FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
13-110-9031
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 allegations are as follows:

1. Inhumane treatment of a recipient.
2. A recipient suffered retaliation for filing an Office of the Inspector General (OIG) complaint.
3. Inadequate internal OIG complaint investigation.
4. Staff violations of Code of Conduct.

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code, the Illinois Administrative Code, facility policies and the facility's Code of Conduct.

Complaint Statement

According to the complaint, since a recipient filed an OIG complaint, a security therapy aide (STA) had treated a recipient differently and had used verbal threats to intimidate him. It was also alleged that the OIG complaint which was filed regarding staff using profanity, intimidation and physical harm to patients when they are in restraints was referred to the OIG but no one ever spoke to the complainant about the allegations. Another allegation was that staff members were sleeping, smoking, texting and smelled of alcohol while on shift and that staff "cover" for each other during OIG investigations.

Investigation Information

To investigate the allegation, 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. With written authorization, copies of information from the recipient's clinical chart were reviewed. Facility Policies relevant to the complaints were also reviewed.

I. Interviews:

A. Recipient: The Recipient informed the Team that he filed an OIG report in March regarding negative staff interactions with other patients. After the OIG report was filed, a STA on the unit "treated him differently." About a month later, the recipient was feeling agitated and requested to be placed in seclusion to calm down. When he came out of seclusion, this STA said "I could take you…I will [explicit] you up…I could break your face." He filed an OIG report on this incident when it happened and he provided the HRA with the date it was filed. The internal OIG investigator for the facility interviewed him and told the STA that he was being investigated but the recipient did not hear the investigator tell the other STA who filed the complaint against him. The recipient never heard what the outcome of the investigation was. He also said that another recipient had moved to this recipient's unit and complained of having a similar experience (where staff members were trying to use verbal threats to intimidate him). He provided another STA's name to the HRA but he did not know the other recipient's name. He said when incidents occur, peers are told to go to their room. He feels like this is done so there is no one to witness what happens, just the staff members and the recipient involved.

This recipient said he also filed a human rights committee complaint in April because he was denied lunch as a punishment. He said he "had words" with another recipient in the lunch line. He was taken back to his room and didn't get to eat but the other peer did. He said a memo regarding this complaint came back to him saying "complaint not supported."

The recipient also gave the HRA a number of another human rights committee complaint that was filed regarding staff members using profanity, intimidation and physical harm to patients while they are in restraints and also that staff come to work smelling of alcohol. It was also alleged that while on shift, staff members smoke in the rest rooms, text on their cell phones and sleep. He said it was referred to the OIG but no one has ever interviewed him regarding this case and that he was never notified of the outcome of the investigation. The HRA was able to review the OIG report regarding these allegations in order to confirm that the investigation had concluded. According to the Illinois Administrative Code (59 IL ADC 50.60), the OIG is to notify the complainant, the individual or his legal guardian, and the person alleged to have committed the offense of the outcome of the investigation once it is concluded. The OIG liaison at Chester told the HRA that the OIG sends notice to the administrator and from there the patient gets a copy of the letter. The HRA found no documentation in the chart indicating that notice was ever sent from the administrator to the recipient. The administrator informed the HRA that the OIG notifies the recipients directly. The HRA checked with the OIG and was told that they do notify recipients at Chester directly when an investigation in which they are involved is concluded. The OIG looked up these 4 OIG reports and provided the HRA with copies of the letters notifying the recipient of the outcomes. However, the address they had for him on 3 of these letters was the county jail that he came from and those were returned to the OIG. There was one letter sent to the recipient at Chester that he should have received. The HRA forwarded the other letters to the recipient at the OIG's request.

Another incident he described involved a STA from another unit whose ribs were broken while on duty. Staff at Chester allegedly called this STA at home to ask him how they should

respond to the investigation or what they can do to help him and he said "just don't look at the tape." He said staff "cover for each other" like this frequently and "get their stories straight" so they all say the same thing when OIG investigates.

B. Chairman: The HRA met with the Chairman of the Human Rights Committee at Chester to inquire about how complaints that are received are handled. The Chairman reported that the process begins with him receiving the complaint. The complaint is assigned a number. If there is an allegation of abuse or neglect, the complaint is reported to OIG through the STA IV who acts as the liaison at Chester for OIG. If abuse or neglect is not alleged, after a number is assigned, an opening letter is sent to the complainant. The formal complaint is typed and assigned to a committee member for review. The complainant is sent a findings letter stating the outcome of the review. This letter also includes the address and phone number of the Guardianship and Advocacy Commission, Egyptian Regional Office for appeal. The Chairman provided the HRA a sample opening letter, complaint form and a findings letter to review.

II. Clinical Chart Review:

A. Human Rights Committee Complaints: The first complaint form was completed in March and received by Quality Improvement and Assessment (QA & I) and notice was sent to the recipient 3 days later. This complaint alleges that he was denied lunch and commissary as punishment and that he was not allowed to go to the courtyard and had his level dropped. (Chester operates on a 3 level system, green for good behavior, yellow for a minor infraction and red for a more significant infraction. The level status impacts a recipient's facility access and privileges. Red level also prohibits transfer from the facility until the recipient can maintain green level for a set amount of time.) The findings in this complaint states the recipient was "brought back from the dining room because of disruptive behavior, arguing with staff, excessive noise, horseplay and not following staff directions while in the lunch line in the patient dining room." A Behavioral Data Report (BDR) was completed. There was no documentation stating whether or not he received a tray. The recipient said he did not, however a STA I said he was offered a tray but was so upset that he stated he did not want one. An hour later, the recipient was denied going to the courtyard because of his previous actions. It is also noted that his level was not lowered, but the STA II decided he could not go based upon his previous actions which, according to the narrative, is a decision the STA II makes. The letter to the recipient states "in reviewing your complaint [number] the HREC has considered the information. 1) Your complaint could not be supported by the available facts. With this information the HREC has determined this complaint resolved." The letter listed contact information for the Guardianship and Advocacy Commission (GAC).

The second complaint reviewed alleged that "unit staff members use profanity, intimidation, physical harm while patients are in restraint and employees have alcohol on their breath." Since this complaint alleged mental and physical abuse, it was "forwarded to the Office of the Inspector General via CMHC (Chester Mental Health Center) reporting policy." The letter to the recipient stated "your complaint of mental and physical abuse is beyond the scope of this committee and has been forwarded to the Office of Inspector General." This letter also listed contact information for the GAC.

B. OIG reports: The OIG report involving physical and mental abuse filed in March was reviewed. The allegation is listed as "STAs [2 STA names] physically abused individual [recipient name] and others by 'roughing individuals during the restraint process, even after they are strapped down.' In addition [2 STA names] mentally abused [recipient name] by calling him demeaning names such as [explicits] and threatened to beat his ass." The synopsis noted that restraint records were reviewed for this recipient during this timeframe but could not find one incident of restraints being used. It also noted that the two STAs named mainly work on a different unit than this recipient lives. The facility investigator interviewed 11 individuals who live on the unit where these STAs work and out of 11, only 1 other recipient made a negative statement about staff members. The facility investigator also interviewed 4 different staff members that work with these two STAs and they all denied hearing or seeing any abuse by the two accused. During a follow up interview, this recipient denied being physically abused and said that he had only heard others receiving the bad language but he did not remember names. The OIG re-interviewed the two staff members that the facility investigator spoke to and they reiterated their original statements that they had never heard or witnessed any abusive behavior. However, the **Clinical Nurse Manager stated that foul language was common between both staff and individuals but she said the foul language's intent was never to be demeaning, demoralizing or disrespectful to either individuals or staff members and admitted it was common language between the STAs and patients.** The OIG found no credible evidence to support the allegations but did recommend that the facility review and take appropriate actions towards staff members for using unprofessional language that seemed to be everyday common language.

Another OIG report was reviewed that involved this recipient. This report alleged that in April a STA told the recipient that he was going to "break your face, break you in half" and told the recipient to come out onto the stem (where there are no cameras) and the STA would "knock your teeth out." This allegedly occurred when the recipient was coming out of voluntary seclusion 2 days earlier. The recipient was interviewed twice and gave the same account both times that he tapped this STA on the shoulder and they had no problems at all, but then "out of the blue" this STA made the threatening statements to the recipient. The recipient also gave the name of another STA who witnessed the incident and stated that the RN "knows about all the abuse that goes on here." The OIG interviewed the STA and RN who both denied seeing or hearing threats by this STA accused. In a follow up interview the STA named as a witness stated that the recipient was being a "smart ass" and that several staff members reminded him that he needed to be calm and compliant. The video recording that the OIG reviewed showed the recipient tapping the STA accused on the upper arm and that "all seemed fine and calm." The recipient spent 16 minutes one on one speaking with the STA named as a witness. It was noted that the progress notes only documented that the recipient had been upset about the program choice on the TV and decided to go into seclusion. There were no other facility records to review. Since the witnesses identified did not corroborate the statements of the recipient but all of the staff statements did corroborate, the OIG found the allegation of mental abuse unfounded.

A third OIG report was reviewed involving another allegation of mental abuse by this same STA that allegedly occurred in April, 13 days after the previous allegation. However, it was not reported to the OIG until early May and this delay "denied the investigator the ability to collect timely evidence to support or contradict the allegations." The recipient told the facility

investigator that the STA and he had exchanged a greeting of "what's up" and the STA said "do you want to do something about it" trying to provoke a fight. The STA could not remember exchanging any words with the recipient and re-stated this to the OIG during a follow up interview. Statements were obtained from other STAs and were consistent and corroborated the accused STA's statement, however the OIG report did not list specific names of which other STA's were questioned. Since there were no witnesses or evidence to support the allegations made, it was determined to be unfounded.

The HRA reviewed a report from May that alleged that a different STA was observed sleeping on the job and that another STA was alerted and allegedly replied "you never know what he's been going through." The recipient told the facility investigator that he witnessed a STA sleeping on the job and told another STA about it and said that "she didn't care." **This STA was interviewed and denied that anyone told her that another STA was sleeping,** however if someone had reported it to her, she would have in turn reported that to the STA II. She also told the OIG that she believed that the recipient was trying to get the STA accused in trouble for writing him up a few days earlier. **There were several individuals that provided statements indicating that the STA accused was sleeping.** The STA accused denied sleeping while on duty and could not remember if he had written the recipient up a few days earlier. When asked about the witnesses, he replied "[recipient] had ways of getting others to comply." The OIG asked if it was possible that he fell asleep and the STA responded that "anything is possible." During an OIG follow up interview, the STA named as the one the recipient told about the other STA sleeping again denied being told that.

The OIG reviewed a facility video recording which was "inconclusive since the camera angle did not show STA [name] clearly." However, **the report stated that the recording did show the STA sitting in a chair watching TV for a long period of time and said "he was viewed, from the day room camera, sitting in a chair with his head nodding. His hands, arms and legs appeared still; however his head was viewed as flinching."** Since the camera did not show the front of his face, the report stated "there was no way to determine if STA [name's] eyes were closed, however his face was viewed looking straight up to the ceiling." The report also stated that **the video clearly showed the recipient pointing in the direction where the STA was located, and charading what "appears to be someone sleeping" and the STA he was talking to "failed to respond and did nothing but sat at a table."** The OIG report concluded by saying **although there were witnesses who provided information that this STA was sleeping on duty, there were no incidents or harm caused during that time period therefore, the incident did not meet all the elements of neglect and the allegation was found "unsubstantiated."** The OIG did recommend that Chester addresses the actions of the STA accused as he "clearly was sitting in an arm chair watching television for a long period of time instead of conducting programs with individuals." The OIG also recommended that Chester "address STA [name's] failure to report the alleged sleeping of an employee in a timely manner which violates 20 ILCS 1305/1-17 (a) willful failure to comply with OIG's reporting requirements and is a class A misdemeanor."

> *The HRA reviewed the OIG handbook that is posted on the OIG website to determine what constitutes neglect. The handbook lists neglect as "An employee's, agency's, or facility's failure to provide adequate medical care,*

personal care, or maintenance, and that, as a consequence: causes an individual pain, injury or emotional distress; results in either an individual's maladaptive behavior or the deterioration of an individual's physical condition or mental condition; ***or places an individual's health or safety at substantial risk of <u>possible injury</u>, harm or death.*** *(Neglect that causes presumable mental injury is reportable to OIG.* ***Neglect allegations do not require an identified harm to be reportable****.)*

<u>C. Treatment Plan Reviews (TPRs):</u> TPRs for January, March and May were reviewed by the HRA. The <u>January TPR</u> was his initial one upon admission. He was admitted to Chester from Court as Unfit to Stand Trial (UST) and was remanded to DHS for treatment to attain fitness. The recipient denied being UST and said he had not done anything to be found unfit. It was explained to him the factors that were considered by the court to find him UST including refusal to cooperate with the forensic examiner and his public defender and refusing psychotropic medications. The treatment team determined he was unfit to stand trial but with treatment is likely to achieve fitness within one year.

The <u>March TPR</u> stated in the <u>discussion section</u> that the recipient attended his meeting but was very quiet and guarded. He was not prescribed any medication at that time and had not had any behavioral issues or incidents and did not appear motivated to attain fitness. It was noted that he presented as paranoid and suspicious and was "notably depressed." His diagnosis is listed as Axis I Adjustment Disorder with Mixed Disturbance of Emotions and Conduct, H/O (history of) Depressive Disorder NOS (not otherwise specified), Psychotic Disorder NOS, Polysubstance Abuse in a controlled environment; Axis II no diagnosis; Axis III No Diagnosis; Axis IV UST status; confinement Axis V GAF (global assessment of functioning) 50. <u>The justification section</u> noted that he had been reported to have appeared depressed and paranoid in jail but had not displayed that at Chester. He mainly verbalized his displeasure, unhappiness and frustration about his legal situation which he believed should have already been resolved and wondered "what's going on." No gross delusional thinking has been noted nor any signs of psychosis. He had been uncooperative with his public defender and exhibited disruptive behavior in court. "The possibility of his mainly having an adjustment reaction to his current legal situation is being considered." The recipient was described as uncooperative and argumentative denying his UST status and mental illness. The TPR report mentions that he had been enrolled in fitness class but had not attended. His therapist noted that he was receiving 1:1 UST instruction. The therapist also noted there had been no symptoms of acute psychosis, mania or depression reported or observed. There were no specific behavioral incidents noted, but the RN (registered nurse) stated that the recipient refused to answer to his last name and refers to himself as another last name and also requires "much redirection to follow module rules". The AT (activity therapist) listed the activities the recipient enjoys and stated he had attended 27 off unit programs and was "making good progress toward his goals." It was also noted that he was not taking any psychotropic medication at the time of the TPR and the treatment team still believed he was unfit to stand trial but with treatment would likely achieve fitness within one year.

The <u>May TPR</u> report stated verbatim what the March TPR discussion and justification sections had stated. The notes from the AT and therapist were also verbatim of what was reported in the March TPR. A new RN commented on this TPR report and stated verbatim what the first RN

had said but added "patient had several instances of hostile and threatening behavior during this period." The TPR report did not elaborate on what the behaviors were. The response to medication section of this TPR had additional information than the March TPR had listed which stated he had made no significant progress and was unwilling to discuss his charges rationally. It also stated in this month's meeting he was "not very cooperative…reluctant to answer questions and avoided purposefully in order to remain here. He was unrealistic and wants to charge the current judge on his case…some of his behavior is intentional and purposeful in order to delay court matters." The treatment team noted that he was still unfit to stand trial at that time, but was likely to achieve fitness within one year.

D...Progress Notes: Progress notes from January through June were reviewed. There was an incident in February where the recipient became rude, unruly and uncooperative with 2 staff members but was able to be redirected. In March there was a nursing note saying he was uncooperative, refusing redirection and refusing to follow module rules. The recipient agreed to go to the quiet room to gain control of his behavior. The psychiatrist, RN and STA IV were all notified. After 40 minutes he was able to return to the living unit. There was a STA note regarding the incident in the dining room "due to arguing and threatening a peer over commissary money. Upon returning to unit, recipient continued to threaten to attack peer and was inquiring what would happen if he [illegible] on him." The next case note was 14 days later regarding medical treatment he received unrelated to this incident.

Another STA's note in April stated that the recipient was walking across the stem and told staff to "watch your back." Recipient said this to staff twice as he walked by. (This STA was the same one accused of making verbal threats to the recipient) There was a late entry in case notes by another STA I that stated the day prior the recipient "was returning from the dining room and began making direct verbal threats towards staff as he walked through the stem. The recipient was asked to stop and go into the module to his room, but he continued to threaten and began laughing as he walked into the module."

The same day in April a third STA entered a case note stating there was a hospital shake down after medication pass. The recipient "began yelling expletives about the staff because this cut into his phone time. Recipient [name] was asked several times to quiet down…he remained yelling at his door then began walking around the module while staff shook down rooms. Recipient [name] disrupts other patients often and verbally threatens staff under his breath." (This was the same STA listed in the OIG report as a witness to the other STA's verbal threats who referred to this recipient as being a "smart ass".) This same STA had a case note in early May which said this recipient "woke up and began bitching at another rec. (recipient) as staff was having a conversation with this rec. the other patient was not talking about him, but rec [name] told him to 'shut up'. He 'was a bitch and better quiet down' [recipient name] was asked to leave him alone and to go back to bed and treat people right. [recipient name] grumbled under his breath some verbally assaultive comments towards staff as he likes to do to disrupt the module and undermine rules." Five days later this same STA had another note which stated this recipient "wanted to take late shower, the shower time from 0700-0800 he wasted time and did nothing but get his personal comm. (commissary) items out of closet, when he wanted a shower, housekeeping was cleaning. Then he would not put up his personal items in closet. Staff took his personal items (shampoo and body wash) gave them to [staff name] she will hold them til the

appropriate time. [recipient name] said 'my shit would be taken care of' and 'if you were on the street I'd beat you' [recipient name] was offered a PRN and he disrupts the module and other patients with his narcissistic behavior and pushes staff."

Another STA I case note in early May stated the recipient "was returning from the dining room and when he walked by staff on the stem he made the statement 'I got you bitch' and laughed as he walked by. Recipient's comment was ignored because he tries to get staff to react to his actions, and then he turns around and blames staff for intimidating or threatening him. Rec. is extremely manipulative towards staff and is successful in manipulating recipients in making false claims against staff. Recipient is responsible for [illegible] a hostile and unsafe work environment."

E. Nursing Assessment Summary: The HRA reviewed summaries from January- May. The initial week long review in January stated that the recipient had no seclusion or restraints, was cooperative, followed module rules and noted his request to be called by a different name. The February summary stated that the recipient had "a couple episodes where he was uncooperative with staff. Staff (members) have noted fluctuating mood swings." There were no restraints or seclusions used and no medication was given or ordered. The March summary did note that the recipient refused to follow module rules and was placed in "quiet room for 40 minutes." This summary also mentioned the incident in which the recipient was returned from the dining room after a verbal altercation with a peer however, there was no use of seclusion, restraints, special observation or medication required. The April summary stated that the "quiet room was utilized for 80 minutes" after the recipient became angry with peers over TV programming. No use of seclusion, restraints, special observation or medication occurred. The May summary stated that the recipient "had several instances of hostile and threatening behavior…patient refuses redirection and is very uncooperative at times." However, no use of seclusion, restraints, special observation or medication had to be used.

<u>III...Facility Policies:</u>

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

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

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

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

<u>C. Chester Policy EC 04.01.02.03 Use of Recreation Yard</u> states "…when unit staff believes a patient should be kept from the yard for a given day based upon patient behavior, the STA II will enter a progress note in the clinical file documenting the reasons that the patient was not allowed to attend yard. The STA II will review this action with the unit director or unit manager (or in their absence an available therapist) within the same shift for further treatment team review."

<u>D. Chester Policy EC 04.04.00.02 Reporting and Investigating Incidents and/or allegations</u> states "The Chester Mental Health Center has established procedures to **ensure that all allegations of abuse and neglect of patients and certain other incidents are reported and investigated** in accordance with Department of Human Services Act [20 ILCS 1305], Department of Human Services Policy and Procedure **<u>02.01.06.010</u>** Prevention of Abuse and/or Neglect of Individuals; **<u>02.01.06.020</u>** Reporting and Investigating Incidents and Allegations of Abuse and Neglect… Incidents are identified as, but are not limited to, the following occurrences and/or allegations of Mistreatment of service patient by employees including Physical Abuse…Sexual Abuse…Sexual Contact…Financial Exploitation…Mental Abuse: The use of demeaning intimidating or threatening words, signs, gestures or other actions by an employee about an individual and in the presence of an individual or individuals that results in emotional distress or maladaptive behavior, or could have resulted in emotional distress or maladaptive behavior, for any individual present. Neglect... All other allegations or indications of possible corruption, misconduct, conflicts of interest, malfeasance, misfeasance, threats to employees, illegal narcotics on facility grounds, fraud, and theft of employee or state property, or any other

occurrence which, in the opinion of the Facility Director or his/her designee, is serious enough to warrant reporting."

Under the Conducting the investigation section of this policy it states "The Facility Director or designee will ensure that evidence is preserved and the safety of patient, employees, and property is maintained. This includes: ordering immediate medical examination on all patient alleged to be victims of physical or sexual abuse, impounding records and other appropriate documentation, securing all relevant physical evidence such as clothing, and preserving and photographing the scene of the incident and the patient's injury when appropriate."

Under the Investigation by facility section of this policy it states "Integrity: Investigations conducted by the facility must be completed in a timely manner, and steps are to be taken to maintain their integrity. The Facility Director must ensure that at least one person is thoroughly trained to conduct facility investigations and that there is no cause to question his/her objectivity."

The Other requirements section states "Liaison: The Facility Director will designate a liaison for communications with appropriate reporting and investigating entities. The STA IV-OIG Liaison will perform this function in the Chester Mental Health Center. In his absence, another STA IV may assume this role in addition to other designee responsibilities referenced in this directive…Administrative Action: When an investigation indicates, based on credible evidence, that an employee is the perpetrator of abuse, the Facility Director will take necessary action to ensure the employee is immediately barred from any further contact with patient, pending the outcome of any further investigation, prosecution or disciplinary action against that employee. In addition, the Facility Director or designee is responsible for promptly notifying OIG of the employee(s) placed on administrative reassignment or administrative leave pending an investigation."

E. Chester Policy EC .04.09.00.08 Code of Conduct states "at Chester Mental Health Center (CMHC) we strive to promote the welfare of those with whom we have contact and to prevent mental or physical harm. All patients, employees and visitors shall be treated with dignity, respect and courtesy…Chester Mental Health Center has zero tolerance for workplace violence and intimidating and disruptive behaviors. In accordance with AD .01.02.03.040 Rules of Employee Conduct and AD .01.02.03.170 Reporting Misconduct." Under the section entitled unacceptable employee conduct it lists some **"zero tolerance" behaviors** as "Harassment (verbal or physical conduct that denigrates or shows hostility or aversion toward an individual) - this includes: epithets, slurs, teasing, ridicule, making someone the brunt of pranks or practical jokes, negative stereotyping, threatening, intimidating, bullying, or hostile acts, racial jokes, stalking, malicious or mischievous gossip, written or graphic material showing hostility or aversion toward a group or individual. **Improper Language** - this includes vulgar, profane or loud/disruptive language. Threats- this includes direct, indirect and/or conditional threats of bodily harm… Physical aggression- this includes aggression toward patients, visitors, other staff and property. **Being under the influence** of illicit drugs or impaired by alcohol… Excluding or isolating individuals. Undermining performance, reputation or professionalism of others by deliberately **withholding information, resources or authorization or supplying incorrect information…**" This policy continues to say that all DHS employees are required to expose

without fear or favor, illegal or unethical conduct of others and states that "All DHS employees who are victims of, witnesses of, or who become aware of any incident/behavior that undermines a culture of safety and the facility Code of Conduct policy, **must report it immediately to his/ her immediate supervisor and write an incident report** - CMHC-207 - concerning the incident." According to this policy, the supervisor is required to report any incidents to the hospital administrator and retain a copy in the employee's supervisory file and will respond by "taking necessary steps" to prevent further breaches in the Code of Conduct. The administrator is required by this policy to "ensure that all reported incidents of Code of conduct violation are taken serious and addressed…ensure that disciplinary action is taken for any employee who intentionally violates his or her responsibility to report misconduct; intentionally makes a false report alleging misconduct; fails to cooperate with DHS OIG…"

F. DHS Policy 01.02.03.040 Rules of Employee Conduct states "Any employee who fails to comply with these rules will be subject to discipline up to and including discharge." The listed rules include not participating in or condoning fraud, dishonesty or misrepresentation in the performance of duties; providing full cooperation with OIG or any official investigative entity; not using vulgar, profane or loud/disruptive language in the workplace; an employee's conduct while off-duty may subject the employee to discipline up to and including discharge; an employee shall not make direct or indirect threat of bodily harm to another employee, client, recipient, student or any other person covered by the services of the department; an employee shall not demonstrate inappropriate behavior and/or discourteous treatment of the public, co-workers, clients and/or applicants. This policy also states that **any violation of these provisions should be immediately reported** by the observing employee to his/her immediate supervisor.

G. DHS Policy 01.02.03.170 Reporting Misconduct states "Every employee of the DHS is charged with reporting promptly any incident of alleged employee or independent contractor misconduct upon becoming aware of the incident…DHS employees are prohibited from interfering with or obstructing any investigative process." Some other examples of misconduct listed in this policy are bribery, waste, fraud, abuse, misfeasance, malfeasance and neglect. The proper procedure for reporting misconduct is also laid out in this policy including other program directives that can be referenced.

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…" Adequate and humane care and services is defined as "services reasonably calculated to **result in a significant improvement of the condition of a recipient of services** confined in an inpatient mental health facility so that he or she may be released or services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others" (405 ILCS 5/1-101.2).

The Code (405 ILCS 5/2-112) states "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect." Section 5/1-101.1 defines abuse as "any physical injury, sexual abuse, or **mental injury inflicted** on a recipient of

services other than by accidental means." Section 5/1-117.1 defines neglect as "…the failure to provide adequate medical or personal care or maintenance to a recipient of services, which failure results in physical or mental injury to a recipient or in the deterioration of a recipient's physical or mental condition."

The Administrative Code (59 IL ADC 50.10) defines neglect as "An employee's, agency's or facility's failure to provide adequate medical care, personal care or maintenance, and that, as a consequence, causes an individual pain, injury or emotional distress, results in either an individual's maladaptive behavior or the deterioration of an individual's physical condition or mental condition, or places an individual's health or safety at substantial risk of **possible** injury, harm or death."

The Administrative Code (59 IL ADC 50.20) states "If an employee witnesses, is told of, or suspects an incident of physical abuse, sexual abuse, mental abuse, financial exploitation, neglect or a death has occurred, the employee, community agency or facility shall report the allegation to the OIG hotline according to the community agency's or facility's procedures. The employee, community agency or facility shall report the allegation immediately, but no later than the time frames specified in subsections (a)(2) and (3) of this Section... 2) Within four hours after the initial discovery of an incident of alleged physical abuse, sexual abuse, mental abuse, financial exploitation or neglect, the required reporter shall report the following allegations by phone to the OIG hotline: A) Any allegation of physical, sexual or mental abuse by an employee; B) Any allegation of neglect by an employee, community agency or facility; C) Any allegation of financial exploitation by an employee, community agency or facility; and D) Any injury or death of an individual that occurs within a facility or community agency program when abuse or neglect may be suspected… 5) Retaliation. It is a violation of Sections 1-17(k)(3) of the Act for any employee or administrator of an agency or facility to take retaliatory action against an employee who acts in good faith in conformance with his or her duties as a required reporter… d) Training and technical assistance/Other requirements 1) Agencies and facilities shall have a policy detailing procedures for reporting allegations of abuse, neglect, financial exploitation and deaths as set forth in Sections 50.10 and 50.20. 2) All employees, as defined in Section 50.10, shall be trained in Part 50 requirements upon being hired and at least biennially thereafter. 3) Any person, community agency, or facility may request training or technical assistance from OIG in identifying, reporting, investigating and preventing abuse, neglect, financial exploitation, reporting of deaths, or participation in applicable OIG-sponsored training as referenced in Section 1-17(h) of the Act."

The Administrative Code (59 IL ADC 50.40) states "…OIG shall notify the authorized representative, the alleged victim or guardian (if applicable) and the accused in writing when an investigation will be opened and to whom the primary responsibility for the investigation will be assigned."

Section 50.50 of the Administrative Code states " Depending on the nature of the allegation, an investigation shall consist of, but not be limited to, the following procedures whether done by OIG, the community agency or the facility: 1) Ensure that the victim is not in imminent danger; 2) Protect the integrity of the investigation at all times; 3) Secure the scene of the incident; 4) Identify and separate witnesses; 5) Preserve and secure all evidence; 6) Obtain statements from

persons involved including victims, alleged perpetrators, and witnesses by face-to-face interviews, in writing, or by telephone; and 7) Obtain copies of pertinent documents relating to the investigation, i.e., progress notes, incident or injury reports, patient or resident records, photographs, etc…b) Confidentiality. Any allegations or investigations of reports of abuse, neglect and financial exploitation shall remain confidential until a final report is completed (Section 1-17(m) of the Act). The identity of any person as a complainant shall remain confidential in accordance with the Freedom of Information Act [5 ILCS 140] or unless identification is authorized by the complainant… All investigations shall be conducted in a manner that respects the dignity and human rights of all persons involved."

Section 50.60 states "… After determining the finding in all cases, the Inspector General shall notify the complainant, the individual who was allegedly abused, neglected or financially exploited or his or her legal guardian (if applicable), and the person alleged to have committed the offense. The notice shall identify the outcome of the investigation and include a statement of the right to request clarification or reconsideration of the finding. In substantiated cases, the Inspector General shall provide the perpetrator with a redacted copy of the investigative report…"

Conclusion

Allegation 1: Inhumane treatment of a recipient. The complaint alleged that staff use threats, profanity and intimidation when interacting with recipients. Since other recipients from this same unit declined to speak with the HRA, the allegations of staff making threats and using intimidation when interacting with recipients cannot be substantiated. However, a nurse indicated that "foul language" was common between both staff and individuals but said the foul language's intent was never to be demeaning, demoralizing or disrespectful to either individuals or staff members. There was also staff documentation referring to a recipient as "smart ass" and that another was "bitching". Regardless of intent, this language likely carries on to dialogue with recipients, is counter therapeutic and has no place at Chester according to commons standards and Chester policy. According to Chester policy EC .04.09.00.08, improper language defined as including "vulgar, profane or loud/disruptive language" is a zero tolerance behavior subject to disciplinary action. DHS policy 01.02.03.040 also lists improper language as employee misconduct. The HRA contends that foul and pejorative language can prevent an improvement in one's clinical condition, not to mention constitute mental injury. Therefore the HRA **substantiates** this portion of the allegation and makes the following
recommendation:

1. **Chester staff should be retrained on Employee Code of Conduct and Code of Ethics policies as well as the DHS Code of Conduct and Reporting Misconduct policies. Chester administration should notify the HRA once training has been completed.**

Allegation 2: A recipient suffered retaliation for filing an Office of Inspector General (OIG) complaint. The complaint alleged that a recipient had been isolated from peers by being sent to his room, being denied lunch and "yard" time as retaliation for filing OIG complaints. Upon review of the chart and the Human Rights Committee investigative report, it was discovered that

the recipient had caused a disruption in the lunch line. The recipient admitted he "had words" with another peer. The recipient said he did not receive a lunch tray; however the STA said he was offered one but refused it. The progress notes do not mention if a food tray was or was not offered to the recipient.

The progress notes did state that the recipient continued to make verbal threats against this peer even after being returned to his living unit. There was nothing in the case progress notes indicating that the recipient was restricted from "yard" activities that day and no restriction of rights forms were found in the file indicating it was restricted. However, the recipient stated that he was restricted from attending "yard" activities that day. According to Chester policy, the STA II on duty has the authority to restrict a recipient from activities if it is deemed necessary due to behavioral issues or for the safety of others. Therefore, the STA was within his authority to keep the recipient from participating in "yard" activities if he was indeed restricted from activities. The HRA was given no other staff names to interview who might have observed the incident and the events that occurred once he returned to the living unit. Since there was no documentation in the case notes indicating whether or not a lunch tray was offered and/or refused, the HRA could not make a determination if food was denied or not or if "yard" activities were restricted. Therefore, this allegation is **unsubstantiated**. The HRA makes the following suggestions:

1. When a recipient refuses food, it should be documented in the case progress notes not only to give an account of events that may have occurred, but also for health and medical reasons.

2. If a recipient is restricted from activities or other privileges, Chester staff should complete a restriction of rights form and enter a case note indicating the same.

<u>Allegation 3: Inadequate internal OIG complaint investigation.</u> It was alleged that a complaint was not followed up on and that staff "cover" for each other during investigations. The HRA could not interview staff members who allegedly covered for other employees because the complainant did not know their names. The HRA attempted to interview other recipients on this same unit, but they declined to speak with the HRA. Therefore, this portion of the allegation cannot be substantiated.

The other portion of this allegation was that a recipient was never interviewed or notified of the outcome of a complaint that was filed. The HRA reviewed four OIG reports regarding these allegations and this recipient's name was listed in all of the reports as being interviewed by the facility investigator. The HRA checked with the OIG and received copies of letters sent to the recipient notifying him of the outcome of all the investigations. Although the recipient did not receive them all, due to his address changing and OIG not having a forwarding address, it is the OIG's responsibility to notify the recipient not Chester staff. Based on the information reviewed it appears that Chester conducted the investigation as required. Therefore, the allegation is **unsubstantiated**. The HRA makes the following suggestion:

1. When staff members are on duty they should wear their nametags where they are clearly visible.

Allegation 4: Staff violations of Code of Conduct. It was also alleged that staff sleep on duty, smell of alcohol and have negative interactions with recipients. The HRA reviewed the OIG report that was filed regarding some of these same allegations. The OIG did not substantiate neglect because no injuries reportedly occurred during this timeframe but recommended that the facility address the actions of the STA who was sleeping on duty, as per witness accounts, as well as the STA who failed to report the alleged sleeping of another STA which violates 20 ILCS 1305/1-17 (a).

Although neglect was not substantiated by the OIG because no one was reportedly harmed, the HRA questions whether that coincides with OIG's own definition of neglect and based on the facts reviewed, the HRA **substantiates** the allegation that staff violated the Code of Conduct by not following Chester policies EC 04.04.00.02 and EC 04.09.00.08 which are detailed above. The HRA reiterates the recommendations made in the OIG report and **recommends** that Chester provide the HRA with information on how the facility addressed:

1. **The actions of the STA who was viewed on videotape sitting in an arm chair, watching television for a long period of time appearing to be asleep rather than conducting programs with individuals.**

2. **The failure of the other STA to acknowledge a recipient's accusations as required by Chester policy and her failure to report the alleged sleeping of an employee.**

The HRA also makes the following suggestions:

1. Although the HRA could not substantiate negative staff interactions due to recipients saying one thing and staff saying another, the HRA is very concerned about the number of complaints received from different recipients involving negative staff interactions. The HRA reiterates the recommendations from Allegation 1 above as suggestions for this allegation and strongly suggests that Chester administration consider unannounced visits to the units during all shifts to view first hand the staff interactions with recipients, if this is not already being done.

2. In a previous report, the HRA made a suggestion that cameras be placed in the dining room, unit stems and unit restraint rooms to provide further protection for both staff and recipients. The HRA would like to reiterate that suggestion for this allegation and also request that the facility consider cameras that record sound as well as video.