested a diet without fish/tuna, egg salad, tomato sauces, carrots, green beans and corn. The dietician said "Pt has been on a meat free diet with no fish to accommodate his preferences. Unable to assess pt's need d/t refusal to be weighed. Refuses medications. Pt. reports he does not want fish or tuna. Reports he dislikes egg salad and it makes him sick. Please change to meat free, no fish, no egg salad." There is another note at the bottom of the form that says "no change in diet-pt is psychotic and starving himself." It cannot be determined by the signatures if this was a note from the dietician or someone else.

The dietician referral and report dated 7/11/12 states "dietician received pt letter from unit manager. Referral completed 7/3/12 per RD w/diet changed to meat free, no fish, no egg salad. Spoke with patient re: request. No labs and no current weight is available as pt. refuses. Attempted to encourage pt. to get on scale for weight, however pt. refused/declined. Staff reports pt. refusing breakfast meal. Also refuses medication therapy. Pt. states 'I don't drink milk, tea or lemonade'. c/o milk makes him 'dizzy' and he has had a 'bad experience' with

breakfast. Pt. would not explain. Pt. appears thin and ? < IBW of 155-189 will suggest to add PBJ sandwich and 4 oz juice for 10 am and HS snack. Cont. to encourage labs & wt. status."

E...Progress Notes:

RN Progress notes dated 8/13/12 stated that "Dr. [name] wrote orders for Olanzepine PO now - IM if he refuses for psychosis, emergency enforce one time. Patient refuses breakfast every morning and picks through food on the other 2 meal trays. He believes staff is serving him rotten food."

A RN nursing note dated 8/13/12 at 0945 stated that the patient was very thin with poor muscle mass, skin with mucus membranes dry, patient encouraged to drink water, patient states "it's my human right not to eat or drink".

The Unit Director note dated 8/13/12 states "members of the treatment team met with [recipient] to encourage him to cooperate with obtaining his weight and vital signs. We explained that it was important to obtain this information so his concerns could be addressed. He stated he did not need to have this information and would call his lawyer."

A Psychiatry note dated 8/14/12 states "he says 'I am loosing wt because of eating rotten food - I am not comfortable, verbal abuse from these people day after day, get weighed, no need to be weighed it is not relevant'". The doctor stated "medication will help you" and the recipient responded "no kind of medication will help. I have no disorder I am disrespected for ex immortality". The assessment states "he is irritable and has delusions of persecution and stated 'I am verbally assaulted with STD, my testicles hurt from verbal abuse, sexual assault everyday when I open my eyes'".

A 1/14/13 psychiatry note states "he attended his TPR meeting, complained in irritable manner about food dehydrating and splitting his lips and stated 'I have seen alcoholic stuff on my sandwich.' He is paranoid and refused blood test for vitamin deficiency."

A 1/14/13 nursing note states "spoke with recip & tx team about c/o wanting a cheese sandwich because jelly sandwich has alcohol in it. Also c/o that people are adding soy to his food and it is making his lips crack. No visible open areas on lips, recip freq. expresses concerns about diet and believes people are altering his food. Recip. Continues to refuse labs, v/s, wts. Benefits explained. Continues to refuse. Recip is currently on a no meat/fish diet w/jelly sandwich and juice at hs to substitute cheese when possible. Recip is aware."

A 2/11/13 quarterly nutrition review note states "unable to assess current nutritional status - pt. refuses weight to be obtained and labs have not been drawn since 5/11 as pt refuses. Remains on meat-free diet with no fish (sub cheese when possible), jelly sandwich/juice at HS. Appetite reported as good. No diet change. Will continue quarterly reviews - refer as needed."

A 3/14/13 Doctor's note states "pt c/o dry cracked lips, pt. pulled skin off lips- lips dry & cracked, dry, cracked mucus membranes. Petroleum jelly ordered."

III...Facility Policies:

A...Monthly Weight Policy: According to the Policy Statement, "It is the policy of Chester Mental Health Center to keep an accurate record of weight on all patients in order to readily identify those patients with significant weight losses or gains."

The Procedure is listed as follows: 1) Unit nursing staff will assess weights of all recipients on a monthly basis. Scales are kept on each individual module. 2) Recipients' weights are recorded on weight record sheets each month within three working days after the weight was taken. Recipients' weights are entered monthly into the Patient Information System by an assigned Unit Nurse. Referral for a nutritional assessment will be made if any of the following occurs; 1) a weight loss of 5 % from the previous month, 2) 7 ½ % or more for the previous three month period; 3) a weight loss of 10% or more for the previous six-month period; and 4) a weight gain of 10% or more since in the previous month's recording.

B. Standardized Recipes Policy:

There shall be standardized recipes for all food production to assure high quality, palatable food, while providing appropriate quantities of food.

The Health Technologies Dining Manager (Menu Systems and Software) Program will provide recipes to be used for all menu items.

C. Ordering and Serving Modified Diets Policy:

All modified/special diets must be ordered by a physician. The unit nurse will transcribe the order from the IL 462-0047 Physician's Order Form, and complete the Diet Prescription CMHC-195. In the event a patient requires immediate dietary considerations, the unit RN will assess the patient with respect to these concerns. If special dietary changes are determined to be appropriate, the RN will contact the physician and obtain a written/telephone order.

Any modified/special dietary need that is the result of a patient's personal preference request that is not medically warranted must be referred to the patients' treatment team for consideration and approval prior to a physician ordering the special dietary request. The treatment team should consider the patients individual treatment goals and needs prior to approving the diet. If the treatment team approves of the special dietary request, the patient's request will be referred to the dietician for evaluation and recommendation. If the physician feels a special dietary request is needed and documents the justification for the special dietary need, he or she may implement the diet change or request prior to receiving the treatment team's approval.

D. Ordering and Serving Increased Calorie Diets:

Chester Mental Health Center utilizes increased calorie diets in order to provide a systematic means for ensuring that a patient receives the additional essential nutrients and calories when ordered by a physician.

Any time that it has been determined that a patient requires additional essential nutrients and calorie intake to that which is normally provided and an increased calorie diet has been determined to be the action of choice, an IL 462-0047 Physician Order form shall be completed by the physician ordering such a diet modification.

E. Patient Access to Commissary Policy:

Chester Mental Health Center maintains a process for patients to exercise the privilege of purchasing food/personal products consistent with treatment needs through the commissary. Patients may spend up to $27.00 twice a week on commissary items, $7.00 of which may be spent on food items. Perishable items (foods that will spoil without refrigeration) will be restricted to two items per order even with double orders.

Summary

According to the Recipient whose rights were alleged to have been violated, his request for a change in snack choice has not been honored even though others are allowed chips, cookies and other snacks. The facility Physician ordered a jelly sandwich BID for snack. Documentation in the dietician referrals show that the recipient was placed on a vegetarian diet and then a meat free diet per his request. Documentation in progress notes also indicate to substitute cheese when available for his snack

Conclusion

Based on review of the recipient's clinical chart, his requests for a vegetarian/meat free diet were honored. The facility physician ordered a jelly sandwich to help increase his caloric intake and the notes in the chart indicate to substitute with cheese whenever possible in order to give him a snack that he would prefer. Therefore, the allegation that the facility did not honor the recipient's dietary request is **unsubstantiated**. The HRA would like to offer the following suggestions.

- A goal should be included in his TPR to address meal refusal, refusing weight checks and labs to ensure the recipient's medical and nutritional needs are being met as per Chester Mental Health's Monthly Weight Policy.

- When seen by the facility dietician between 6/28/12 and 7/28/12, a jelly sandwich BID was ordered for snack. The Team could not find a follow up appointment to see if this was successful and found no orders for an increased calorie diet as per Chester Mental Health's policy to ensure that a patient is receiving essential nutrients and calorie intake. The dietician report dated 7/11/12 stated patient appears thin and below ideal body weight and that the patient was "psychotic and starving himself." The RN, Psychiatrist, Unit Director and Treatment Team all met in August, 2012 to encourage him to cooperate with weight checks and vitals. In February, 2013 for the quarterly nutrition check, there was a note that the dietician couldn't assess him due to refusal of weight checks but the only order was to continue quarterly follow ups. The physician saw the recipient in

March, 2013 for an unrelated issue, but made no note of weight loss and no dietary changes were ordered. The HRA suggests that all members of his treatment team, dietician and physician work more collaboratively and that the recipient have more frequent follow ups than just quarterly to ensure that his nutritional and medical needs are met. According to the weight records, the recipient's ideal body weight (IBW) is 155-189 pounds. He is currently at 147 pounds which is 8 pounds below his IBW and also represents a significant weight loss of 51 pounds since admission in May, 2011.

- Since the recipient indicated an interest in eating a cheese sandwich as a snack and given his extreme weight loss, consider providing the cheese sandwich on a daily versus "when possible" basis.

Allegation 2 (involved 2 recipients): Medications are administered inappropriately when crushed and put into food without a Court Order in place and absent an emergency.

I...Interviews:

A. Recipient 1: The recipient informed the team that the facility is crushing medication and putting it into his food even though he has no Court Order for medication. The Recipient stated this is at regular meal times when he isn't exhibiting any type of non-compliance. After he eats meals, he has "dizzy spells". Therefore, he is refusing to eat meals except breakfast and sometimes his evening snack. He also reports a decline in his health due to not being able to eat meals which is affecting his ability to participate fully in activities throughout the day.

B. Recipient 2: The recipient informed the team that the facility violates his rights when they crush his medication. He wasn't sure why the facility was crushing his medications but he admitted that he doesn't like to take them because they make him dizzy.

C. Recipient 2 Guardian: The HRA spoke with the recipient's guardian. He said the recipient does not like his medication crushed. He can take them whole, but Chester crushes them. The guardian was unsure why they do this.

D. Chairman: Recipient 1 had been refusing medications. However, the Team found no indication in the chart that he was given medication on a crush order, only that he was given two emergency enforced medications in August. The Team spoke with the chairman in general about crush and observe medication orders. A crush and observe order might be utilized if a patient is "hoarding" medications for suicide attempts by overdose, if the patient is on court ordered medication and is "cheeking" his medications or if a patient is trying to trade with or sell his medications to another recipient at the facility.

According to the chairman, he spoke with recipient 2 who told him he does not want to take his medication because it makes him feel dizzy. The recipient was encouraged to discuss this with someone on his treatment team. The chairman spoke with the recipient's therapist about the medication making him dizzy. He was told there was a treatment plan review scheduled on November 29, 2012 and it would be addressed. The therapist advised the chairman that the recipient is on crush and observe due to his reluctance to take the medication, and no court order.

He also indicated there were some elevated, but not toxic, lithium levels recently that are also being addressed. The chairman asked the therapist about the recipient's right to refuse treatment and was told by the therapist that "he is aware of the recipient's right to refuse medication if he is on crush and observe."

II. Clinical Chart Review:

A. Treatment Plan Reviews (TPRs):

Recipient 1: The TPR dated 11/19/12 stated that the treatment team informed the recipient of circumstances under which the law permits the use of emergency forced medication, restraint or seclusion. However, the recipient refused to designate his preferences and personal safety plan. The treatment team noted that he will be encouraged to designate preferences. Individualized treatment/habilitation goals listed in the recipient's TPR were reviewed by the HRA team. Goals were listed to address him being unfit to stand trial and noncompliance with medication and treatment. The latter had specific objectives to address it as "stating symptoms of his diagnosed mental illness, identifying factors that have contributed to decompensation of mental condition and increased understanding of medication, potential side effects and expected effects." The TPR also notes that he attended 54 off unit activities this past month. His attendance and participation has been maintained.

The TPR dated 1/14/13 stated that the recipient continues to refuse to take medication and appears paranoid, suspicious and guarded. He still refused to designate emergency preferences. Under "current medication and intended outcome" on the TPR it lists "None because he could not be reasoned with." It also states that "because of his thought disorder and oppositional attitude, he will not be able to cooperate or assist his attorney in his own defense. He is unfit to stand trial." The TPR makes note that his psychiatrist, RN and STA1 all said he refuses to take medication. However, there is a note that he attended 27 off unit activities this past month which is "good progress."

Recipient 2: The TPR dated 11/7/12 states that the recipient asked for a "shot" earlier and was commended on his ability to recognize that he was angry. It also states that he was placed on "crush and observe medication" order on 10/28/12 but no reason was listed. On 10/29/12 Lithium was added. It is stated that attempts are being made to control his mood swings and aggression. He received 5 contingency medications this review period. He had barricaded himself into his room by putting a desk in front of the door. He also made a weapon by placing a bar of soap in the bottom of a sock tied with a knot. He was also on 1:1 observation 10/26 through 10/29 due to his threats to kill himself. The nurse noted he has had no medication refusals. The recipient's emergency preference is listed as medication first then restraints. Seclusion is not an option due to his MR status. There was a note indicating that the recipient stated he was in agreement with his treatment plan goals. However this recipient has been deemed incompetent and has a legal guardian who should have participated in or at least signed off on the treatment plan. The guardian is not listed as a participant and did not sign the treatment plan.

The TPR dated 12/4/12 states that his behavior has improved the past few weeks. He has been able to attend more off unit activities. The recipient denied having any concerns except that he did not want his medication crushed any longer. The physician discontinued the crush order but left the order to observe. The nurse noted that the recipient was medication compliant but is on crush and observe "to ensure compliance." The recipient stated he was in agreement with his treatment plan goals. The guardian is not listed as a participant and did not sign the treatment plan.

The TPR dated 1/2/13 states that his response to treatment has been favorable. His aggressive behaviors have decreased. He did not require restraint but did receive contingency medication due to severe agitation on four occasions during this review period. It is noted that he responded favorably to the lithium that was added and was encouraged to be more involved in classes. It was noted that he is on an observe order for medication to ensure compliance and has had no refusals. The recipient stated he was in agreement with his treatment plan goals. The guardian is not listed as a participant and did not sign the treatment plan.

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B. Progress Notes:

Recipient 1: A RN nursing note dated 8/13/12 at 9:55 a.m. stated "Dr. [name] wrote orders for Olanzepine PO now - IM if he refuses for psychosis, emergency enforce one time. Patient refuses breakfast every morning and picks through food on the other 2 meal trays. He believes staff is serving him rotten food."

A RN nursing note dated 8/13/12 at 9:45 a.m. stated "patient is resistive to taking PO Olanzepine after much encouragement patient continued to refuse. IM Olanzepine prepared with security staff present, patient turned around and took IM injection. Patient very thin with poor muscle mass, skin with mucus membranes dry, patient encouraged to drink water, patient states 'it's my human right not to eat or drink'. "

A STA note dated 8/13/12 9:45 a.m. states "recipient (name) was earlier informed by the treatment team that he was being placed on emergency enforced medication by the doctor, but he was extremely uncooperative and argumentative when his medication was offered to him by the nurse…despite numerous requests by staff to comply, the recipient would not and had to be given his medication via injection with the unit director, unit manager and charge aide present."

A RN nursing note dated 8/13/12 at 9:45 a.m. states "medication emergency enforced ROR given to patient." The Team reviewed a restriction of rights notice dated 8/14/12 at 8:15 a.m. The reason for restriction (administered emergency medication) was "due to physical and mental declining. Refuses to eat majority of time d/t delusions."

A RN nursing note 8/13/12 at 2:15 p.m. states "new order received from Dr. (name) 24 hour emergency enforced medications for deterioration of mental and physical status."

An 8/14/12 psychiatry note at 6:00 pm says "recipient stated he is losing weight because of eating rotten food and there is no need to be weighted it is not relevant"

According to documentation in a psychiatry progress note dated 11/19/12 recipient "attended his TPR meeting appeared tense, guarded, irritable, angry and paranoid when counseled to take medication he stated 'you are harassing me, you have no respect for me, I am tired of being discriminated.' Without medication he will not attain fitness to stand trial."

The HRA would also like to note that a discrepancy was found in the charting of this recipient's medication. The progress notes state that emergency meds were given on 8/13/12 while the MAR showed that they were given on 8/14/12. Since there are several entries noting the situation on the 8/13/12, the Team assumed this was the date the medication was actually given.

Recipient 2: A 10/24/12 nursing note at 12:45 pm stated the recipient was angry with a peer and requested a PRN. The physician was called and ordered "Lorazepam 2 mg 1x now." Recipient accepted the medication.

A 10/24/12 nursing note at 4:30 pm stated that the recipient was pacing the unit with clinched fists, calling staff names. He was unable to be redirected. The doctor was called and ordered Haldol 10 mg and Diphenhydramine 50 mg for agitation. The recipient was offered and accepted the medication. At 5:30 pm it was noted he placed a desk in front of his door and made a weapon out of a bar of soap and sock. Staff was able to voluntarily gain access to his room and redirect him to the quiet room to calm down with the door open and unlocked.

A 10/25/12 case note stated the recipient was upset about being on red level, attempts to redirect were unsuccessful. The recipient was offered a PRN medication and accepted it.

A 10/26/12 case note stated the recipient was placed on 1:1 observation due to him saying he wanted to kill himself.

A 10/27/12 nursing note stated the doctor continued the order for 1:1 observation and made a note that "the recipient was compliant with his morning medications."

A 10/28/12 nursing note at 10:00 am stated the doctor saw the patient and renewed the order for 1:1 for self injurious behavior. Patient denied thoughts of suicide or harming self.

A 10/28/12 nursing note at 6:00 pm stated the doctor wrote a new order to have medicine "crush and observe." No reason is listed.

A 12/3/12 nursing note stated that "recipient voiced that crushed medications are making him sick. Spoke with physician, changed lithium carbonate to lithium citrate. Order completed and sent to pharmacy."

A 12/4/12 nursing note stated "new order received to discontinue crush and observe and observe with mouth checks. Order completed."

C. Medication Administration Record (MAR) and Medication Orders:

Recipient 1: The MAR for August, 2012 showed "Olanzepine 5 mg PO BID for psychosis emergency enforced. If refuses, Olanzepine 5 mg PO give Olanzepine 5 mg IM BID for psychosis." According to the MAR Olanzepine was given on 8/13/12 at 9 pm and on 8/14/12 at 9 am. No psychotropic medication is listed on either the November, 2012 or February, 2013 MAR.

The Team also reviewed a psychotropic medication refusal for the week ending 8/19/12. On Monday 8/13/12 it shows that the recipient refused psychotropic medication and emergency meds were administered. The doctor signed off on the form. It was indicated on the form that court ordered medication was not petitioned at that time because "other, less restrictive services were more appropriate." It was also noted that a box was checked indicating that a petition for court enforced medication had been initiated on 8/15/12. A restriction of rights form was provided for each administration.

The HRA coordinator spoke with the ADON to clarify the last statement and was told that he refused his morning medication and received emergency medication. The physician indicated that the reason a petition for court enforced medication was not initiated at that time (8/13/13) as other, less restrictive services were more appropriate. It also appears that on 8/15/13 the psychiatrist submitted a petition for court enforced medication. When asked if other, less restrictive services were more appropriate, then why was he given emergency medication, she responded that a petition was submitted, it appears the physician involved may have completed the form incorrectly.

The Team reviewed medication orders that were in the chart dated 1/8/13, 1/24/13, 2/19/13 and 3/16/13, none of them listed any psychotropic medication. Upon admission he had an order for up to 12 mg a day of Tab Risperdone.

Recipient 2: The Team reviewed CMHC form 535 showing the following medications as of 7/31/12: Haldol up to 40 mg per day; Divalproex Na up to 3000 mg per day; Cogentin up to 4 mg per day and Lorazepam up to 10 mg per day.

The MAR for January, 2013 also lists Lithium Carbonate as well as contingency orders for Lorazepam.

The physician's order for crush and observe medication dated 10/28/12 states the reason for the order is "to ensure compliance"

D. Court Documents:

Recipient 1: The Team reviewed the Petition for Administration of Enforced Medication (Olanzepine PO/IM and Risperdone and Lorazepam if Olanzepine is ineffective) dated 8/14/12. According to the Petition, the patient was found UST on 4/27/11 and was admitted to Chester on 5/19/11 due to refusing psychiatric medication at the jail and he could not be reasoned with to take antipsychotic medication. There were examples listed of question and answer sessions which show the patient "refused to give any relevant information." The Petition states several different examples of responses that were disorganized, paranoid and off topic. For example "I

have been televised, polygraphed, audited, corrupted, raped, verbally abused since third grade. State has already murdered me, I just happen to be alive, incarcerating people who have not been convicted. They were told not to audit 20 years ago….you talk about medication that is verbal abuse, verbally disrespect me. I am constantly being neglected for millennium."

The Petition stated 9 reasons for the administration of enforced medication including refusal to submit to treatment by psychotropic medication and that he lacks capacity to give informed consent; that because of said mental illness of schizophrenia, he exhibits deterioration of the ability to function, is suffering and displays threatening behavior. It is noted that in May 2011 he weighed 198 pounds and has lost about 50 pounds, looks emaciated but refuses to be weighed, refuses labs and vital signs and states that these procedures are essential for the safe and effective administration of treatment. It also lists delusions, prior hospitalizations, living on the street "for decades", and other less restrictive services have been explored and found inappropriate.

There was an Order for Administration of Authorized Involuntary Treatment in the recipient's chart, but it was not signed by a judge.

Recipient 2: The team found no petitions or orders for court enforced medication.

III...Facility Policies:

A. Chester policy TX.02.04.00.02 states in section C "Regarding the use of emergency medication III.C.1a (page 6): The physician or RN initiating the use of emergency medication must document in the progress note that due consideration was given to the patient's treatment preference regarding emergency medication and must include justification for deviation of the patient's treatment preference."
B. Rights of Individuals Receiving Mental Health Services was available in the Recipient 1's clinical chart dated 5/18/11 at 3:45 p.m and states "Refusing Services: if you are over 18 and do not have a guardian, you have the right to refuse services including medication or ECT [or a guardian on your behalf]….if you refuse services, you will not be given such services except when necessary to prevent you from causing serious harm to yourself or others or if a judge orders it…" Also stated on this form was "Emergency Medication, ECT, Restraint, Seclusion: the facility must advise you, your guardian or substitute decision-maker, if any, of the following circumstances under which the law permits the use of emergency medication/ECT, restraint and seclusion. At the same time you, or your guardian or substitute decision-maker may tell the facility which form of intervention you would prefer if any, if the circumstances should arise. Your preference will be noted in the record and the facility must give consideration to your preference." The recipient did not sign this form.

The team spoke with the ADON to see if Chester had a policy on when crush and observe medication could be ordered. The response was that Chester does not have a policy that states when a patient can be placed on crush and observe but the Team was provided with the medication compliance policy which indicates that patients requiring increased attention due to suspected current non-compliance will have specific interventions identified in their treatment

plan. The policy states as follows "Patients have the right to refuse medication under the Mental Health Code unless they are imminently physically dangerous to self or others. The nurse who administers medication should always encourage medication compliance and should explore with patients any reasons for their reluctance to take medication. Medication non-compliance must be addressed in the patient's treatment plan and a consistent intervention formulated by the treatment team members with involvement of the patient"

Summary

Recipient 1 alleged that medication was being put in his food which made him feel dizzy and stated he was refusing meals because of this. There was documentation that Recipient 1 had refused breakfast for over a month but had eaten his snack everyday at the time emergency medication was given. He had eaten anywhere from 20% to 100% of lunch and supper during this same time frame; at times only eating one meal per day and others eating some of both lunch and supper. There was also documentation that the recipient made delusional, paranoid and off topic statements as referenced in the Petition for Involuntary Treatment. The Team could find no documentation that his medication was ever crushed and put into food, but he was given emergency enforced medication for "psychosis." The case notes reflect that the recipient was given many opportunities to refuse his medication, was allowed to refuse his medications and did try to refuse them, until the doctor ordered "Olanzepine PO now - IM if he refuses for psychosis, emergency enforce one time." Restriction of rights notices were given both times that emergency medication was administered.

Recipient 2 alleges that his medication was being inappropriately administered when it was crushed without a court order in place. The team found no court order for emergency enforced medication. The therapist had informed the chairman that the recipient was on crush and observe due to his reluctance to take medication and there was no court order. However, the Team could find no documentation in the TPRs or case notes to indicate that he was refusing to take medication. The case notes reflected that he was medication compliant and even requested PRN medications on occasion. The TPRs also stated that he was medication compliant and during the 12/4/12 TPR meeting, the recipient stated that he no longer wanted his medication crushed. Although the TPR stated the recipient was in agreement with his treatment plan, this individual has a legal guardian who should have participated and signed off on the TPR indicating agreement with the plan which included an order to crush and observe medication.

Conclusion

Recipient 1: Per the Mental Health Code 405 ILCS 5/2-107, emergency enforced medication can only be given if "there is an eminent risk of physical harm to self or others". A deteriorating mental condition or psychosis is not sufficient reason for administering emergency medication. Therefore, even though there is no evidence that medications were not crushed and put into food, per the Code, the medication was still administered without instance of potential serious and imminent physical harm and the allegation is **substantiated** and makes the following recommendation:

- The HRA acknowledges that this same issue was addressed by Chester in a prior case but would like to take this opportunity to provide a reminder recommendation that all staff continue to receive training on this topic as part of annual rights training.

Recipient 2: Since there was no Court Order for medication and the Team could not find any documentation to indicate that the recipient was refusing medication to warrant a crush and observe order per Chester's medication compliance policy, the allegation is **substantiated** and makes the following recommendations:
The HRA reiterates the above recommendation for this recipient.

- Ensure that the legal guardian is notified and allowed to participate in treatment planning meetings. If the guardian cannot attend the TPR meeting, then the guardian should be provided a copy of the TPR to sign indicating agreement with the plan.

- Ensure that all adult recipients and all guardians are aware of "crush and observe" orders and that all have the opportunity to refuse them. Whether medications are called "contingency", "PRN" or "emergency enforced", every single psychotropic prescription must come with proper informed consent (405 ILCS 5/2-102a-5) or meet the standards for forced administrations (405 ILCS 5/2-107). In all instances, written drug information must be provided to recipients and guardians (405 ILCS 5/2-102a-5).

Allegation 3 (involved 1 recipient): There are inappropriate staff interactions with recipients.

I. Recipient Interview: Around November 15, 2012, the recipient told the Team that Security Therapy Aides (STAs) wake him up for commissary even though he has requested that his name be removed from the list since he has no money to purchase commissary items. Rather than just opening his cell door and telling him to wake up, they enter his room and kick his bed continuously to wake him up. The recipient also alleges that around November 15, 2012, he was sitting at a dining table and a female STA hit him on the back of the head for unknown reasons. In addition, the recipient stated that an STA threatened to have 20 people assist him in "beating down" the recipient. OIG reports were filed regarding these incidents. The recipient also said that around January 15, 2013, staff members were taunting him to contact the HRA saying "they can't do anything to help you" and that staff sit next to him when he makes phone calls and smile and laugh at him.

II. OIG Reports: The OIG reports regarding the above referenced allegations were reviewed. The allegation that a female STA hit the recipient on the back of the head was unfounded due to the fact that the recipient could not provide any details of why this occurred and he could not provide any witnesses to the incident. The recipient refused an examination by the doctor so there was no medical evidence to support or contradict his claim. The nursing assessment completed 4 days later when the facility learned of the allegation documented that the recipient denied any injury or pain.

The allegation that staff said they were going to "beat him down" was also unfounded. The reason stated was because when the facility investigator interviewed the recipient he stated that

he had already reported this to the OIG months ago. It was determined that this was the same allegation as in another case that was investigated a few months ago and listed the case number. However, when HRA reviewed that case number it involved an allegation that an STA had continually opened the shower door while the recipient was showering, not an allegation of being threatened to be "beat down". The HRA questioned both the facility investigator and the OIG to try and locate the original investigation regarding this issue, but they did not have any other cases except the two mentioned here. Since the OIG report did not fully address the recipient's concerns, the HRA made additional contact with OIG for further review of the allegation of threats that staff members were going to "beat him down".

The allegation that staff kicked his bed to wake him was also unfounded. The reasons stated were that the recipient changed his story of how the incident occurred and named a staff person as the perpetrator who has been on administrative leave which began 10 months prior to this allegation. Video tapes from the day before through 2 days after this allegation was made were also reviewed which showed that he exited his room on his own without any staff member entering his room.

III. Case Notes: The Team reviewed case notes around the time of all three of the above incidents. On 11/19/12 there is a nursing note that the facility investigator reported that patient called the OIG hotline and reported that on 11/15/12 at breakfast, he was tapped on his head for no reason. He denied any injury and none was noted. He stated he doesn't know what he was tapped with. There is no mention in the case notes that he ever complained about staff kicking his bed to wake him. When reviewing the case notes, the Team found no notes reflecting that he had complained about staff or telephone use, only complaints about his food.

IV…TPRs: The Team reviewed the TPRs dated 11/19/12 and 1/14/13. The recipient was present and participated in his TPRs. There was no mention in the discussion section in either TPR that he has complained about staff interactions, just that he continues to refuse medication and appears paranoid, suspicious and guarded and refuses all tests, weight checks and vital signs.

Conclusion

There was no documentation to show that the recipient reported to anyone at Chester regarding any of the alleged negative staff interactions, with the exception of the 11/19/12 nursing note showing that an OIG report had been filed regarding a female staff hitting the back of his head. All of the OIG reports regarding staff abuse, including this one noted in the case notes, were determined to be unfounded, mostly due to the recipient providing inaccurate information, being unable to provide witnesses and changing his allegations. That, along with the numerous notes throughout his file referring to him as being paranoid, suspicious, guarded and uncooperative with treatment made it difficult for the HRA to prove that negative staff interactions did occur. Therefore, based on the available evidence that was reviewed by the HRA, the allegation that there are inappropriate staff interactions with the recipient is **unsubstantiated**.