FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
13-110-9028
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:

1. **A recipient is not receiving adequate medical care.**
2. **A recipient was told he could not refuse a medication and passed out when emergency enforced medication was given over objection.**
3. **Staff denied a recipient food as a punishment**.

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2) and the Illinois Administrative Code (59 Ill. Adm. Code 112).

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 re-determined 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 5/2-201.1) requires that "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."

According to the Code (405 ILCS 5/2-209), "Seclusion may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. In no event shall seclusion be utilized to punish or discipline a recipient, nor is seclusion to be used as a convenience for the staff."

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

The Illinois Administrative Code (59 Ill. Adm. Code 112.90) states in section b), Informed Consent, that "Prior to prescribing psychotropic medications or ECT in non-emergency situations, a physician shall ascertain and document whether the recipient is capable of giving informed consent."

In subsection A) Legally and Clinically Competent Recipients, it states that "if the recipient is able to give informed consent, the physician shall advise the recipient, in writing, of the following:
i) nature and purpose of the proposed treatment;
ii) whether the proposed treatment requires periodic testing/procedures to ensure safety/efficacy;
iii) side effects, risks and benefits of the proposed treatment;
iv prognosis and risks without the proposed treatment;
v) alternative treatments and their risks, side effects, benefits and efficacy; and
vi) the right to refuse the proposed treatment.
B) The required information shall be given to the recipient in a manner consistent with his/her ability to understand, including regular use of sign language for any deaf or hard of hearing individual for whom sign language is a primary mode of communication.
C) Informed written consent shall be obtained from the recipient…. "

In section c) Refusal of Treatment, it states "A recipient's refusal to receive psychotropic medication or ECT does not in itself constitute an emergency. Such refusal, as documented in the clinical record, shall be honored except in the following circumstances: 1) Emergencies: In an emergency, when treatment is necessary to prevent a recipient from causing serious and imminent physical harm to self or others. A) In such an emergency, a member of the treatment/habilitation team shall document in the recipient's clinical record that the staff have explored alternative treatment options to contain the emergency. The documentation shall include a written explanation of the reasons why alternative treatments are not appropriate. B) For administration of psychotropic medications the prescribing physician or a nurse in consultation with a physician shall document his/her determination that an emergency exists based on a personal examination of the individual. Administration of the medication shall be accompanied by a physician's order. C) In prescribing psychotropic medications on an emergency basis the prescribing physician shall examine the recipient and document his/her determination of the initial emergency and response, including the circumstances leading up to the need for emergency treatment, in the recipient's clinical record as soon as possible, but within 24 hours. Psychotropic medication may not be continued unless the need for such medication is re-determined at least every 24 hours and the circumstances demonstrating that need are set forth in the recipient's clinical record. A redetermination is based on a personal examination of the recipient by a physician or a nurse with the consultation of a physician. D) Treatment shall not be administered over a recipient's refusal under Section 2-107 of the Mental Health and Developmental Disabilities Code for a period in excess of 72 hours, excluding Saturdays, Sundays and holidays, unless the treating physician with the support of the treatment/habilitation team files a petition for a court order under Section 2-107.1 of the Code and the treatment continues to be necessary in order to prevent the recipient from causing serious and imminent physical harm to self or others. If no such petition is filed, treatment must be discontinued. E) A restriction of rights form shall be completed for each administration of emergency treatment. F) ECT may be administered over a patient's refusal only with a court order and prior written physician's order or in emergency situations as defined in Section 2-107 of the Code. G) *Upon commencement of services, or as soon thereafter as the condition of the recipient permits, the facility shall advise the recipient as to the circumstances under which the use of emergency forced medication is permitted under Section 2-107(a) of the Mental Health and Developmental Disabilities Code* [405 ILCS 5/2-200(d)]. Concurrently, the facility shall ask the recipient which

form of intervention he/she would prefer if any of these circumstances arise. The recipient's preference shall be documented in the clinical record and communicated by the facility to the recipient's guardian or substitute decision maker, if any. If any such circumstances arise, the facility shall give due consideration to the preferences of the recipient regarding which form of intervention to use as communicated to the facility by the recipient or as stated in the recipient's advance directive. H) Under no circumstances may long-acting psychotropic medications be administered under Section 2-107 of the Code".

Subsection 2, Administration of Treatment on Court Order, states "If the treating physician, with the support of the treatment/habilitation team, determines that psychotropic medication or ECT is clinically indicated for a recipient who does not at the time pose an imminent risk of serious physical harm to self or others…the facility may file a petition in the circuit court under Section 2-107.1 of the Code for court-ordered treatment…If the court grants the petition for involuntary treatment pursuant to Section 2-107.1 of the Code, the recipient may be administered treatment over his/her refusal (or the guardian's or substitute decision maker's refusal if the recipient was legally incompetent but did not object) within the constraints and for the duration of the court order."

Investigation Information

To investigate the allegations, the HRA Investigation Team (Team), consisting of two members and the HRA Coordinator conducted a site visit at the facility. During the visit, the Team spoke with the Recipient whose rights were alleged to have been violated and the 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: A recipient is not receiving adequate medical care

I. Interviews:

A. Recipient 1: The recipient told the Team that he has plates in his legs and shoulder because he jumped off a bridge in 2006. As a result, he often has pain in his legs and shoulder. He said the facility only gives him Naproxen for the pain and it does not help relieve the pain. Prior to being in Illinois Department of Human Services (DHS) facilities, he said he used heroin on the streets to help with the pain. He also said he has panic attacks for which the facility will not prescribe medication. He stated at his previous DHS facility, he was given Valium and Ativan for his anxiety. At the time of the HRA interview with the recipient, he had been at Chester for approximately 40 days and had been requesting medication for his panic attacks since he arrived but had not received any.

B. Chairman: Before the HRA was able to meet with the recipient, they approached the chairman to check on the recipient and follow up on this allegation. The chairman discovered that this patient has a history of substance dependence and said the recipient was demanding Ativan and Klonapine during his visit as well. In his opinion, the course of treatment "seemed appropriate for his phase of recovery."

The chairman informed the HRA of the medical treatment available "in house." He said each unit has a Primary Care Physician who makes rounds at least 2 times a day and follows any medical concerns and issues that arise. They also hold clinics for patients identified with various medical issues. If a patient exhibits extreme symptoms, Chester implements their Critical Assessment Response Effort (CARE) or Code Blue (medical emergency) policy. If the patient needs a higher level of medical monitoring Chester has the ability to transfer them to their infirmary where the patient to nurse ratio is better and medically complicated patients can receive care.

II. Clinical Chart Review:

A. Treatment Plan Reviews (TPRs): The 2/15/13 TPR notes that the recipient attended and participated in his TPR and admitted to a history of drug abuse including cocaine, marijuana, acid, mushrooms, heroin, and alcohol. He stated that he used heroin as recent as 2/6/13. The discussion section stated that he "was argumentative and did not display any insight into his reason for admission. He was easily agitated and kept asking for different medication than what he was prescribed. He described his recent drug and alcohol abuse, reporting that he used them on the 'streets' to keep warm." The recipient listed his emergency preferences as 1) Medication 2) Seclusion and 3) Restraint. His "Problem" section lists verbal/physical aggression, history of self harm, psychiatric symptoms and substance abuse as the four areas of treatment that will be addressed. His Diagnosis is listed as follows: Axis I Bipolar Disorder NOS (not otherwise specified), Polysubstance Dependence, in remission in controlled environment; Axis II Antisocial Personality Disorder; Axis III No diagnosis; Axis IV Homelessness, legal issues, chronic mental illness and Axis V GAF=20. His medication plan included Risperidal 3 mg PO (by mouth) BID (twice per day) to control psychotic symptoms, Lorazepam (Ativan) 2 mg for agitation and Chlorpromazine (Thorazine) 50 mg every 4 hours PRN (as needed) for agitation. There was no mention of the recipient having plates in his legs or any plan for pain management as part of his treatment plan.

The 3/6/13 TPR also included respiratory disorder/disease as another "problem" area in which treatment will occur. The recipient attended and participated in this TPR and the discussion section stated "He was argumentative and stated that he was not going to take the medication that Dr. [name] was prescribing. He once again asked for pain killers or muscle relaxers…[recipient] refused to sign the CMHC 757 indicating whether he was in agreement with his treatment plan goals. He denied having any changes to his preferences or safety plan at this time." The TPR also noted that the recipient was "minimizing his substance abuse history. He has no desire to engage in substance abuse treatment at this time." Under the response to medication section it was noted that the recipient said the Risperidal was not helping with his labile moods and anger and requested that he be put on Quetiapine on 2/20/13. However, it stated that he had been refusing the Quetiapine every day. On 3/6/13 the team discontinued it at his request and increased the Clonidine dose. This TPR also noted that he is still displaying "drug seeking behavior and argues about getting Benzos on a regular basis" and that he frequently makes verbal threats against staff.

In the 4/3/13 TPR, the discussion section stated that he attended his TPR meeting. He was described as "easily agitated during the meeting and was difficult to redirect. He continued to present as drug seeking. He stated that he has been having 'panic attacks' regularly." He again refused to sign indicating whether or not he was in agreement with his treatment plan goals. He did not make any changes to his preferences or safety plan. This TPR also noted that the recipient had no desire to engage in substance abuse treatment at that time. The response to medication section noted that "he refuses to cooperate with his medication adjustment."

An interim treatment plan dated 4/11/13 noted that the doctor filed a petition for enforced medication on 4/10/13 due to daily verbal aggression to staff and patients and also stated that he had been "noncompliant with his medication and other forms of treatment." The recipient had been returned from the dining room twice in February and given PRN medication due to "loud and threatening behavior." On another occasion in February, he was given emergency enforced medication "after he had an altercation with a peer." In March he threatened a STA stating he was going to "beat his ass and beat him like a woman." He was also placed in seclusion in March.

The 5/1/13 TPR again stated that the recipient attended and participated in his meeting and that he was on court enforced medication at that time. It noted that he had attended more activities and was commended on the improvement. He had requested to see the dietician for double portions and a referral was made. This TPR also noted that the recipient "has no desire to engage in substance abuse treatment at this time." He again refused to sign indicating if he was in agreement with his treatment plan goals. He denied any changes to his preferences or safety plan. The response to medication section had an additional note on this TPR that on 4/5/13 he hit a peer and "ended up in restraints so was started on Emergency Enforced medication and petition was filed to court, which was approved on 4/12/13. On 4/12/13 he was started on PO Risperidone. He showed improvement with less irritability and argumentativeness and no delusional statements."

A 5/29/13 TPR was also reviewed. The discussion section stated that he attended and participated but had reported not feeling well. The team encouraged him to comply with blood work and he refused. He stated "my blood turns into rubies and you can't have it." He continued to present as delusional and is often hostile toward treatment team members. The doctor increased his Risperidal at that time. The recipient again refused to sign indicating agreement with his treatment plan goals and denied having any changes to his preferences or safety plan. The recipient was still refusing to attend substance abuse treatment at this time. Under the response to medication section of this TPR, it was noted that his PO Risperidone was "switched to Risperidone Consta" (injectible form) but it doesn't indicate why the change occurred. The recipient was still displaying "argumentativeness and irritability" therefore on 5/10/13 he was started on Divalproex ER 500 mg BID with improvement in his irritability. However he refused blood draws because he "thinks if he gives blood it will cause a curse on him." The treatment team decided to increase Risperidone Consta at this treatment meeting. The recipient refused to sign his TPR indicating agreement with his treatment plan goals.

The 6/26/13 TPR's discussion section stated that he attended and participated in his meeting but was "argumentative and demanding with staff." It noted that he had not been physically

aggressive, but still directed verbal aggression at staff and peers. The response to medication section additionally noted that on 5/29/13 his Risperidone Consta was increased and since then he had not been talking to himself and has not made any delusional statements. In June he agreed to have his blood drawn and it showed elevated liver enzymes. Therefore, his Divalproex ER was discontinued and he was started on Lithium. It noted that "he continues to do fairly well. However, he still displays antisocial behaviors and anger management problems." This TPR also noted that he was still on Court enforced medication and there had been no refusals so far. However, the recipient was still refusing to engage in substance abuse treatment at that time and again refused to indicate if he was in agreement with his treatment plan goals, but he did sign his TPR.

The 7/24/13 TPR again stated that the recipient attended his meeting and said that "overall his behavior has improved and he has not been physically aggressive. He has become more cooperative with staff. He continues to have issues with taking blood but he has been compliant. He has been actively attending AT [Activity Therapy] and Rehab." The response to medication section included the following additional information: on 7/3/13 his "Lithium was increased to 600 mg BID and Risperidal Consta to 50 g IM every 2 weeks. Since then he is doing really well with no major management problems. Will continue current medications." The recipient signed the TPR form and indicated he was in agreement with his treatment plan goals and also denied having any changes to his preferences or safety plan at that time.

Finally, the 8/21/13 TPR was reviewed. The discussion section noted that he attended and was appropriate. The Security Therapy Aide (STA) staff denied having any behavioral problems with him. He signed consent for medication on that date and expressed intent to continue taking his medication when he leaves Chester. He was recommended for transfer to a less secure facility on that date. The response to medication section had no additional information than what was stated in his 7/24/13 TPR. The recipient signed his TPR and indicated that he was in agreement with it.

B. The Intake Physical Exam listed the following for history and plan of treatment: "Acute medical problem found - No; Allergies - no; Bowel pattern regular - yes; rectal exam performed - not indicated; smoker - yes; H/O (history of) alcohol/substance abuse - yes; Hx (history of) self (illegible) healed; Hx Lt Rt leg surgery; left shoulder surgery secondary to fall from bridge. Plan: admission work up per protocol; bowel prophylaxis PRN; PRN acetaminophen; generated problem list; f/u (follow up) in new admit clinic."

C...Progress Notes: The HRA first reviewed the infirmary admission note which indicated that he was an emergency admission from another state mental health facility. The recipient stated he was "allergic to nothing." A pain assessment tool was explained and it is noted that the recipient understood the tool. At the time of admission, he was complaining of a "pain rating 10 out of 10, but shows no signs of discomfort. Chronic pain assessment was initiated." There was no mention in this note that the recipient had plates in his legs from an old injury. He listed his emergency preferences as 1) medication 2) seclusion and 3) restraints. It was noted that the recipient was also within his ideal body weight.

A 2/14/13 "psych coverage note" taken at triage lists the recipient as having a diagnosis of psychotic disorder not otherwise specified and heroin dependence. It stated the recipient "has been receiving Risperidone 3 mg BID and PRN of Thorazine and Ativan for agitation. Currently pt (patient) is cooperative but wanting valium, Ativan etc…" The next few case notes just indicate he complained of a headache and was given Tylenol which was effective and he requested Ativan and was given a PRN of Benadryl. On 2/15/13 his 3 day review was held but the recipient was "easily agitated and discussed that he thinks about torturing and killing people on a daily basis." The meeting ended prematurely due to his "escalating agitation and inappropriate talk."

A 2/20/13 "psych note" stated that the recipient wanted to change from Risperidone to Quetiapine due to Risperidone not calming him down. The doctor agreed to do so.

A note on 2/27/13 indicated the recipient had refused medications for 3 days and refused to come out of his room. At 10:15 a.m. a therapist note was reviewed stating he was seen due to his continued refusal of medication and verbal aggression. The recipient was "hostile in the meeting. He stated that he was refusing the medication because he didn't use the Seroquel. He stated that he needs pain killers and muscle relaxers. He said if he was given those medications then he would take the Seroquel." It was noted that he had been noncompliant with all treatment and verbally aggressive daily.

A 3/18/13 "MD note" is the first case note that discusses his pain complaints. It stated that the recipient complained of "ongoing chronic pain in neck, back, L hip, R arm, R leg for 6 years after a 35 ft. fall from a bridge (suicide attempt). Pt. used Heroin/Methadone, Vicodin, Percocet for pain relief and requests Methadone, Vicodin or Percocet now for pain relief. Last on these meds 3 years ago. States Tylenol not relieving his pain." The doctor ordered X-rays of the "C-spine (3v), LSS (3v), Lt. Hip, Rt. Forearm and Rt Tib/Fib." These X-rays, according to the case notes, were completed on 3/22/13. The recipient complained of pain from headaches and hip pain over the next several days and stated "I'm always in pain."

On 3/25/13 the recipient again complained of "pain all over" rated as a 10/10 on the pain scale. He was given Tylenol 650 mg an hour later the recipient stated his pain was now a 3/10 on the pain scale. Another case note on 4/9/13 stated the recipient complained of pain that was 10/10 on the pain scale, was given Tylenol and an hour later he described his pain as 2/10 on the pain scale.

On 4/27/13 at 8:30 a.m. the recipient requested Tylenol for pain rated 5/10. At 9:30 a.m. he denied having any pain.

On 4/30/13 there was a case note that indicated the recipient complained to the nurse and medical director that he was feeling anxious. The case note is detailed under allegation 2 below. Another case note on 5/11/13 indicated that the recipient requested a PRN for increased anxiety. The doctor was contacted and gave a one time order for Lorazepam. When the nurse followed up with him an hour later he was "much calmer" and stated "he is no longer anxious PRN effective."

A 5/12/13 doctor's note at 6:50 p.m. stated "anxiety attack. Ativan given."

The Team reviewed all the case notes through 9/23/13 and there were several other instances where this recipient complained of "pain all over" or having a headache but once Tylenol was given and the nurse followed up with him, he admitted that his pain was better and that the medication was effective.

There was several case notes dated from about 4/11/13 through 8/28/13 that refer to the recipient complaining off and on about a "bump on his right forearm." On 4/11/13 he was evaluated by the doctor and was diagnosed with an "inflamed cyst." The doctor prescribed antibiotics and Bacitracin cream and performed an "I & D lesion" and noted that the recipient had a history of plates and screws in his arm. He was followed up with wound assessments and monitoring. The spot healed and returned off and on with antibiotic treatments. On 8/24/13 the doctor noted that the cyst was forming again over the plate/screw/pin area on his forearm. A note on 8/27/13 noted that he had surgery the next day for plate removal. This surgery was completed at the local community hospital on 8/28/13. Later that day, he was escorted back to the hospital for "IV therapy-antibiotic post operative surgery to right arm - plate removal." He was returned later that day. He was given Acetaminophen/Hydrocodone 500/5 for post operative pain and placed on frequent observation to monitor arm sling and PIC line. On 9/1/13 wound cultures came back positive for a staph infection and the recipient was again transported to the community hospital for IV antibiotic therapy. He was placed on IV antibiotic therapy for at least 2 weeks and Chester transported him out to the community hospital every time he was due for a treatment and frequent observation continued throughout this time. On 9/18/13 the PIC line was removed and IV antibiotics were discontinued.

The recipient was transferred to another state mental health facility on 9/24/13.

III...Facility Policies:

A. PE .01.01.01.12 Medical Screening On New Admissions From Jails and Department of Corrections (DOC): states "Chester Mental Health Center facilitates communication between jails and Department of Corrections (DOC). Prior to admission, medical information will be obtained from the sending facility to provide continuity of medical care to patients referred to our hospital." Once the recipient has been screened by the medical doctor on duty, the doctor will document any findings on the admitting "Physical Exam" and "Medical History" forms and the nurse documents the findings on the "Initial Nursing Assessment" form. The findings are then followed up by the recipient's assigned unit treatment team and physician.

B. CC .05.00.00.01 Utilizing the Medical Information Flow Sheet: states "It is the policy of the Chester Mental Health Center to communicate and record general medical conditions and diagnoses on Axis III as they may have potential relevance to the understanding and management of the patient's mental condition." The procedure for the flow sheet is listed as follows. "The Medical Information Flow Sheet will be utilized as a work sheet for the physicians to list significant physical findings/impressions/diagnoses and to help identify recurrent signs and symptoms that may have potential treatment or diagnostic relevance." This flow sheet is to be filed in the recipient's chart in section one. The physician that completes the

admission assessment will document physical impressions/diagnoses identified upon admission as well as any other significant physical findings. The attending nurse will assure that pertinent medical information is listed by the physician. The treating psychiatrist will routinely review the medical information flow sheet and utilize the information there to provide a relevant Axis III diagnosis.

The Team did not have the opportunity to review a medical information flow sheet for this recipient as it is not considered a part of the permanent record and is removed before transferring the recipient to another facility. This recipient was transferred prior to the completion of the HRA investigation.

Conclusion

The recipient told the Team that he was not receiving adequate medical care for pain management or anxiety attacks. Upon review of the chart, the HRA determined that there was a clear history of substance abuse/dependence. The recipient admitted to having abused substances as recently as 9 days prior to admission to Chester Mental Health Center. There were several case notes by different staff members describing the recipient as exhibiting drug seeking behaviors. There were case notes indicating that PRN medication of Acetaminophen was effective when given for pain relief, by the recipient's own report. Additionally, when the recipient expressed feelings of anxiety, the case notes stated that Ativan was given and was effective. Finally, when the recipient began having trouble with a cyst on his arm related to the plates in his arm, Chester took appropriate steps to get him the treatment he required including transporting him out to the local hospital for surgery and IV antibiotics. Therefore, the allegation that recipient did not receive adequate medical care is **unsubstantiated.**

Allegation 2: A recipient was told he could not refuse a medication and passed out when emergency enforced medication was given over objection

I...Interviews:

A. Recipient: The Recipient informed the Team that he was on the phone with the Office of Inspector General (OIG) when he fainted due to medication he is allergic to (Thorazine) being given over his objection. He said 10 Security Therapy Aides (STAs) came into the room to give him the medication and told him that he could not refuse it and that he had to take the medication. He said Thorazine makes him feel faint, dizzy and sick to his stomach. He also said that staff were "threatening him with Haldol" to which he is also allergic. He said Haldol "makes his tongue stick out and he gets stiff."

B. Chairman: Due to the serious nature of this allegation, the HRA approached the Chairman to follow up on this allegation prior to the visit by the Team to the facility. There was no history in his chart of allergies to Thorazine or Haldol. The Chairman said the recipient had not been given Thorazine for some time, but he tolerated it without incident when it was given to him.

II. Clinical Chart Review:

A. Treatment Plan Reviews (TPRs): All TPRs reviewed by the Team are detailed under allegation 1 above. None of them mentioned any incident of him passing out when given medication.

B. Court Order: The HRA reviewed a Court Order for involuntary medication dated April 17, 2013 ordering that a psychiatrist at Chester is authorized to administer Risperidone Consta up to 50 mg IM (intramuscular) every 2 weeks, Risperidone up to 16 mg per day, Lithium up to 2400 mg per day or per therapeutic blood level, Lorazepam up to 10 mg IM per day, Olanzapine up to 30 mg per day either orally or IM, Divalproex ER up to 4000 mg per day depending on blood level and Benztropine up to 8 mg per day po/IM for 90 days.

C. Progress Notes: Progress notes dated from 2/12/13 through 9/23/13 were reviewed by the Team. There were several notes stating that the recipient requested PRN medications and most of the time they were given to him. There were a few instances where he requested Ativan and was offered Benadryl instead; sometimes he accepted the Benadryl and other times he did not.

On 2/20/13 a nursing note indicated that at 8:45 a.m. the recipient requested his albuteral inhaler. He was given 2 puffs and there were no signs of shortness of breath or difficulty breathing after. He was monitored throughout that day and another case note at 5:20 p.m. indicated he again requested his inhaler stating "I feel a little short of breath." It was noted that there was "no obvious signs of respiratory distress." The recipient was also given his inhaler on 2/22/13.

A 2/25/13 therapist note that was reviewed noted that seclusion was eliminated as one of his treatment preferences due to his history of self harm.

On 2/26/13 at 9:30 a.m. a nursing note indicated the recipient had refused his routine medication for two days and also refused PRN medication. He was exhibiting "severe agitation, yelling, screaming and cursing." He had also been in an altercation with peers across the hall and in and out of their rooms. He was refusing to follow directions, arguing with staff and peers. **The nurse spoke with the Psychiatrist and received a new order for emergency enforced Chlorpromazine 50 mg IM. The medication was given to "LUOQ gluteal." It also noted that a restriction of rights was given to the recipient. A nursing note at 10:30 a.m. stated that the recipient was "resting quietly in room on bed with eyes closed 0 s/s of distress noted." Another nursing note at 11:50 a.m. this same day stated "Pt in dayroom nurses' station side, fell hitting head on the floor.** Assessed for injuries approx 3 cm circular reddened area to posterior head. No loss of consciousness. Talking to staff. Assisted up to chair per security staff." He was given Tylenol but the case note indicated he was "demanding Valium and Vicodin, attempts to educate/console pt unsuccessful. Demanding more pain meds. Pt is known heroin addict, pt uncooperative with staff voicing pain everywhere, rates pain 10 on scale of 1-10 explained acetaminophen is all that is ordered for pain at this time." His vitals were taken and neurology checks were within normal limits. The doctor was unable to come to the unit but requested that the Psychiatrist evaluate him for self injurious behavior since the recipient had been uncooperative and demanding of pain medications. Another case note at 12:30 p.m. stated that both doctors came to see the recipient and no new orders were issued from the Psychiatrist, however the medical doctor ordered neurology checks every shift for 24 hours and

to notify him of any changes. A nursing note at 8:15 p.m. stated that the recipient denied any dizziness and stated "I feel fine, why is everyone bugging me, just leave me alone."

A note on 2/27/13 indicated the recipient had refused medications for 3 days and refused to come out of his room. He was seen by his therapist and Psychiatrist "due to his continued refusal of medication and verbal aggression." This therapist note is detailed in allegation 1 above. There were several case notes from this date through March 6 that indicated the recipient refused his Quetiapine. The case notes indicate that staff tried to educate him on the importance of taking medications as prescribed with no success therefore, the doctor was notified of refusals and eventually on 3/6/13 the medication was discontinued due to the refusals. His other medication was adjusted and the case note indicates he was educated on the changes. After this date, the recipient started refusing his Clonidine daily and the case notes reflect that the doctor was notified of the refusals.

On 3/11/13 there was a nursing note which said the Clonidine was refused again, medication education was attempted but the recipient grinned and stated "if I keep refusing, they'll have to give me something else." The case note further states that he insisted on Valium and Vicodin which was not prescribed due to his history of drug addiction. Case notes indicate that through at least 3/18/13 the recipient continued to refuse his medication. On that date there was a therapist note stating that she consulted with a Psychiatrist regarding the recipient's "continued verbal threats against staff, his threatening behavior in an attempt to intimidate staff and peers and his noncompliance with treatment." The next several case notes do not mention any medication refusal or enforced medication and all involve other medical issues for which the recipient was being treated.

On 3/11/13 the recipient was placed in seclusion at 11:00 a.m. for threatening staff. The STA tried to redirect him unsuccessfully and he refused a PRN medication. Therefore, after continued threats to staff, he was placed in seclusion. The therapist note stated "patient has not engaged in self harm since his admission to this facility. His history of self harm is when he is abusing substances in the community, according to him. Patient is monitored continually while in seclusion. If patient were to start engaging in self harm, he would immediately be removed. Seclusion was the least restrictive option given his risk of harming staff." A case note at 7:30 p.m. stated he was calm and cooperative and met release criteria. He was released from seclusion at that time.

On Saturday, 4/13/13, a "psych coverage note" stated that the recipient "**has been on emergency enforced meds** pt has serious mental illness with significant [illegible] violence. Continues to be at imminent risk of harm without use of psychotropic medication. Pt not exhibiting any side effects of meds. Benefit of meds outweighs the risk at this time. Will continue with emergency enforced meds of Risperidal and Zyprexa as alternative." A case note from a nurse that same day states "rec. took po [oral] emergency enforced Risperidone 2 mg this am. ROR [restriction of rights] given."

On 4/14/13 a "MOD note" states that "emergency meds renewed for 24 hours for psychosis." A nursing note at 9:30 a.m. stated "pt. did take po Risperidone 2 mg per emergency enforced order with difficulty. Restriction of rights given to pt." At 4:40 p.m. a nursing note stated "staff report

pt was redirected from taking others food. Pt began screaming, yelling and slamming doors. Verbal redirection not effective. Pt. cont. highly agitated behavior. Offered & ref Chlorpromazine prn po pt stated 'I'll take a prn, just not that one.' Doctor [name] notified and T.O. (telephone order) received Lorazepam 2 mg po for agitation x 1 now. Pt offered and accepted Lorazepam 2 mg po." At 5:40 p.m. a nursing note indicated "pt reports his prn was effective;" at 7:35 p.m. a "MOD note" referenced the patient's "agitation. Given PRN Lorazepam."

A 4/15/13 nursing note at 9:15 a.m. stated "recip cont. on emergency enforced medication due to unpredictable behaviors and aggression recip cooperative with med pass, restriction of rights given."

The emergency enforced 24 hour medication renewals continued for four days (through Wednesday 4/17/13) when a Court order for enforced medication was obtained.

On 4/30/13 a nursing note at 6:30 p.m. indicated that the recipient complained of "dizziness and was observed sitting on floor. Pt. stated he thought he was going to faint. Took VS [vital signs] BP [blood pressure] 90/53 HR [heart rate] 60 Pt. cold and clammy. Called Dr. [name] she will come to assess. The MOD note at 6:40 p.m. stated "pt c/o feeling anxious to the nurse was dizzy BP 90/53 according to nursing report. Pt reported to this writer that he was feeling panicky earlier, but feels better now. Had received **Olanzapine** this am as PRN first time. BP 88/64 HR 72 pt reports feeling better now. He has had BP in 90s/60s in the past. Possibly medication related side effect will hold Risperidone tonight pt encouraged to drink more fluid pt educated on slowly changing his position from lying to sitting to standing f/u with tx team in am." The psych note on 5/1/13 at 10:30 a.m. stated "pt got a PRN [illegible] Olanzapine [illegible] his BP and made him dizzy. Will D/C [discontinue] Olanzapine order."

D…Medication Administration Records (MAR): February MAR lists Quetiapine twice a day for psychosis/agitation, Chlorpromazine (Thorazine) PRN for agitation, Clonidine twice a day for anxiety/agitation, Lorazepam PRN with Chlorpromazine, Risperidone twice a day, Albuteral inhaler PRN, Acetaminophen PRN, Docusate Sodium PRN, Milk of Magnesia PRN, Diphenhydramine (Benadryl) every 8 hours PRN for anxiety for 7 days and Emergency enforced Chlorpromazine IM now 1 time on the 26th. **The Quetiapine, Clonidine and Risperidone were all given twice daily. The Risperidone was discontinued on the 20th.** PRNs of Lorazepam were given on the 17th & 19th along with Chlorpromazine; Benadryl was given on the 15th-18th one time each day and the emergency enforced Chlorpromazine was given on the 26th. The recipient required his inhaler twice on the 20th and once on the 22nd. Tylenol was given on the 15th, 16th, 20th and 22nd.

The March MAR did not list Quetiapine, Lorazepam or Risperidone. Naproxen three times daily for 10 days was added on March 26th. With the exception of some medications that were added for a brief period of time to treat medical conditions, the rest of the MAR was the same as February's. Clonidine was given at bed time daily, Tylenol was given daily and the Naproxen was given three times daily as ordered. Oral Thorazine was given on the 11th.

The April MAR showed the oral Chlorpromazine (Thorazine) as being discontinued and only given once prior to discontinuing. Acetaminophen was given 21 times this month. Clonidine was given daily until the 12th and then was discontinued. Naproxen was given 3 times a day for 4 days until discontinued as ordered. A new order for "emergency enforced Risperidone 2 mg po am crush & obs [observe] mood stability and psychosis. If refuses PO give Olanzapine 10 mg IM" was listed and it appeared that Risperidone was given 8 times from the 9th to the 19th. The initials were illegible and there were no lines dividing them which made it hard to tell for sure how many times it was given. There was no indication that the Olanzapine IM was ever given. There was a one-time order for Lorazepam on the 14th for agitation. Risperidone twice daily was given starting on the 18th through the end of the month. There was no indication of Olanzapine being given due to refusal of Risperidone. Risperidone Consta was started on the 26th. On the 30th Olanzapine (oral) was given for severe agitation.

The May MAR listed injectible Olanzapine PRN as being discontinued; Risperidone was discontinued after the 4th and Acetaminophen was discontinued; Risperidone Consta IM was discontinued after the 24th and Risperidone oral was discontinued after the 5th. Valproic Acid twice daily, and court enforced was added on the 10th. Lorazepam was given on the 10th, 11th & 12th. Allergy medication and an ointment for a medical treatment were the only other additions to this month. Thorazine was not listed or given this month.

The June MAR listed the same medications as May's did with the addition of Lithium twice daily and "observe with mouth checks." Thorazine was not listed or given this month.

The July MAR included the same medications as June's with the addition of Ibuprofen PRN for pain. There was also a one time order for Thorazine (oral) for agitation on the 23rd.

Drugs.Com defines Chlorpromazine (Thorazine) as "an anti-psychotic medication in a group of drugs called phenothiazines. It works by changing the actions of chemicals in your brain. Chlorpromazine is used to treat psychotic disorders such as schizophrenia or manic-depression, and severe behavioral problems in children. It is also used to treat nausea and vomiting, anxiety before surgery, chronic hiccups, acute intermittent porphyria, and symptoms of tetanus. Chlorpromazine may also be used for purposes not listed in this medication guide"

The drugs interaction section on drugs.com lists a "moderate interaction" between **Thorazine and Clonidine** and states using them together "can lower your blood pressure. This can cause a slow heartbeat, **headaches, dizziness, or feeling like you might pass out**. If you take both medications together, tell your doctor if you have any of these symptoms. You may need a dose adjustment or need your blood pressure checked more often if you take both medications."

Another "moderate interaction" between **Thorazine and Quetiapine** is listed on drugs.com. It states "combining these medications can increase the risk of an irregular heart rhythm that may be serious. Your doctor may be able to prescribe alternatives that do not interact, or you may need a dose adjustment or special monitoring by your doctor to safely use both medications. You should seek immediate medical attention if you develop sudden **dizziness, lightheadedness, fainting, shortness of breath, or fast or pounding heartbeats** during treatment with these medications, whether together or alone."

Finally, a "moderate interaction" between **Clonidine and Risperidone** is listed on drugs.com. It states "Risperidone and Clonidine may have additive effects in lowering your blood pressure. You may experience **headache, dizziness, lightheadedness, fainting, and/or changes in pulse or heart rate.** These side effects are most likely to be seen at the beginning of treatment, following a dose increase, or when treatment is restarted after an interruption."

According to the MAR, on February 26th when the recipient fell and hit his head he was taking Clonidine and Quetiapine twice daily and the Risperidone had just been discontinued on February 20th. He had also been given the Thorazine injection two hours before his fall. These medications when used together warn of headache, dizziness and lightheadedness as listed in the above in the drugs interactions listed on drugs.com. In April when the recipient was found sitting on the floor and complained of feeling dizzy, he was taking Clonidine and Risperidone, according to the MAR and had been given an injection of Olanzapine that day as well. Drugs.com lists a "moderate interaction" between **Clonidine and Risperidone** as having "additive effects in lowering your blood pressure." It also states that "you may experience **headache, dizziness, lightheadedness, fainting, and/or changes in pulse or heart rate."** A "moderate interaction" between **Olanzapine and Clonidine** is listed and states "may have additive effects in **lowering your blood pressure. You may experience headache, dizziness, lightheadedness, fainting, and/or changes in pulse or heart rate**." Finally, a "moderate interaction" is listed between **Risperidone and Olanzapine** and also states when used together they "may increase side effects such as drowsiness, blurred vision, dry mouth, heat intolerance, **flushing, decreased sweating,** difficulty urinating, abdominal cramping, constipation, rapid heart beats, confusion, and memory problems." The doctor noted that the recipient felt "cold and clammy". The Olanzapine order was discontinued after this episode.

III...Facility Policies:

A. 02.06.02.020 Administration of Psychotropic Medication: states "In an emergency necessitating the immediate administration of psychotropic medication, the requirements of procedures (I)(A) need not be met when the prescribing physician has determined, by personal observation or information supplied by another clinician (physician, nurse or psychologist) with a thorough knowledge of the individual's current clinical condition that the individual is in need of medication to prevent the individual from causing serious and imminent physical harm to self or others." It further states "An individual's refusal to take psychotropic medication does not in itself constitute an emergency. An individual's refusal to take psychotropic medication, as documented in the clinical record shall be honored except in the following circumstances: In an emergency when treatment is necessary to prevent an individual from causing serious and imminent physical harm to self or others…Administration of Treatment on Court Order…If the individual has previously executed a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act or a power of attorney for health care under Article IV, 'Powers of Attorney for Health Care' of the Illinois Power of Attorney Act [755 ILCS 45/Art. IV] the subsequent treatment must take into consideration the provisions of that declaration or power of attorney."

Conclusion

The recipient alleged that he was given Thorazine over objection and passed out as a result. Upon review of the record, the Team found only one instance where a Thorazine injection was given and that was on February 26th due to "severe agitation, yelling, screaming and cursing." He had also been in an altercation with peers across the hall and in and out of their rooms. This meets the Code's requirement for medication over objection *in order to prevent the recipient from causing serious and imminent physical harm to the recipient or others*. On this same date, the Team reviewed a case note stating that at 10:30 a.m. the recipient was "resting quietly in room on bed with eyes closed 0 s/s of distress noted." It wasn't until 11:50 a.m. that there was a case note indicating the recipient had fallen and hit his head on the floor. However, it was also noted that the recipient did not lose consciousness. The only documented instance of the recipient having a reaction to a medication was on April 30th when he received injectible Olanzapine and reported feeling faint and dizzy but never actually passed out. (At this time, there was court ordered medication for the recipient). After the doctor assessed him, the medication order was discontinued. For these reasons, the allegation that the recipient was told he could not refuse a medication and passed out when emergency enforced medication was given over objection is **unsubstantiated.** The HRA would like to make the following suggestions:

1. A 2/25/13 therapist note that was reviewed noted that seclusion was eliminated as one of his treatment preferences due to his history of self harm. On 3/11/13 the recipient was placed in seclusion for threatening staff. The STA tried to redirect him unsuccessfully and he refused a PRN medication (which was his first choice for emergency intervention) so he was placed in seclusion as the "least restrictive option." The recipient's emergency protocol preference was followed; however, once the therapist had noted that seclusion was eliminated due to history of self harm, this should have been discussed in the treatment plan meetings and reassessed to clarify if seclusion was still an appropriate option or if it should indeed be eliminated and if so, the emergency protocol preferences should have been changed. All the TPRs reviewed indicated that the recipient's preferences remained the same. The therapist did make a note regarding the 3/11/13 seclusion which stated that "patient has not engaged in self harm since his admission to this facility. His history of self harm is when he is abusing substances in the community, according to him. Patient is monitored continually while in seclusion."

2. The HRA was concerned about the medication interactions in the recipient's regimen. It was clearly documented in case notes that the recipient frequently complained of headaches and there were at least two instances when he felt dizzy or faint, both of which are listed as interactions between several of the medications this recipient was taking. Although the HRA understands that interactions listed are not always going to occur with every patient, in this case, the frequent headaches and/or dizziness should have been reviewed more closely by the treating physicians to determine if medication interactions/side effects contributed to the recipient's headaches, dizziness and/or blood pressure changes.

Allegation 3: Staff denied a recipient food as a punishment:

I. Interviews

A. Recipient 1: The Recipient informed the Team that he was placed in seclusion for threatening behavior and staff took away his food tray because he asked them why he could not eat in the dining room with everyone else.

II. Clinical Chart Review:

A. Treatment Plan Reviews (TPRs): All TPRs reviewed by the Team are detailed under allegation 1 above. None of them mentioned that food was not given for any reason.

B. Progress Notes: On 2/17/13 a nursing note stated that the recipient was pacing, agitated and argumentative with staff in the dining room and was escorted back to his unit. He continued to be argumentative and demanded breakfast. The STA II talked with the recipient and reinforced module and dining room rules and explained that he would receive breakfast. PRN medication of Lorazepam 2 mg and Chlorpromazine 50 mg were offered and accepted at that time. Another note an hour later stated that the recipient consumed 100% of breakfast and has been cooperative since eating.

A 2/21/13 nursing note stated the recipient was "loud and disruptive" in the dining room and was escorted back to the unit by security staff. He continued to be loud, yelling and cursing. A PRN of Chlorpromazine was offered and accepted. An hour later another nursing note indicated that he had one more "outburst of yelling and cursing" but had gone to lie down and stated that the PRN was "marginally effective." There's no mention in this case note if he ate prior to being escorted from the dining hall or not and it does not mention a food tray being delivered to him.

On 3/13/13 a STA case note stated that the recipient "refused to take his breakfast tray, was asked several times, continued to refuse. Became very loud and disruptive, was asked to take PRN, he refused asked to go to room and calm down (pt demanding to go to dining room)." There were no other case notes indicating if his breakfast tray was ever offered to him in his room, if he returned to the dining room or if he ate breakfast that day.

On 6/23/13 at 9:00 a.m. a nursing note stated that "pt refusing to eat breakfast, states 'I'm not eating until I see the dietician' explained to pt that his wt is stable and he is on higher end of IBW, pt refuse to listen and became argumentative." A nursing note at 1:00 p.m. this same date stated "pt refused lunch x 3." A nurse's note at 6:10 p.m. stated "refused supper x 3." Then at 8:30 p.m. a nurse's note indicated that the recipient consumed" at HS [night] snack and 8:02 prune juice. Pt states 'I'm not eating until I get enough." A 6/24/13 therapist note stated "On this date, this writer was informed that patient has been refusing to eat since 6/23/13 at breakfast. He is stating that he is on a hunger strike because he doesn't get adequate amounts of food." A 6/24/13 nursing note again stated that the recipient refused breakfast and lunch and wanted to talk with a dietician. The dietician did meet with him and said that he was demanding extra portions but that "pt is within IBW, Albumin WNL, lipids good, pt is not candidate for increased calorie diet, pt states to dietician when you decide to give me double portions then I'll decide to eat."

III...Facility Policies:

A. Patient Handbook: The Chester patient handbook states that the dietary department provides 3 meals a day and a night time snack. It also contains a section on restriction of rights which states "According to the Mental Health and Developmental Disabilities Code, your privileges or rights may be restricted in order to protect you and others from harm, harassment or intimidation. You and your guardian (if you have one) will be notified of your restriction of rights."

B. RI.01.01.02.01 Patient Rights: This policy lists the right to "adequate and humane care and services in the least restrictive environment..." This policy further states that "Individuals shall have the right not to be restrained or secluded except as specified in Sections 2-108 and 2-109 of the Mental Health and Developmental Disabilities Code…Individuals shall not be subject to treatment by unusual, hazardous, or experimental therapies without the individual's informed consent. Such treatment shall follow applicable federal or State statutes or regulations…If any of the patient=s rights as described in Section I. of this procedure are restricted then a Restriction of Rights of Individuals form (IL462-2004M) will be initiated. This includes when a patient is restrained, secluded and/or subject to a physical hold."

Commissary is an additional privilege that recipients at Chester have which allows them to purchase additional snacks if they have funds available. Chester Policy RI.01.01.02.02 Commissary Restrictions states that "if a patient's treatment team decides that a restriction of the patient's ability to order commissary items is appropriate, the commissary will honor that request if: A) The commissary receives the notification in writing on completed form CMHC-161 and B) The form has been approved (signed) by the Unit Director."

Conclusion

The Team reviewed two case notes that stated that the recipient was escorted from the dining room for agitation and loud and disruptive behavior. The 2/17/13 note stated that the STA told him he *would receive breakfast* but there was no further note indicating if a food tray was ever offered to him. The 2/21/13 case note stated after being escorted from the dining room, a PRN of Chlorpromazine was offered and accepted. An hour later another nursing note indicated that he had one more "outburst of yelling and cursing" but had gone to lie down and stated that the PRN was "marginally effective." There was no mention in this case note if he ate prior to being escorted from the dining hall or not and it does not mention a food tray being delivered to him. Due to the lack of documentation indicating whether or not the recipient was ever offered food trays on these two instances, the HRA **substantiates** a rights violation and **recommends** the following:

1. When a recipient is displaying maladaptive behaviors that impact food consumption and require staff to escort him from the dining room, the STA should clearly document in the case notes when a food tray is provided to the recipient or if he ate prior to being escorted. If the recipient refuses food trays that should be clearly documented as well.

2. Staff should be retrained on restriction of rights policies and how to properly document in recipients' charts.