FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 13-110-9040
Chester Mental Health Center

INTRODUCTION

The Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, opened an investigation after receiving complaints of possible rights violations at Chester Mental Health Center. The complaints alleged the following:

1. **Inappropriate staff interactions.**
2. **Overmedication.**
3. **Inadequate Office of Inspector General (OIG) investigative process.**

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.) and Rule 50, OIG reporting requirements (59 Ill. Admin. Code 50).

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

To investigate the allegations, HRA team members interviewed the recipient and reviewed documentation that is pertinent to the investigation. Such documentation included recipient records, with consent.

FINDINGS (including record review, mandates, and conclusion)

With the proper consent, the HRA reviewed records and documents related to the complaints alleged in this case, contacted Chester and OIG staff, and interviewed the recipient in question.

A. Recipient Interview

To investigate the complaints, the Human Rights Authority conducted an interview with the recipient on June 28th, 2013. The recipient stated that a Security Therapy Aide (STA) from the B3 unit had cornered him in the quiet room two and a half weeks prior to the interview. The recipient claimed that, having been cornered, he swung at the STA, and as a result the STA choked and handcuffed the recipient. The recipient stated that he spoke with Chester's internal

Office of the Inspector General (OIG) investigator, as well as another OIG member, who told the recipient that they were "looking into" the matter of a report of abuse involving that incident. The recipient stated that they then ceased to act, and nothing was ever done about that investigation.

Furthermore, the recipient claimed that staff was "messing with" his medication. During the interview, the recipient demonstrated slurred speech and some drooling, and at one point, upon trying to stand up, the recipient stumbled and almost fell.

B. Correspondence with OIG Staff

The Human Rights Authority contacted Chester's internal OIG liaison in writing regarding the complaint about the abuse allegations involving the recipient being overlooked. The OIG liaison indicated that he could not find any case involving the recipient from the end of May or the month of June.

The Human Rights Authority continued the attempt to locate records of any OIG reports filed involving the recipient around the date in question. In an email exchange with the OIG, an OIG representative (not the Chester liaison) indicated that they did have record of a call to the OIG on 6/22/13 and 6/27/13. An OIG representative indicated in writing that a message was left regarding an incident with Chester staff and the recipient, and that the internal OIG liaison at Chester was instructed to speak to the recipient regarding that complaint. An OIG representative indicated that the complaint they had on record was "short-form," meaning that having spoken to the recipient, the Chester internal OIG liaison indicated that the recipient did not have any concerns or want to make a complaint.

C. Recipient Record Review

Regarding the recipient's complaint of inappropriate staff interactions, the Human Rights Authority reviewed the recipient's Progress Notes. There was an incident recorded in the Progress Notes dated 5/30/13 describing the recipient having gotten agitated, escorted to the quiet room, and being removed from the quiet room thirty minutes later, with no mention of a staff altercation. Another incident, dated 6/2/13, was recorded in the Progress Notes as having taken place around 1:30pm, and better matches the recipient's own indication of when the inappropriate staff interaction took place. The Progress Notes indicate that the recipient had been agitated and aggressive with a peer in the dining room and was thus escorted out, to sit in the quiet room at 1:30pm, where he agreed to take Olanzapine to calm down. The Progress Notes then say "(the recipient) began to escalate, requiring a [sic] emergency enforced meds," referring to the fact that the recipient was forced to take emergency enforced Haloperidol half an hour after his PRN (as needed) of Olanzapine, and following his daily dose of Quetiapine. The recipient is documented to have "struggled and fought" against the emergency enforced medication, and that it was administered via an injection to his buttocks. There is no documented justification or rationale in the Progress Notes for the use of emergency enforced medication, only the vague mention of the patient "escalating" and the medication thus being "required." Such justification may have been included on the Restriction of Rights notice, but that documentation was not available to the Human Rights Authority at the time of this report.

Upon the administration of the emergency enforced medication, the Progress Notes indicate that the recipient continued struggling, resulting in his being placed in a physical hold at 1:50pm and metal handcuffs at 1:55pm. The recipient was then placed in 5-point restraints "for the safety of all," according to the Progress Notes, at 2:00pm. The circumstances documented for the recipient's restraint, which was the second Restriction of Rights in this sequence of events, were the recipient's "violent" responses to the first Restriction of Rights (in this case, the emergency enforced medication). The Progress Notes indicate that a Restriction of Rights notice was given upon the recipient's restraint.
The recipient's Designation of Emergency Preference and Notification form, dated 9/7/11, indicated that in the event of emergency circumstances requiring intervention by the facility, the recipient would prefer that seclusion be the first resort, restraint be the second, and *emergency medication be the last resort*.

Regarding the recipient's complaint of overmedication, the Human Rights Authority examined the recipient's Progress Notes, as well as the Medication Administration Record from June of 2013. The Medication Administration Record indicated that in June 2013, the recipient was receiving 1200mg of Oxcarbazepine, 1000mg of Divalproex, 600mg of Quetiapine, 400mg of Phenytoin sodium, 100mg of Trazodone, 100mg of Docusate sodium, 40mg of Famotidine, 30mL of milk of magnesia, and .025mg of Levothyroxine sodium on a daily basis. Furthermore, the patient was authorized to receive injections or tabs of Haloperidol (5mg) or Olanzapine (10mg) as needed. The Medication Administration Record indicated that the recipient received pro re nata (PRN, or as needed) doses of Haloperidol on 6/2, 6/14, and 6/22, and Olanzapine on 6/2, 6/9, and 6/28. The Progress Notes document PRN medication being given on 6/2, 6/22, and 6/28, but not on 6/9 or 6/14. The documented administration of the recipient's medication was consistent with the prescriptions laid out in the Medical Administration Record.

D. Policy Review

The HRA examined policies pertinent to the allegations. Chester Mental Health Center's "Patient Rights" policy guarantees the right to adequate and humane care and services in the least restrictive environment, pursuant to an individual treatment plan. This right is repeated in the Patient Guide, within the "Rights of Patients" section, stating, "A patient shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual treatment plan."

The "Patient Rights" policy also indicates that patients have the right to refuse medication, and that the restriction of any of those rights (including that of adequate care in the least restrictive environment) may only take place based on an assessment of whether the patient or situation is affecting the safety of the patient or others.

The "Use of Psychotropic Medication" policy labeled TX .02.04.00.02 states that "The physician or RN initiating the use of emergency medication must document **in the progress note** that due consideration was given to the patient's treatment preference regarding emergency medication and must include justification for deviation from the patient's preference." (Emphasis added).

A "Risk Medication" policy confirms that Chester complies with Administrative Code rules 112.80 and 112.90 and indicates that there is a Maximum Daily dose List issued by the Illinois Department of Human Services (DHS) regarding certain medications. This list (Illinois Department of Human Services Review of Psychotropic Drugs 2013) indicates that the maximum daily dose for Quetiapine is 800mg, for Trazodone is 300mg, for Carbamazepine (of which Oxcarbazepine is a derivative) is 1200mg, and for Olanzapine is 20mg.

A Chester policy entitled "Patient Rights and Organization Ethics," ID RI .01.01.02.01 states that:

> "4. A progress note will be made in the patient's chart upon initiation of the Restriction of Rights and shall include the following.
>
> a. Date and time initiated.
> b. Circumstances and/or assessment that resulted in the Restriction of Rights.
> c. Rationale for the Restriction of Rights." (II. B. 4. a-c.)

"Reporting and Investigating Incidents and/or Allegations," a Chester policy marked EC .04.04.00.02 states that among the types of incidents to report are allegations of mistreatment of service patients by employees, including physical abuse and neglect. Physical abuse is defined as "an employee's non-accidental and inappropriate contact with an individual that causes bodily harm," and neglect is defined 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 as substantial risk of possible injury, harm, or death." The policy states that any allegation of an incident that constitutes the above must be reported immediately to the Facility Director or designee, who then has four hours to call the OIG Hotline. Screening or withholding reports of incidents by any person including the Facility Director is prohibited.

The Illinois Department of Human Services has identified "DHS Facility Investigative Protocol for Calendar years 2014 and 2015" as last revised on 10-30-13. The protocol, under IV. Procedures, C. Investigation, there is a subsection entitled, "Objectivity and integrity" which states the following:

(a) The facility shall ensure that there is the absence of real or apparent conflict of interest or bias by the OIG authorized facility investigator, or designated employee who has been trained in the OIG-approved methods to gather evidence and documents.
(b) No person identified in the "prohibited persons" section shall assist in conducting interviews or otherwise be involved in investigations into alleged abuse/neglect or deaths at the facility.
(c) Under no circumstances is an interview to be conducted by an OIG authorized facility investigator who is from or supervises the unit or office where the incident occurred or who is in the same collective bargaining unit as the person(s) involved.

The protocol also identifies "prohibited persons" as the authorized representative, assistant facility director, assistant hospital administrator, personnel, labor relations staff, family members

of the above-listed individuals, any staff with substantiated abuse/neglect findings, or any person OIG determines to have a conflict of interest.

E. Mandates

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) guarantees the right to:

…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. ….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…shall be noted in the recipient's treatment 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 Mental Health and Developmental Disabilities Code (405 ILCS 5/2-200) regarding emergency enforced medication also states that:

…the facility shall inquire of the recipient which forms of intervention the recipient would prefer if any of these (emergency) *circumstances should arise. The recipient's preference shall be noted in the recipient's record and communicated by the facility to the recipient's guardian or substitute decision maker, if any, and any other individual designated by the recipient. If any such circumstances subsequently do 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.*

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107) also requires the following with regard to the refusal of medication and then the administration of forced medication:

(a) 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.

The Illinois Administrative Code (59 IL ADC 50.10 et seq) establishes the Office of the Inspector General and sets up rules that govern the OIG body. A number of those rules are relevant to this case, and are listed below.

59 IL ADC 50.10: *"Authorized representative". The administrative head or executive director of a community agency appointed by the community agency's governing body with overall responsibility for fiscal and programmatic management, or the facility director or hospital administrator of a Department facility.* ***If this person is implicated in an investigation, the governing body of the community agency or the Secretary of the Department shall be deemed the authorized representative for that investigation.*** (emphasis added)

59 IL ADC 50.20 (a)4: *Screening, delaying or withholding reports of incidents or allegations of abuse or neglect from OIG is strictly prohibited.*

59 IL ADC 50.30 (a): *OIG shall be available 24 hours a day to assess reports of allegations of abuse, neglect, financial exploitation, or death and provide any technical assistance with making the report.*

59 IL ADC 50.30 (b): *OIG staff receiving the report of the allegation are responsible for assessing, based on the information received at intake, whether the allegation could constitute abuse, neglect, or financial exploitation and whether OIG has the authority to investigate in accordance with the Act. OIG shall make these assessments within one day after receiving the call.*

59 IL ADC 50.30 (f): *If the allegation of abuse, neglect or financial exploitation is within the jurisdiction of OIG, the authorized representative or his or her designee of a community agency or facility shall:*

1) Ensure the immediate health and safety of involved individuals and employees, including ordering medical examinations when applicable; and

2) ***Remove alleged accused employees from having contact with individuals at the facility or agency when there is credible evidence supporting the allegation of abuse pending the outcome of any further investigation, prosecution or disciplinary action against the employee [405 ILCS 5/3-210]*** (emphasis added); *and*

3) Ensure OIG is notified; and

4) Unless otherwise directed by OIG, initiate the preliminary steps of the investigation by a designated employee who has been trained in the OIG-approved methods to gather evidence and documents and for whom there is no conflict of interest. This may include the need to:

A) Secure the scene of the incident and preserve evidence, if applicable;

B) Identify, separate potential witnesses, and interview when applicable;

C) Identify and record the names of all persons at the scene at the time of the incident and, when relevant, those who had entered the scene prior to the scene being secured;
D) Secure all relevant documents and physical evidence, such as clothing, if applicable;
E) Photograph the scene of the incident and the individual's injury, when applicable.

59 IL ADC 50.40 (a)3: *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.*

59 IL ADC 50.50 (c): *All investigations shall be conducted in a manner that respects the dignity and human rights of all persons involved.*

F. Conclusions

1. Inappropriate staff interaction. The recipient claimed that a security therapy aide cornered and choked him before handcuffing him in the quiet room, but the Human Rights Authority could not corroborate that claim with any other documentation. For this reason, the complaint is found **unsubstantiated**. *However*, in conducting this investigation, the Human Rights Authority came upon evidence that warrants the following **comment** and **suggestions:**

The incident on June 2nd, 2013 escalated from a PRN and time alone in the quiet room for the recipient to an unjustified violation of the recipient's preferences with emergency enforced medication, and then further rights restriction in the form of five-point restraints. Chester's policies (which follow the Mental Health and Developmental Disabilities requirements for documentation of emergency treatment preferences) dictate that the Progress Notes had to document the circumstances and rationale for *any* rights restrictions, and further that those Progress Notes must document the consideration of the patient's treatment preferences in emergency situations, as well as justification for any deviation from those preferences. This would mean that the Progress Notes had to include:

1. Date and time of rights restriction
2. Circumstances/assessment resulting in rights restriction
3. Justification for the rights restriction
4. Documentation that due consideration was given to the patient's preferences regarding emergency treatment (such as emergency enforced medication)
5. Justification for any deviation from the patient's preferences regarding emergency treatment

The Human Rights Authority found that components b, c, d, and e were all lacking in the Progress Notes; "the patient began to escalate" was not specific enough to describe any of the actual circumstances or behaviors that led up to emergency enforced medication being administered to the recipient, nor did it contradict the patient's own account of having been cornered and therefore swinging at the staff member. There was no documentation of the

patient's preferences having been considered by any of the staff in the Progress Notes, and instead, the recipient's last resort preference was utilized as a first resort without any justification in the Progress Notes. While such justification may have been present in the Restriction of Rights Notices that the HRA did not have access to, Chester policy should have dictated that justification be present in the Progress Notes. Furthermore, the Mental Health and Developmental Disabilities Code states that the facility must "give due consideration" to the recipient's communicated preference as well as any advance directive (such as, the recorded order of preference of emergency intervention). In this case, the recipient's violent struggle against emergency enforced medication suggests that he would have preferred another emergency treatment method. In addition, he also documented his preference that emergency enforced medication be administered only if seclusion and restraint were impossible. Clearly, the recipient's second preference, restraint, *was* possible, as it was utilized immediately after emergency enforced medication. The justification for the recipient's was his violent protest at being forced to receive emergency enforced medication via an injection to the buttocks. For these reasons, the Human Rights Authority offers the following **suggestions**:

a. That staff follow Chester policy TX .02.04.00.02 (I)(C), which dictates that the initiator of emergency medication must document *in the progress note* that due consideration was given to the patient's emergency treatment preference and must include justification for deviation from the patient's preferences.

b. That, in following Chester policy RI .01.01.02.01 (II)(C)(4), staff ensure that the "circumstances and/or assessment that resulted in the Restriction of Rights," must be documented in a progress note, be clear, and include a description of what behaviors and actions took place rather than a vague description of the situation as "escalating."

c. That staff ensure that they are taking recipients' emergency preferences into account before initiating restrictive emergency treatment, and that staff not treat protests (unless needed "*to prevent the recipient from causing serious and imminent physical harm to the recipient or others")* as justification for disregarding those preferences or for implementing further restrictions.

2. Overmedication. The recipient's slurred speech, drooling, and near fall in his interview with the HRA was cause for concern. Upon review of the recipient's chart, the HRA determined that the patient's Medication Administration Record reflected that he was given medication *as prescribed* by his doctor. The HRA also notes that the medication dosages fall within the maximum dose limits per Chester's "Risk Medication" policy. Since it is outside the HRA's scope of authority to question a physician's clinical expertise or course of treatment and the medication dosages fell within the maximum dose limits, this complaint must therefore be found **unsubstantiated**.

3. Inadequate OIG Investigative Process. In an interview, the recipient claimed that he had been "cornered" in the quiet room by a Chester Security Therapy Aide, that the recipient swung at the STA, and that the STA then choked the recipient. This was the basis of a call to the OIG involving the recipient. Further documentation shows that as a result of the recipient's "escalation" in the quiet room, the recipient was forcibly injected with medication despite his

protests and violent struggle. The Progress Notes indicate that this struggle against emergency enforced medication led to his being placed in five-point restraints.

OIG representatives confirmed in writing that an incident with the recipient had been called in to Intake for the OIG and that a message had been left. OIG representatives indicated that they did not speak to the caller, but sent a message to the OIG liaison at Chester instructing him to speak with the recipient about that call. The call involved alleged mistreatment by a Security Therapy Aide at Chester. As the HRA has previously been told, internal OIG liaisons at Chester must sometimes act as supervisors for other STAs, and indeed Chester's internal OIG liaison was an acting Security Therapy Aide at Chester, with supervisory responsibilities over other Security Therapy Aides. There is no evidence that the internal OIG liaison made an effort to determine whether he had a conflict of interest in the situation, by documenting whether he had any supervisory capacity over the STA involved in the incident, worked in the same bargaining unit as the STA being reported, or *was the STA being reported* as prohibited by DHS investigation protocol. In addition, Administrative Code rules clearly state that reports cannot be screened, nor can implicated individuals remain in contact with involved recipients. In this case, the Chester OIG liaison was not the specific STA being reported, but the fact that the liaison's unknown supervisory capacity over the STA in question was not investigated or documented by the liaison or the facility indicates a potential problem of unaddressed conflict of interest.

The recipient said that he did speak with the Chester OIG liaison, who informed the recipient that he would "look into" the recipient's ill treatment referred to by the call. The recipient said that nothing was ever done to investigate that report. The OIG records reflect that the Chester OIG liaison had informed the OIG that when the liaison spoke to the recipient, the recipient had no complaints. Thus, no report was ever filed. The recipient claims that he never indicated that he did not have concerns or complaints.

In a previous case, marked 12-110-9017, the Human Rights Authority issued the following recommendation:

"As per OIG protocol and to ensure that there is not a conflict of interest as required by OIG regulations, ensure that the OIG liaison/investigator is not from the same bargaining unit as those being investigated nor should the liaison/investigator have supervisory responsibilities over those investigated."

This indicates that, more than once, the Human Rights Authority has noted a problem of the possibility of a conflict of interest in the OIG liaison, and the risk of screening cases (which is strictly prohibited) if the OIG liaison is the Security Therapy Aide being investigated, works with the STA being investigated, or has supervisory responsibilities over the STA being investigated.

In this particular case, it is the word of the recipient against the word of the internal OIG liaison. It is impossible to determine what exactly occurred with a preponderance of evidence. The complaint of inadequate OIG investigative process must therefore be found **unsubstantiated**.

However, as the possible conflict of interest of the internal OIG liaison has been a repeated, documented concern, and as it is reasonably possible that the internal OIG liaison could have conflicts of interest with the STAs that are subject to OIG investigations, the Human Rights Authority makes the following **suggestions**:

1. Ensure that the OIG liaison/investigator from Chester is not from the same bargaining unit as those being investigated, nor should the liaison/investigator have supervisory responsibilities over those investigated, in order to comply with 59 IL ADC 50.30(f) and DHS facility investigation protocol. Ensure that conflict of interest requirements are met by documenting the staff member reported, their unit, and that of the OIG internal liaison, even if the complaint is withdrawn, so that it can be proven that the internal OIG liaison was indeed not implicated by reports. This will also create the potential to disprove allegations of screening, which is prohibited by 59 IL ADC 50.20(a)4.

2. Ensure that the internal OIG liaison is following 59 IL ADC 50.40(a)3 by communicating to recipients who are alleged victims the status of OIG investigations concerning their treatment.