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Egyptian Regional Human Rights Authority
Report of Findings
Case #13-110-9032
Chester Mental Health Center

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

1. A recipient is receiving inadequate care when incident reports aren't responded to and dietary requests are not honored, resulting in significant weight loss.

2. A recipient isn't being served in the least restrictive environment.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.), the Illinois Administrative Code (59 Ill. Admin. Code 50) and Chester policies.

Chester Mental Health Center is a state-operated mental health facility serving approximately 240 recipients; it is considered the most secure and restrictive state-operated mental health facility in the state.

To investigate the allegations, an HRA team interviewed a service recipient and facility staff, reviewed a recipient's record, with consent, and examined pertinent policies and mandates.

COMPLAINT STATEMENT

According to the complaint a recipient's request for double portions of food was denied even though the recipient had reportedly lost 80 pounds. In addition, a recipient had an incident involving a first shift staff person that was reported for over a month and no one responded to the concern. Finally, the complaint stated that the recipient would like to be transferred to a facility closer to family but there has been no progress in the request.

FINDINGS

Interviews

A recipient was interviewed who reported that he weighed approximately 278 lbs. in November 2012 and now weighs approximately 198 lbs. He put in a request for extra portions and a referral to the dietician due to the weight loss but the extra portions have been denied. The recipient also reported that he had an incident with staff; he stated that staff straddled him on his bed and then choked him while he was in restraints. He reported completing an incident report which he put in the Chester mail and he has not heard back from the facility. Finally, the recipient stated that he wanted to be transferred to Elgin Mental Health Center.

Chester staff reported that the recipient is within his ideal body weight but they are checking his weight twice per month. According to staff, the Illinois Department of Human Services' Office of Inspector General (OIG) investigated the allegation of the staff person straddling and choking the recipient. Finally, staff reported that the recipient's court involvement impacts his placement.

Record Review

The HRA examined two treatment plans for the recipient. A 03-18-13 treatment plan, developed the same day of his Chester admission, stated that the recipient was "adjudicated as Unfit to Stand Trial" on felony charges in February 2013. "His decision making is significantly impaired due to his delusions; and he would be unable to participate meaningfully in his own defense….He was transferred to Chester MHC for stabilization and restoration to fitness for court." His diagnoses were listed as follows: Bipolar Disorder, Manic; History of Substance Abuse; and Personality Disorder, Not Otherwise Specified, Antisocial with Paranoid Traits. His treatment plan goals included fitness restoration by 12-31-13; being free from aggression towards other by September 2013; the reduction of psychotic symptoms; and engagement in the substance abuse recovery process. The treatment plan stated that the recipient attended the treatment plan meeting, presented with "grandiose and paranoid delusions," was agitated with questions and signed a medication consent while indicating he did not need medication. The plan's "Criteria for Separation" from Chester included being able to communicate with an attorney and participate in a defense; being oriented to time, place and things; being able to understand his court proceedings; having sufficient memory related to alleged criminal offenses; and demonstrating reduced aggression. The treatment team concurred that the recipient is unfit to stand trial and estimated fitness within a year.

A subsequent treatment plan dated 05-29-13 stated that the recipient had been responsive to medication and compliant with unit rules. He enrolled in a class pertaining to fitness education and court procedures, scoring 100% on an exam. He made progress on all treatment plan goals and the team recommended fitness and a return to the county jail from which he was sent. According to the treatment plan, he was awaiting a June court date. There was no discussion about a transfer to another facility.

The recipient's initial psychiatric evaluation completed on 03-18-13, the day of admission, stated that the recipient was unable to explain the events that led to his admission to Chester. He was described as having "acute, delusional thinking," "disjointed," and "disorganized." The evaluation stated that the recipient was "…out of touch with reality and without any question he is suffering from delusions of both paranoid and grandiose. He was unable comprehend his current status of being UST [Unfit to Stand Trial]." His prognosis was described as being good if compliant with treatment. It was determined by the psychiatrist that the recipient was unfit to

stand trial "due to his acute psychotic symptoms but there is substantial probability that he will attain fitness within one year."

A nutritional screening completed on 03-18-13 listed the recipient's height at 70", current weight at 203 and ideal body weight range at 149 to 183 lbs. He was described as having a large frame. The screen stated that the recipient reported weight loss in the last 180 days with a comment that the recipient had "much loose skin on chest - reports loss of wt while locked up."

A dietician consultation completed on 03-25-13 stated that the recipient's height was 70", his weight was 203 and his ideal body weight range was 149-183 lbs. According to the consultation, the recipient was 11% above his ideal body weight range. A separate, nutritional/dietary assessment completed on the same date recommended a regular diet and indicated that the recipient had "no active medical problems." According to the assessment, the recipient reported a 65 lb weight loss while in jail. Lab work had been done and reviewed. The dietician indicated that the recipient's regular diet is adequate to meet his needs and no diet change was recommended although the dietician recommended monitoring weight and following up.

The physician reviewed the recipient's lab work on 03-28-13 and did not find the lab work abnormal nor did the physician see a need to schedule the recipient for more medical follow-up at the time.

On 04-15-13, the recipient requested to see the dietician because he was very active and hungry. The recipient's weight had increased 2 lbs since admission with his current weight being 205 lbs. The dietician noted that the recipient remained above ideal body weight range with a regular diet that was estimated to meet his nutritional needs given lab results and stable weight. The dietician did not recommend any diet changes but recommended monitoring and dietary referrals for any significant changes.

Progress notes were also reviewed. A note on 04-02-13 indicated that the recipient was upset about meals and his weight resulting in a referral to the dietician and a discussion about ideal body weight. Weight on 04-02-13 was documented at 208 lbs. Constipation was noted on 04-21-13. On 05-17-13, progress notes documented that the recipient "alleged he was choked by an unknown named staff member while he was in restraints on May 10, 2013. Notified supervisor…and [physician]. Assessed pt. No apparent injury noted. Pt. denies pain and denies injuries now. Pt. stated he was choked by a staff member while in restraints about one month ago. Stated he was in restraints for 17 [hours]." There were no progress notes about restraint use on 05-10-13. The only note about restraint use was on 03-19-13 for aggression.

An injury report was completed on 05-17-13 after the recipient reported the incident of a staff person choking him while in restraints. Nursing staff examined the recipient and notified the physician. The injury report indicated that OIG had been notified apparently by the recipient after obtaining OIG contact information from the Guardianship and Advocacy Commission (GAC) after a GAC visit. Tylenol was offered to the recipient at the time of the report but it was refused. The report indicated no apparent injury. The physician examined the recipient who reported a swollen neck and Adam's apple. The physician found no scars, redness or swelling.

An OIG report indicated that on 05-13-13 the OIG was notified of a choking allegation involving the recipient and a staff person. The recipient reported that the incident occurred in early April 2013 but wasn't reported until May 2013. The investigator indicated difficulty in collecting evidence due to the reporting delay; the OIG report also stated that the investigator was unable to obtain a video of the alleged incident because of the delay. The investigator examined the recipient's chart to find only one incident of restraint use on 03-19-13 which indicated no complaints of injuries or staff abuse at the time. A staff person was identified by name but when presented with photos of staff, including the staff person the recipient named, the recipient did not identify the staff person. The named staff person was interviewed by the investigator but denied the allegation. The OIG determined that the complaint was "unfounded."

The HRA examined the recipient's initial finding of unfitness as per the court and the order that he be placed in the custody of the Department of Human Services for inpatient services. A fitness test completed by the recipient on 04-30-13 rendered a score of 95% out of 100%. A 90 day fitness evaluation was completed by the psychiatrist on 05-22-13 stating that the recipient was fit to stand trial and he could return to court for a hearing. The criteria used to determine the recipient's fitness was listed and included the following: mental and physical stability; treatment compliance; symptom-free; participation in fitness education and testing with passing test results; understanding of charges/penalties/court participants' roles; and ability to assist his attorney.

Policy Review

Chester's "Screening, Assessing and Reassessing Nutritional Needs" Procedure requires an assessment when there is a dietary concern or significant weight changes. The dietician is to interview the recipient and may consult with nursing and other staff. The dietician will determine the need for any recommendations which are then forwarded to the physician for review. A nutritional plan will be developed and revised as needed. Recipients considered to be a nutritional risk are monitored on an ongoing basis.

A policy entitled "Continuity of Care Contact for Patients who Are Unfit to Stand Trial" states that Chester provides ongoing discharge planning for individuals who are adjudicated as UST. The therapist serves as the liaison with the court. The therapist also communicates with community providers if a recipient may be considered for release by the courts and coordinates discharge planning and after care appointments. According to the "Transfer Recommendation of NGRI and Involuntary Criminal Patients" Procedure, all transfers are to be in accordance with the Mental Health Code requirement of treatment in the least restrictive setting. Transfers begin with a determination by the treatment team and then a transfer recommendation by the psychiatrist. The therapist then addresses transfer issues.

The facility "Treatment Plan Procedure" states that the section of the treatment plan that addresses Criteria for Separation is to "Describe the criteria that must be met before the patient can be transferred to another facility or be returned to court."

The Patient Rights Procedure states that the recipient is to "…be provided with adequate and humane care and services in the least restrictive environment pursuant to an individual treatment plan."

According to the "Reporting and Investigating Incidents and/or Allegations" Procedure, allegations of abuse are to be reported to the Office of Inspector General and the Illinois Department of Public Health within 4 hours. An incident report is to be completed.

Chester's Code of Conduct for employees requires that recipients be treated with respect and dignity and be free of abuse. The Code also directs employees to complete incident forms and notify supervision of abuse allegations.

Chester's Guide for Patients describes the provision of dietary services including 3 meals per day, special diets if ordered by the physician and dietary staff to ensure a proper diet. The section states that night time snacks are provided and a commissary is available where recipients can purchase food items if the recipient has funds. Perishable food purchases are limited to $7.00. A separate section on mealtimes states that if a recipient feels that a special diet is needed then he can contact the module nurse or ask to see the dietitian. The Guide also includes a section on transfers and returns to court. This section describes the UST status as well as guidelines for handling money and personal property should the recipient be found fit and be returned to jail after a court hearing. "If you are UST and are being returned to court, your therapist will contact your community mental health center. Your therapist will provide you with the information you need to continue treatment in the community. It is important that you follow your aftercare instructions if you are released. Your treatment team will determine the proper time for transfer to another facility. For further information, speak with your therapist, who is familiar with your case." Some rights are listed in the Guide but not the right to be free from abuse or the OIG contact information.

MANDATES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.) requires the following with regard to care, services and least restriction:

> *(a) 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. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan. (405 ILCS 5/2-102)*

With regard to transfers between state-operated facilities, the Code (405 ILCS 5/2-707) states:

The facility director of any Department facility may transfer a client to another Department facility if he determines that the transfer is appropriate and consistent with the habilitation needs of the client. An appropriate facility which is close to the client's place of residence shall be preferred unless the client requests otherwise or unless compelling reasons exist for preferring another facility.

Section 5/2-112 of the Code guarantees the right to be free from abuse and neglect.

The Illinois Administrative Code (59 Illinois Admin. Code 50.20) addresses abuse reporting requirements for a facility that serves persons with disabilities and states that:

> *1) 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. Such an employee or representative of a community agency or facility shall be deemed the "required reporter" for purposes of this Part. Such reporting will additionally meet any requirements of 59 Ill. Adm. Code 115, 119 and 132 and Department administrative directives, as applicable.*
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> *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;*

CONCLUSIONS

With regard to the allegation that the recipient's dietary concerns were not being met, the HRA found evidence that the recipient's weight was relatively stable, was within his ideal body weight range, was evaluated in terms of lab work and was being monitored by dietary and medical staff. A request for double portions was denied due to the recipient's current weight being above his ideal body weight range. The HRA notes that the recipient may have had excessive weight loss prior to his admission to Chester. Chester policies and procedures require dietary assessment and oversight of recipients' dietary needs. The Mental Health Code requires the provision of adequate care and services pursuant to a treatment plan. Based on the evidence, the HRA does not substantiate the complaint that the recipient was receiving inadequate dietary care. The HRA does suggest the following:

1. Continue to monitor the recipient's weight for any further weight loss or dietary concerns.

The allegations also stated that the recipient received inadequate care when he did not receive a response to an incident report. Documentation indicated that facility staff did not become aware

of any incident until 05-17-13 at which time an incident report was completed prompting a nursing review and a physician's exam. A report had already been filed with the Office of Inspector General on 05-13-13, perhaps by the recipient, and referred to an incident in the prior month in which the recipient had been restrained; however, the recipient's record indicated that the recipient had not been restrained during the reported time frame but had been restrained in March shortly after admission. The OIG indicated that the untimely reporting denied the investigator the ability to fully investigate, to collect evidence and to review a video. The HRA found that as soon as the staff became aware of the incident, an incident report was filed and exams were completed; the OIG was already involved and there was no evidence of any recipient reports of the incident prior to the May incident report. Chester's Code of Conduct requires that staff treat recipients with dignity and respect and ensure that recipients are free of abuse. In addition, Chester policies require the reporting of abuse when staff learn of an incident. The Mental Health Code guarantees the right to be free from abuse and the Administrative Code requires abuse reporting. The HRA does not find that the facility provided an inadequate response to an incident report but does offer the following suggestions:

1. Examine the time frame for maintaining videos. Although there was a delay in the recipient reporting the incident by approximately 1 ½ months, the HRA questions if the video should have still been available for viewing.

2. The Chester Handbook does not include information about the right to be free from abuse in the rights section nor does the Handbook include contact information for the OIG. It appeared that the OIG was contacted by the recipient after obtaining OIG contact information from the Guardianship and Advocacy Commission during a visit. The HRA strongly encourages the facility to revise its handbook to include information about abuse protections and the OIG contact information. The HRA also suggests that the facility periodically check to ensure that OIG contact information is posted on individual units that recipients can access.

3. It is unclear whether or not the facility contacted OIG after learning of the allegation or if the facility acknowledged the OIG's involvement. The HRA suggests that the facility review their responsibility to report after learning of an incident even if OIG may already be involved due to the potential of having new or additional information that could facilitate the OIG investigation.

The final complaint states that a recipient is not being served in the least restrictive environment. The recipient, who was ordered to a Department facility after being found unfit to stand trial, expressed interest in moving closer to family. His condition had improved markedly in a short duration to the point that he was determined to be fit to stand trial as per his May 28, 2013 treatment plan which also noted his responsiveness to and cooperation with treatment. The recipient's treatment plan makes no mention of a transfer recommendation to a less restrictive environment in spite of the recipient's response to treatment; the "Criteria for Separation" section focuses only on the recipient's return to jail. Chester's Continuity of Care Policy for recipients who are UST states that discharge planning is to be ongoing with the therapist handling discharge arrangements. Chester's Transfer Recommendation Procedure states that transfers are to be in accordance with the Code's least restriction requirement and begins with a transfer

recommendation by the team and then the psychologist. The facility's treatment plan procedure requires the Criteria for Separation to address criteria to be met for a transfer to another facility or court. And, the recipient's rights procedure guarantees the right to services in the least restrictive environment. While the recipient's treatment plan did address criteria for a return to fitness and court, the treatment plan made no mention of a transfer to a less restrictive environment. Granted, while the time period of his pending court case tentatively scheduled for mid-June may have made it impractical, the HRA contends that, in keeping with its own policies and the Mental Health Code provisions guaranteeing the right to least restriction, Chester must include a review of transfers to less restrictive placement as part of its treatment plan reviews and document accordingly. **Due to the lack of treatment plan review of less restrictive placement, the HRA substantiates a violation of the right to least restriction and recommends the following:**

1. **Ensure that treatment plan reviews include a review of transfer to a less restrictive placement as part of the Criteria for Separation, including for individuals who are UST. Document the review accordingly.**

2. **If the recipient in this case continues to reside at Chester, convene a treatment plan meeting to review the potential for transfer to a less restrictive placement.**