FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
14-110-9001
Chester Mental Health Center

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Chester Mental Health Center, a state-operated mental health facility located in Chester. The facility provides services for approximately 240 recipients serving both forensics and civil commitments. The specific allegations are as follows:

1. **A recipient has been denied access to substance abuse treatment during his commitment at Chester Mental Health.**

2. **Negative staff interactions and inadequate OIG process (a report was filed but no investigation occurred).**

3. **A recipient is not receiving adequate medical care by not being referred to a dietician to address his request for an increased calorie diet due to hyperthyroidism.**

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2) the Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/7) and the Illinois Administrative Code (59 Ill. Adm. Code 50).

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 and staff members at the facility. With the recipient's written authorizations, copies of information from the recipient's clinical chart were reviewed by the Authority. Facility policies relevant to the complaints were also reviewed.

Allegation 1: A recipient has been denied access to substance abuse treatment during his commitment at Chester Mental Health.

I. Interviews:

A. Recipient: The Recipient informed the team that he is at Chester due to being found unfit to stand trial and is there to attain fitness. He expressed an interest in attending a MISA (Mental

Illness Substance Abuse) or other substance abuse group therapy while at Chester. However, he stated that the facility is only trying to find him fit for court and is not offering any type of substance abuse therapy in the meantime. He is enrolled in rehabilitation classes for horticulture, homemaking and music. He stated that he attends his monthly treatment plan review meetings (TPR) and has voiced an interest in substance abuse treatment, but is told that they do not offer that at this facility.

B. Director of Rehabilitation: The HRA checked with the rehabilitation director to see if there are any drug treatment programs being offered at Chester. He said that this issue had been discussed among their Human Rights and Ethics Committee. Although they did not feel it was a rights violation for this recipient, they did feel the complaint had merit and therefore referred it to the Clinical Programs Committee. That committee felt this recipient may benefit from the MISA group and agreed that a referral would be made. They hoped that the Recovery Support Specialist (RSS) could facilitate 12 step groups once hired; it was the understanding of the rehabilitation director that the RSS would be hired within the next two weeks from the time of our discussion which was around August, 2013. He explained that the MISA group varies in size and is conducted by staff at Chester.

Approximately three weeks later, the HRA learned that this recipient still had not been referred to a group treatment program so the team checked with the rehabilitation director on the status. He informed the team that the RSS staff "fell through" but he had inquired with a therapist who implied that she would put him in her MISA group. However, when the HRA checked with this therapist, she stated that she did not have a MISA group and did not recall a conversation with the rehabilitation director regarding this. She did say the recipient would be connected to a Community Resource Group **upon discharge** for Substance Abuse Treatment and **at this time, fitness for court is the goal for him**.

C. Facility Director: The team spoke with the facility director regarding substance abuse treatment at Chester. She told the HRA that they provide individual therapy to address issues of substance abuse. They also conduct an audit on a monthly basis to assess proper identification for patients that are diagnosed with substance use. The audits at that point had yielded the following results: 100% compliance with 132 identified patients in June, 2013; 100% compliance with 127 patients in July, 2013 and 99% compliance with 118 patients in August. Documentation in the treatment plan includes the diagnosis, identified problem and treatment interventions to be utilized when assisting the patient in the recovery process. Individual therapy remains a constant to address issues of substance use. She also explained that the Active Treatment Committee is working diligently to also include MISA groups in programming to address substance abuse.

D. Director of Clinical Operations: In May, 2014, the HRA spoke with the Director of Clinical Operations regarding the status of the MISA group being offered. She informed the HRA that Chester had just received 3 new therapists and they are working on increasing the groups being offered. She explained that MISA is a difficult group to get in because it is an area where the staff have to be trained in as most psychiatric social workers have never worked in substance abuse and are not normally trained in that area. They are however, planning to start a MISA group now that the facility has the new therapists. The first class is scheduled to start May 7th.

II. Clinical Chart Review:

A. Treatment Plan Reviews (TPRs): Neither the 6/14/13 nor the 8/1/13 TPR documented any requests from the recipient to attend a substance abuse class. The discussion section in the 6/14/13 TPR said that the recipient "appeared to be easily distracted by something as he would start to say something, look away, stop, then refuse to finish his statement. Information from admission record reflects similar behavior while in jail." The 8/1/13 TPR indicated in the discussion section that he had responded well to the medication regime and was able to participate in off unit activities at that time. It also stated that the recipient "has his opinion as to why he was admitted to Chester and any legal matters appear to be of little priority to him at this time. [Recipient] was reminded that **becoming fit to stand trial is the focus of his treatment** while here at Chester." The Reason for Admission section in both TPRs stated that he was found Unfit to Stand Trial and admitted to Chester due to "threatening, hostile and highly unpredictable behavior" while in jail. He had refused medication and was uncooperative with a psychiatric evaluation. Therefore, based on his history of Mental Health including history of suicidal ideations, the court remanded him to the Department of Human Services "for stabilization and Fitness Restoration." The problem/goal section of his TPR does list "potential for substance abuse" as a problem and the goal is listed as "will engage in the recovery process for substance abuse by 4/2014." The objective is listed as being able to give a correlation between his substance use and the negative events that have happened in his life through 1:1 sessions with his therapist. The progress for this goal in the 6/14/13 TPR states that the recipient "is not stable enough to focus on substance abuse issues at this time. This will be addressed at a later date." The 8/14/13 TPR stated verbatim what the 6/14/13 TPR had in regards to substance abuse treatment.

B...Progress Notes: The progress notes dated 6/14/13 through 8/12/13 were reviewed. There were no case notes to reflect that the recipient ever requested to be involved in any substance abuse classes. Most of the case notes were documenting several restraint and seclusion episodes due to physical aggression and also documented meal refusals during this time frame. On 6/25/13 a nursing note stated that the recipient's "mental and clinical condition does not permit participation in infection control education. Will attempt when out of seclusion and more stable."

III...Facility Policies:

A. IM .03.01.01.03 Treatment Plan: states that the *Identified Patient Needs or Problems* section should include a list of needs or problems that are "based upon the critical treatment and/or medical issues, as presented from the results of the psychiatric, physical, nursing, security, social assessments, and Personal Safety Plan. Include the date the problem is established and provide all supporting evidence to justify the problem as a critical treatment and/or medical need. Any trauma, substance abuse, violence to self or others, suicidal or homicidal history identified during the assessment process must be included."

Allegation 2: Negative staff interactions and inadequate OIG process (a report was filed but no investigation occurred).

I...Interviews:

Recipient: The recipient stated that around June or July, 2013 he became aggressive and punched staff "due to his psychosis" and a STA (Security Therapy Aide) elbowed his throat and said "I will [explicit] kill you." The recipient believes the thyroid issues he now has are a result of this altercation. He reported this incident to the OIG (Office of the Inspector General) and an inspector came to talk to him but he never heard anything back from the investigation as to the outcome therefore, he does not know if an investigation was ever completed.

Then around September, 2013 he was put into "a quiet room" because he asked if they could check him for lice. A nurse on his unit, whose name he could not recall, allegedly yelled at him and told him that it was impossible to do that and that he has been a burden to staff over the last two weeks. He "stomped" his foot in disgust from about 20 feet away and she claimed that it was a threatening behavior so he was put into the quiet room.

II. Chart Review:

A. OIG (Office of the Inspector General) Reports: The HRA reviewed two OIG reports regarding this recipient. The first alleged that a STA put his elbow into the throat of the recipient and threatened him while he was in restraints. This incident was reported to the OIG in July, 2013. The OIG found no allegation of abuse being reported at the time of the alleged incident by the recipient and no injury was noted upon examination. It was also noted that no injury to the recipient was documented in the progress notes in his chart and that the recipient waited over a month to report this alleged physical abuse, "diminishing his credibility and preventing medical personnel from providing an accurate and timely examination." The complaint was therefore unfounded with recommendations that an injury report be completed upon the conclusion of each restraint episode and that the post-episode debriefing be reviewed to address confusion in some wording on the form.

A second OIG report alleging that staff members deny the recipient access to his therapist and verbally abuse him was also reviewed. The OIG found documentation that the recipient had access to therapeutic personnel every day which "discredits his claim that he was denied access." The recipient also could not identify staff members from a photographic array that had allegedly verbally abused him. Therefore, the OIG determined that this complaint was also unfounded.

The OIG also provided the HRA copies of letters dated 1/20/14 and 2/4/14 which show that the OIG had sent the recipient notification of the outcome of both cases. One was sent to Chester and the other was sent to a private home address that was given to them as a possible forwarding address. Both letters were returned to the OIG as "attempted-not known, unable to forward." There was a handwritten forwarding address on one of the envelopes along with a note which said "sent again 2/20/14." However, the OIG representative informed the team that this address was not good either as the letter was once again returned as undeliverable.

B. Order for Physical Hold: The team reviewed two Orders for Physical Hold during the timeframe of this incident dated 6/15/13 and 6/17/13. The first stated "recip [recipient] wondering around module with tray. He wouldn't sit down. Staff asked for tray – recip grabbed hot dog and told STA he would 'beat the [explicit] out of you' Recip began to struggle curse and verbally threaten." According to this document, the recipient was placed in a physical hold from 4:25 p.m. to 4:30 p.m. and also indicated no injuries were suspected or observed by staff and none were reported by the recipient.

The second document stated "Rec. was given Emergency Enforced Meds due to his behavior. Rec. continued this behavior and doctor order a PH [physical hold] and then restraints." The length of hold was indicated to be from 10:50 a.m. to 11:00 a.m. The form also stated "Rec [recipient] very non-compliant and uncooperative also very upset during and subsequent to PH." It was again noted that no injuries were suspected or observed by staff and the recipient did not report any.

C. Treatment Plan Reviews (TPRs): The 6/14/13 TPR listed his "problems" as 1: Unfit to Stand Trial (UST); 2: Aggression; 3: Psychosis and 4: Potential for Substance Abuse dating back to 2008. His diagnosis is listed as Axis I: Schizophrenia, Paranoid; Axis II Personality Disorder NOS [not otherwise specified] Antisocial with Paranoid Traits; Axis III No Diagnosis; Axis IV Paranoid: out of touch, aggressive, unpredictable, self-injurious and Axis V as GAF [global assessment of functioning] 40. His current medication is listed as Olanzapine 10 mg for aggression and paranoid delusions. The recipient refused to list his preference for emergency intervention (restraint, medication or seclusion). This was his initial TPR therefore no progress could be reported on his "problems and goals." The recipient attended the meeting but refused to sign the form.

The 7/1/13 TPR stated that he attended his meeting, but was confused about being at Chester and asked for his mom and dad. He also tried to discuss his arrest, acted like he wanted to know but then when the Psychiatrist tried to explain, he said he was done and left the room. In the response to medication section it was noted that he was "in and out of restraints. Made some progress by not being violent all the time."

Finally, the 8/1/13 TPR was also reviewed by the team. The discussion section stated that the recipient attended his treatment meeting. It noted that he has responded well to the medication regime and is able to go to off unit activities and socialize with peers and staff. The problem and goals section indicated that the recipient was on court enforced medications, but was compliant with taking them. Although this section stated that he was showing improvement behaviorally, it also stated that he "had numerous episodes of restraints this period." The recipient signed his TPR and marked the box stating "I am in agreement with my treatment plan."

D. Medication Administration Record (MAR): The June 2013 MAR listed "Emergency Enforced Olanzapine PO [given orally]" twice daily and the recipient was on "crush & observe" to ensure compliance. There was also a note which said "if refuses give IM [intramuscular]." The administration records showed that "emergency enforced medication Olanzapine 10 mg IM for refusal of PO" was given on June 19, 20, 21 and 24. The oral Olanzapine was given every day except June 20 and 21.

The July, 2013 MAR listed orders for "Olanzapine PO [given orally] BID [twice daily]" and also "Olanzapine 10 mg IM [intramuscular] if refuses PO," both court enforced. There were also orders for "Lorazepam 2 mg PO BID" and "2 mg IM if refuses PO". The administration records show that the recipient took both medications as prescribed daily and also required "Olanzepine 10 mg IM STAT" on July 2nd, "Ativan 2mg PO emergency enforced" on July 4th, "Lorazepam 2 mg PO NOW emergency enforced" on July 7th and also received Lorazepam for agitation one time on July 6th. The recipient also had an order for "Olanzapine 10 mg IM PRM [as needed]" which he utilized on July 10 and 14. There was also an order to "Inspect and comb pt's [patient's] hair in am for head lice" on July 5th.

The team also reviewed a Petition for Administration of Enforced Medication dated 6/19/13 which listed the "Observations/Progress Since Admission" as "Patient refused medication; he was aggressive, violent against security staff. Assaulted a security therapy aide causing serious injury to head, neck and face; He was started on enforced emergency psychotropics to control his violence (Olanzapine 10 mg BID; Lorazepam 2 mg); He is quite suspicious, uncooperative and restless; he is clearly psychotic and potential to inflect serious harm to others; other less restrictive interventions has proven unhelpful." A subsequent Court Order for Administration of Authorized Involuntary Treatment dated 7/3/13 was also reviewed which granted the Petition for Olanzapine and Lorazepam to be given to the recipient for 90 days. Another Petition was filed on 9/18/13 and an Order dated 9/18/13 was received which again granted the Petition for enforced medication to be given for another 90 days.

E. Initial Psychiatric Evaluation: The initial evaluation documented that the recipient had been evaluated by the placement team with the Illinois Department of Human Services (DHS) and that they had recommended his placement at Chester due to having a history of physical aggression in jail towards the officers and peers. He was housed in a segregation cell and had been isolated during his incarceration. It was also noted that in jail he was agitated and threatening, refusing to be on psychotropic medications and refused to cooperate with evaluations and jail routine. No significant history of medical illnesses was reported and it was noted that he appeared to be in good health. The recipient was not on any medications at the time of this initial evaluation. The diagnostic impression stated that he was likely "suffering from a mood disorder as he has periods of depression and elated moods…recent changes in his behavior may suggest possible psychotic disorder." The Diagnoses were listed as Axis I: Mood Disorder NOS [not otherwise specified]; Psychotic Disorder; Polysubstance Abuse by History; Axis II: Deferred; Axis III: None; Axis IV Legal Problems and Axis V: GAF [global assessment of functioning] 40. His problem identification and treatment interventions were listed as "unfit to stand trial; engage in educational services and Psychotic symptoms: he is refusing to take medication, but should he engage in aggressive behaviors, he will be started on emergency psychotropic medications and petition may be made for court ordered medication." The fitness statement indicated that there was substantial probability that he may attain fitness within one year.

III...Facility Policies:

A. Chester Policy RI .05.00.00.01 Code of Ethics 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."

B. 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…"

C. 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 the following: 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.

Allegation 3: A recipient is not receiving adequate medical care by not being referred to a dietician to address his request for an increased calorie diet due to hyperthyroidism.

I...Interviews:

A. Recipient: The recipient told the team that he has asked to be referred to a dietician to see if he could get an increased calorie diet due to hyperthyroidism, but he has not received a referral. He said he eats commissary food items when he has money because if he does not he has hunger pains from his hyperactive thyroid.

II. Clinical Chart Review:

A…Infirmary Admission Note: The Infirmary admission note was reviewed by the team. Upon admission, the only medical problem listed was a history of gall bladder surgery. It was also noted that the nutritional survey was completed and a referral was not sent to the dietician as the patient was within his **ideal body weight of 176-216**.

B….Medical Information:

On 6/24/13 a lab panel was taken which showed high glucose 138 (on a scale of 65-110); CPK 242 (on a scale of 21-232); T4 Free 2.5 (on a scale of 0.6-1.7) and low TSH 0.009 (on a scale of 0.35-4.0). A 6/27/13 progress note signed by a physician stated that they will check the recipient's thyroid profile.

On 7/1/13 another lab test was completed showing T4 Free 2.1 (on a scale of 0.6-1.7); TSH 0.03 (on a scale of 0.35-4.0) this lab report also included T4 15.3 (on a scale of 6.1-12.0); T3 Uptake 44.4 (32.0-48.4) and Free Thyroxine Index of 17.0 (on a scale of 5.9-13.3)

On 7/12/13 a referral was made and completed for the recipient to have an EKG "for baseline [illegible] hyperthyroidism."

C. Weight Records: Upon admission, the recipient's weight was 202. His weight was checked again on 6/27/13, 7/3/13, 8/2/13 and finally in September 2013 for his "monthly." His weights were 190, 188, 195 and 210 respectively.

D. Medication Administration Records (MAR): The MAR for June did not list any thyroid medication, however the MAR for July listed Tapazole (Methinazole) 10 mg BID PO [given orally twice daily]. This medication was given twice daily from July, 12th through the end of the month. According to drugs.com, this medication is prescribed to prevent the thyroid gland from producing too much thyroid hormone.

E. Nurses Notes charting intake of fluids and meals was also reviewed by the HRA. The chart reviewed was dated from 6/24/13 through 7/10/13. During the month of June, the recipient was eating from 20%-50% of his meals and refused meals at least 3 times. During this time, he was also given ensure on at least 5 occasions. For the month of July, he ate anywhere from 75%-100% of meals and refused on one occasion. He also received ensure on 11 occasions.

F. Treatment Plan Reviews (TPRs): The 6/14/13 TPR did not list the recipient's thyroid disorder as a "problem/goal" but upon further review, the thyroid disorder was not diagnosed until July's lab tests were done. The 8/1/13 TPR did address his thyroid disorder and indicated that medication had been prescribed and the start date for his goal to "stabilize and maintain thyroid hormone levels within normal range" was started on 7/24/13. The nurse indicated that Propranolol was first prescribed and was being tapered off and he had since been started on Tapazole to address the issue. The nurse was to "monitor his thyroid levels every 4 weeks, document results and notify the medical doctor of any abnormal levels." The treatment intervention also required the nurse to "monitor weight every month, record in his record and send a referral to dietary when needed." His Diagnosis had been modified in this TPR to include "Hyper Thyroid" as an Axis III diagnosis. **There was no mention in either TPR of the recipient voicing concern that he had requested to see a dietician or that the request had not been addressed**.

G. Progress Notes: The progress notes dated 6/14/13 through 8/12/13 were reviewed. The recipient did request Ensure to drink on a few occasions, but there were no case notes to reflect that the recipient ever requested to be seen by a dietician. Most of the case notes were documenting several restraint and seclusion episodes due to physical aggression and also documented meal refusals during this time frame.

III...Facility Policies:

A… Screening, Assessing and Reassessing Nutritional Needs Policy: states that "Whenever a nutritional assessment warrants concern or whenever monthly weight monitoring identifies significant loss/gain, a referral IL462-4030 is to be completed and sent to the dietitian."

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

C. Ordering and Serving Modified Diets Policy: This policy requires that "all modified/special diets must be ordered by a physician. The unit nurse will transcribe the order from the IL 462-0047 Physician's Order Form, and complete the Diet Prescription CMHC-195. In the event a patient requires immediate dietary considerations, the unit RN will assess the patient with respect to these concerns. If special dietary changes are determined to be appropriate, the RN will contact the physician and obtain a written/telephone order. Any modified/special dietary need that is the result of a patient's personal preference request that is not medically warranted must be referred to the patients' treatment team for consideration and approval prior to a physician ordering the special dietary request. The treatment team should consider the patients individual treatment goals and needs prior to approving the diet. If the treatment team approves of the special dietary request, the patient's request will be referred to the dietician for evaluation and recommendation. If the physician feels a special dietary request is needed and documents the justification for the special dietary need, he or she may implement the diet change or request prior to receiving the treatment team's approval."

D. Ordering and Serving Increased Calorie Diets: This policy states that "Chester Mental Health Center utilizes increased calorie diets in order to provide a systematic means for ensuring that a patient receives the additional essential nutrients and calories when ordered by a physician. Any time that it has been determined that a patient requires additional essential nutrients and calorie intake to that which is normally provided and an increased calorie diet has been determined to be the action of choice, an IL 462-0047 Physician Order form shall be completed by the physician ordering such a diet modification."

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

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 Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/7) states that Department facilities are to "…provide the highest possible quality of humane and rehabilitative care and treatment to all persons admitted or committed or transferred in

accordance with law to the facilities, divisions, programs, and services under the jurisdiction of the Department…."

The Mental Health and Developmental Disabilities 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 50.60) 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: A recipient has been denied access to substance abuse treatment during his commitment at Chester Mental Health.

The recipient stated that he had expressed an interest in receiving substance abuse treatment while at Chester Mental Health. However, at the time of his commitment, the only substance abuse treatment that Chester offered was individual therapy sessions. Chester administration explained to the HRA that they were in the process of obtaining, and eventually did hire, additional therapists that would be trained in substance abuse treatment. At the time of this report, Chester had scheduled their first group substance abuse meeting.

According to the recipient's treatment team, which included his therapist, he was not stable enough to focus on substance abuse issues at that time and the TPR (treatment plan review) indicated that it would be addressed at a later date. The recipient signed his TPR indicating agreement with his treatment plan. The HRA found no case notes or documentation of this being discussed during his treatment plan meetings or the recipient voicing any concern over substance abuse groups not being offered. Chester policy requires that all issues, including substance abuse, be addressed in treatment planning. This recipient's TPR did list substance abuse as a "problem" but also indicated he was not stable enough to focus on it at that time and

that his main goal was attaining fitness for court. Therefore, the HRA finds that this allegation is **unsubstantiated.** The HRA does take this opportunity to share the following suggestions:

1. Ensure that recipient requests for specific types of treatment are documented and addressed in the treatment plan.

2. Ensure that secondary needs/issues such as substance abuse issues are addressed when priority needs are stabilized.

Allegation 2: Negative staff interactions and inadequate OIG process (a report was filed but no investigation occurred).

The HRA reviewed the OIG investigative report of the alleged incident as well as envelopes that were returned to the OIG showing that they attempted to contact the recipient to provide him with the outcome to the investigation. Therefore, that portion of this allegation is **unsubstantiated.**

The recipient also alleged that around September, 2013, a nurse put him "in the quiet room" when he asked to be checked for head lice and told him that he "was a burden to staff." The HRA found several incidents of restraint and seclusion documented in his chart due to aggressive behavior. The HRA also found an order on his medication administration record indicating that in July, 2013 he was checked for head lice. The HRA found no OIG report for an allegation of mental abuse and no documentation in case notes or TPRs indicating that he had a problem with a nurse or was put in seclusion for an inappropriate reason.

The OIG had conducted an investigation regarding his other allegation that a STA elbowed his throat and made threatening statements to him, however that allegation was unfounded due to no documentation of any injuries at that time and also due to the length of time between the alleged incident and the date it was reported to OIG. The HRA also looked for similar documentation in medical records and case notes and instead found documentation indicating that the **recipient** made the statement to the STA that he had accused the STA of making to him. According to this document, the recipient was placed in a physical hold from 4:25 p.m. to 4:30 p.m. and it was noted that no injuries were suspected or observed by staff and none were reported by the recipient. Therefore this portion of the allegation is **unsubstantiated.**

Allegation 3: A recipient is not receiving adequate medical care by not being referred to a dietician to address his request for an increased calorie diet due to hyperthyroidism.

The recipient alleged that he had repeatedly asked to see a dietician and that Chester never honored that request. Upon admission in June, he was within his ideal body weight and it wasn't until lab results came back in July that he was diagnosed with hyperthyroidism. The thyroid issue was documented and addressed in his next TPR. The plan was to treat his hyperthyroidism with medication. The nurse was instructed to monitor his weight and notify the medical doctor of any significant changes including weight loss and that a referral would then be made to the dietician. The recipient's weight records document that he never dropped below his

ideal body weight to warrant a referral to a medical doctor and then a dietician. It was indicated in case notes that the recipient was given Ensure as a supplementary drink when he requested it or refused meals. Chester policy states that weights are checked at least monthly and referrals are to be made when someone drops below their ideal body weight. Policy also requires that modified diets must be ordered by a medical doctor and that "any modified/special dietary need that is the result of a patient's **personal preference** request that is **not medically warranted** must be referred to the patients' treatment team for consideration and approval prior to a physician ordering the special dietary request." None of the TPRs indicated in the discussion section that the recipient requested a modified diet and the recipient signed his TPR indicating agreement. Therefore, the HRA finds that this allegation is **unsubstantiated.** The HRA offers the following **suggestion.**

1. When a recipient has medical issues relating to his diet such as hyperthyroidism in this case, the treatment team should initially discuss the diagnosis and document such discussion in the TPR explaining to the recipient the diagnosis as well as Chester policies regarding modified diets that might be pertinent.