FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
14-110-9012
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 (CMHC), a state-operated mental health facility located in Chester. The facility provides services for approximately 240 recipients serving both forensics and civil commitments. The specific allegations are as follows:

1. **A recipient is receiving inadequate treatment.**
2. **A recipient was placed in seclusion based on false information.**
3. **A recipient's property was restricted without a legitimate reason.**
4. **There is an inadequate OIG investigative process of staff abuse.**
5. **Unsanitary living conditions exist at the facility.**

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2) and the Illinois Administrative Code (59 Ill. Adm. Code 110).

To investigate the allegations, the HRA investigation team consisting of two members and the HRA Coordinator conducted a site visit at the facility. During the visit, the team spoke with the recipient whose rights were alleged to have been violated and the Chairman of the facility's Human Rights Committee (Chairman). With the recipient's written authorization, copies of information from the recipient's clinical chart were reviewed by the Authority. Facility policies relevant to the complaints were also reviewed.

Allegation 1: A recipient is receiving inadequate treatment.

This allegation involves a recipient receiving inadequate treatment by not being allowed to see his therapist for 7 weeks. It was also alleged that false reports were being filed with the court which inappropriately kept the recipient at Chester on UST status.

I. Interviews:

A. Recipient: The recipient informed the HRA that he had not seen his therapist for 7 weeks. He also said that his psychiatrist stated that he remains unfit to stand trial (UST) even though he passed his fitness test in September, 2013 with a 100% score and therefore felt that the reports filed with the court stating he is still UST were false. The reasons given to him by the treatment

team for his continued UST status were that he was uncooperative with his lawyer and that he made delusional statements by stating that he is innocent of his charges. The recipient stated that he tries to communicate with his lawyer on a regular basis but the attorney is always in court when he is allowed to make calls, therefore he cannot speak directly to him and can only leave messages with the secretary.

II. Clinical Chart Review:

A…Forensic Pre-Placement Evaluation – The 7/10/13 evaluation stated that in jail, the recipient had been housed on the medical unit in administrative segregation due to his "unstable clinical condition." He had refused neuroleptic medication and there had been no reported episodes of threats or physical aggression towards others. He was cooperative with staff redirection and with following the daily routine. His diagnosis only contained information under Axis I which was "Mood Disorder, with psychotic features; Asperger's Disorder; Learning Disorder, NOS; Polysubstance Abuse...In remission in a controlled environment." His orientation was listed as "person, place and time, but delusional about his current legal situation." His Thought Disturbance was listed as "Paranoid delusions, persecutory delusions and grandiose delusions. He states that he has recorded music with many music celebrities." His recommended placement was listed as "Chester MHC (medium secure). Reason for Placement: He is appropriate for a medium secure forensic inpatient treatment program. There have been no reported episodes of threats or physical aggression towards others. He has been cooperative with staff redirection and the daily routine."

B. Psychiatric Evaluation: This initial evaluation was completed by a psychiatrist at CMHC and stated his reason for admission was his legal status of Unfit to Stand Trial (UST) for threats to a public official. He was transferred from jail due to his being housed on the medical unit in administrative segregation "due to his unstable clinical condition. He has no peer contact. He has consistently refused medication. [Recipient] exhibits paranoid and grandiose delusions. He states that he has recorded music with many music celebrities." The personal and social history noted that he had studied music recording and worked as an intern with a record label. His employment history included working independently with musicians and working at a pizza restaurant. The evaluation also noted that the recipient had not exhibited any threatening or physically aggressive behavior in jail. His diagnoses were listed as "Axis I: Mood Disorder, NOS [not otherwise specified] Psychotic Disorder, NOS (provisional), R/O delusional Disorder of the persecutory type, Asperger's Disorder by history, Learning Disorder, NOS, Polysubstance Abuse in remission in a controlled environment; Axis II: Personality Disorder NOS) Paranoid, passive/aggressive, and immature traits); Axis III: Deferred; Axis IV: UST status, Confinement, Adoptive Child Background Substance Abuse, Medication Noncompliance and Axis V: Current GAF [global assessment of functioning] 50."

C. Treatment Plan Reviews (TPRs):

The 9/6/13 TPR was for his initial treatment planning meeting. The *discussion section* stated that he correctly answered questions relating to placement and legal charges but made an allegation that "he was being spied upon." The recipient denied any previous charges other than driving under the influence, but no allegations of being violent. He also relayed history of being

in a drug rehabilitation program due to being over medicated. He stated he does not have a mental illness and will not take another pharmaceutical medication again. He believes the judicial system is very political. At the time of admission, the recipient was not taking any psychotropic medications. The *"problem" section* listed the following problems as a focus of his treatment plan: UST, Aggression, Psychosis, and Potential for Substance Abuse. The TPR form was signed by his coordinating therapist, psychiatrist, a medical doctor and two social workers. The recipient signed his treatment plan.

The 10/21/13 TPR noted that the recipient had taken the UST pre-test and scored 100% and that he would be referred to UST classes with progress being reported after the 21 day treatment plan. The recipient had not displayed any unreasonable anger issues and had been compliant behaviorally therefore he was on the "green level." This TPR noted that his mother had been in contact with the facility and that she was also his legal guardian. It was also noted that she had spent one week with the recipient visiting him every day. The "psychotic Symptoms" *problem section* stated that the Psychiatrist was to evaluate the recipient to determine the need for prescribed medication and it was noted that the recipient "denies mental illness and need for psychotropic medications. No progress. Can't plan or execute actions." The therapist was to monitor his mental status in sessions and she noted that "Patient's cognitive functioning has been free of delusional thought and hallucinations. However, the patient still displays poor insight into his legal situation. He understands the legal terms but he fails to grasp the significance of his behavior in relationship to the law." To address *the potential for substance abuse*, the therapist was to provide 1:1 therapy sessions. It was noted that "the patient vigorously denies having a substance abuse problem. The patient has been treated for substance abuse." The *Criteria For Separation* section stated that to be recommended for return to the county jail as fit to proceed, he had to "be able to communicate with counsel and assist in his own defense, be able to appreciate his presence in relation to time place and things; be able to understand that he is in a court of justice charged with a criminal offense; show an understanding of his charges and their consequences as well as court procedures and the roles of the judge, jury, prosecutor and defense attorney; have sufficient memory to relate the circumstances surrounding the alleged criminal offense and demonstrate that there has been a significant reduction in his aggressive behavior." It was noted that he was considered unfit to stand trial at that time but was likely to achieve fitness within one year from the original date of unfitness. The recipient's signature was not on this document.

At his 11/18/13 TPR it was noted in the *discussion section* that the recipient had passed the pre-test for fitness, is cooperating with his private attorney, but is unwilling to take his advice. The recipient wants to speak in court and his attorney questions whether that is in his best interest. The recipient sincerely believed that his computer was hacked and there has not been a proper investigation into that matter. It was noted that that is one of the obstacles to his fitness and also his refusal to acknowledge that he does have a mental health issue. The other sections in this TPR stated verbatim what the 10/21/13 TPR stated. The recipient signed this TPR.

A different therapist was listed on the 12/19/13 TPR. The *discussion section* stated that the recipient attended and participated in the discussion. The recipient "continues to refuse to consider taking psychotropic medication. He has no insight into his condition or his situation. He exhibits paranoid ideation and insists that he has been framed for his threats to a Public

Official charge." It was noted that the recipient "is able to demonstrate a fairly good understanding of court procedure and the roles of the courtroom personnel…participated in individual fitness instruction with his therapist." His behavior had continued to be appropriate but did note that he had "frequent problems with using the patient phone too much and getting into disputes with other patients about the phone." However it was noted that he remained on "green level." It was stated in the *psychotropic symptoms* section that the recipient denies his mental illness and need for medications and was not on psychotropic medication and would not agree to try it. In the *family contact* section it noted that his mom had been in constant contact and had discussed with the therapist the need for the recipient to be on some kind of psychotropic medication, however at the time of the TPR, the recipient had not "decompensated enough to warrant court enforced medications." The recipient signed this TPR.

Another change in therapist was noted in his 1/16/14 TPR. The *discussion section* stated that the recipient attended and participated in the meeting, but "has trouble listening to the recommendations without constantly interrupting…As meeting progressed he got more angry and tense. He was offered medication for his mood and to assist in becoming fit. He ended the meeting by saying that the team was 'using drugs as blackmail.'" In the UST problem section it was noted by the coordinating therapist that the recipient "scored 100% on the UST fitness test. At this time he does not show he can cooperate with counsel or the court and does not show a rational understanding of his charge." It was noted that he had been referred to group fitness education. The October and November TPRs had also stated that he would be referred to fitness classes and the December TPR stated he had participated in individual fitness instruction with his therapist. The therapist also noted that "he has not displayed any unreasonable anger issues and overall has been compliant behaviorally. He does make demands on staff and argues frequently with peers and staff." The psychiatrist noted that he was still refusing medications therefore, no progress was noted and stated that the recipient "continues to remain as very uncooperative, argumentative and irrational. He is hostile, belligerent and tends to become paranoid." The recipient signed his TPR.

Finally, the 2/5/14 TPR stated that he attended and participated. The team discussed the reasons he is unfit and noted that the recipient "seems to be more receptive to discussing this." It was noted that he would be starting UST fitness group this week and that he was encouraged to focus only on courtroom issues not trying to defend himself or to get on other topics. The psychiatrist had added to his statement regarding his psychotic symptoms by stating "His overall understanding of his charges has not changed. He also concretely believes that he is fit because he passed the fitness test. He is argumentative about his charges." The recipient signed his treatment plan.

B. Medication: The HRA reviewed the medication administration records for October through December, 2013 and found no orders for any psychotropic medication or any PRN [as needed] or emergency medication being administered.

C...Progress Notes: The recipient was admitted on 8/30/13. The first case note from the social worker/therapist was dated 9/11/13 which stated that she met with the recipient to complete the personal safety plan and to place a call to the county jail that he was transferred from to discuss money in his account there. It was also noted that the recipient completed the UST Pre-test and

scored 100%. The next note from the therapist was on 9/12/13 stating she had spoken to the jail and worked out the money issue and the "patient would be notified." The next note was dated 9/16/13 and stated that the therapist had received a call from the recipient's mother informing her that she was his legal guardian. It was noted that up until that point, the therapist was unaware that he had a guardian. On 9/17/13 there was another therapist note documenting a conversation with the recipient's mother regarding what property he can and cannot have. A 9/18/13 therapist note states that she met with the recipient on that date to go over rules and practices of the unit and also noted that they spoke in length about his current legal case. On 10/10/13 the therapist entered a case note documenting that she had met with the recipient and had a "lengthy conversation" regarding his upcoming court date and the therapist answered questions regarding how long it would be before he was able to return to court. On 10/18/13 the therapist's note indicated another meeting with the recipient where they discussed his game boy and the recipient's attorney and legal strategy. The next case note was on 11/14/13 stating that the recipient and therapist met and he was given his Nintendo game. They discussed his feeling anxious about leaving CMHC and his feeling that he is being held unfairly and illegally. The recipient had little to no confidence in his legal representation and then became upset with the therapist when he was told that as it stands now he is still not fit to stand trial and he asked to speak with the psychiatrist about his legal status. Approximately 20 minutes later on this same date, the therapist documented receiving a call from the recipient's guardian/mother expressing concern that he was making delusional and paranoid statements and she expressed an interest in him receiving medication. It was explained that he did not meet the criteria for enforced medication and would have to significantly decompensate in order to be medicated. It was also noted that the recipient "has managed to tightly control his overall behavior." She also asked to speak with the psychiatrist to "possibly strategize a plan to get the patient medicated."

A 2/13/14 therapist note was reviewed which documented a change in therapists for the recipient. On that date, the new therapist met with the recipient and was given a paper that contained comments about him written by a peer. She submitted that paper along with an information report. A 2/21/14 therapist note documents another meeting with the recipient and stated that he has been cooperative and has had no physical aggression since his admission. It also stated he seemed to have a better understanding of the reason he is UST.

III...Facility Policies:

The HRA questioned administrative staff at Chester regarding policies relating to how often a patient is required to see his therapist when undergoing treatment at the facility. The HRA was told that there is not currently a policy which determines or addresses how often a patient should meet with his therapist. The therapist or the treatment team members had been deciding that based on the patient's needs. However, the HRA was also informed that Chester is in the process of adopting the Center for Medicare and Medicaid Services (CMMS) required timeframe that most other hospitals follow. Previously, CMHC did not have this policy because they are not CMMS certified and were not bound to those requirements so it has always been based on individual patient needs. CMHC is, however, going to move toward the CMMS requirements by choice and once those requirements are put into place, the schedule would be as follows: a minimum of once per week meetings with the therapist for the first eight weeks and then once per month after that until discharge.

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…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."

Summary

The allegation was that a recipient had not seen his therapist in 7 weeks. However, the HRA found case notes in his chart from the therapist documenting where she had met with him on 9/11/13, 9/18/13, 10/10/13, 10/18/13 and 11/14/13. The longest time period in between therapist visits was 4 weeks, not 7 weeks as stated in the allegation. The CMHC did not have a policy in place stating how often a therapist is required to meet with patients and there is nothing in the TPRs stating specifically how often the therapist would meet with him, only that the therapist would "evaluate to determine what is needed to achieve fitness…provide anger management skills and assistance in following module rules…encourage the patient to understand the need to take medication in efforts to alleviate symptoms if deemed necessary and provide 1:1 to address his potential for substance abuse." The TPR also documented that the recipient had "participated in individual fitness instruction with his therapist."

Conclusion

Since the recipient was able to meet with his therapist at least once a month and there was no policy in place governing how frequently a therapist should meet with a patient, this allegation of inadequate treatment is **unsubstantiated**. Since CMHC administration advised the HRA that they are in the process of adopting the CMMS required timeframes that most other hospitals follow, no further suggestion is offered at this time.

Allegation 2: A recipient was placed in seclusion based on false information

I...Interviews:

A. Recipient - According to the recipient, he was put in seclusion for 4 hours and in his bedroom for 24 hours due to a Security Therapy Aide (STA) "accusing" the recipient of cussing and threatening him. The recipient denies this allegation and says that it was actually the STA who cussed at him. He stated that his therapist and "7 or so STAs" came into the recipient's room and called a "code red" and stated that there were 5 witnesses who were all STAs that saw the recipient cuss and threaten the STA and therefore he "was forced into the seclusion room." The recipient contends that he was just "asking about watching a Bears game" and staff refused to

change the channel and he made the statement that "it must suck to be your kids." The staff then "wrote him up" for making threats against this STA's daughter.

II. Clinical Chart Review:

A. Seclusion Records: The HRA reviewed a restraint/seclusion order which matched the description of the incident described by the recipient. It stated that he became upset and agitated over the TV channel and when he was redirected to his room, he began slamming the door and was counseled. He then became verbally threatening, agitated and verbally aggressive so emergency preferences were utilized. The recipient's preferences were listed respectively in order of preference as seclusion, restraint and medication. The interventions noted before seclusion were listed as redirection, distraction and verbal support. He was placed in seclusion at 12:25 p.m. and released at 3:15 p.m. The restraint/seclusion flowsheet documented 15 minute checks throughout the duration of seclusion. The seclusion review form signed by the registered nurse (RN) hourly stated that at the first review he was easily agitated over discussion of the incident, voice level increased and speech was rapid; at the second review he denied any wrong doing and was easily agitated with discussion of the incident; the final review documented that he was calm and stated he would be cooperative with staff. "No acute signs of anger or agitation. Meets criteria for release." The post episode debriefing form documented that the recipient stated that he understood that "it was a disagreement over the TV…I realize everyone else wanted to watch something else…they need to have more than one TV…I can just go to my room…I don't really like it." It also documented that one hour post episode, the recipient showed no signs of physical or psychological effects from being in seclusion and stated "I'm fine."

B. Progress Notes: A 9/8/13 nursing note stated that the recipient "walked to seclusion after becoming upset agitated and threatening over TV channel. Pt [patient] directed to room, was slamming door, he then came out verbally threatening. Seclusion utilized as 1st preferences as indicated in chart. 0 [no] physical hold was necessary. Dr [names] notified…" A STA note this same date stated that the recipient was "slamming his room door and cursing and threatening staff." A PRN [as needed] medication was offered but refused. It stated that the recipient continued to threaten and curse at staff. Seclusion was offered per recipient's first preference. The MD note that same date corroborated the previous notes stating that the recipient was slamming his room door, cursing and threatening staff and seclusion was initiated. None of the case notes stated specifically what type of threats or statements were made.

C. Nursing Summaries: The nursing summary for the period of 9/5/13-9/12/13 noted that the recipient was in seclusion one time during the review period due to being "unable to handle his feelings, slamming door and making threats." The remainder of the September summary stated that he had no problems or behaviors documented and again noted his emergency preferences as seclusion, restraints then medication. The November summary stated that the recipient was "often demanding and uncooperative with facility and module rules…remains delusional and paranoid." The December summary noted that the patient was "very argumentative, demanding…consistently pushes the rules and boundaries of facility and module rules."

III. Statutes

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-109) states that "Seclusion may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. In no event shall seclusion be utilized to punish or discipline a recipient, nor is seclusion to be used as a convenience for the staff. (a) Seclusion shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, clinical professional counselor, or registered nurse with supervisory responsibilities. No seclusion shall be ordered unless the physician, clinical psychologist, clinical social worker, clinical professional counselor, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of seclusion is justified to prevent the recipient from causing physical harm to himself or others. In no event may seclusion continue for longer than 2 hours unless within that time period a nurse with supervisory responsibilities or a physician confirms in writing, following a personal examination of the recipient, that the seclusion does not pose an undue risk to the recipient's health in light of the recipient's physical or medical condition. The order shall state the events leading up to the need for seclusion and the purposes for which seclusion is employed. The order shall also state the length of time seclusion is to be employed and the clinical justification for the length of time. No order for seclusion shall be valid for more than 16 hours. If further seclusion is required, a new order must be issued pursuant to the requirements provided in this Section. (b) The person who orders seclusion shall inform the facility director or his designee in writing of the use of seclusion within 24 hours. (c) The facility director shall review all seclusion orders daily and shall inquire into the reasons for the orders for seclusion by any person who routinely orders them. (d) Seclusion may be employed during all or part of one 16 hour period, that period commencing with the initial application of the seclusion. However, once seclusion has been employed during one 16 hour period, it shall not be used again on the same recipient during the next 48 hours without the prior written authorization of the facility director.
(e) The person who ordered the seclusion shall assign a qualified person to observe the recipient at all times. A recipient who is restrained and secluded shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. (f) Safety precautions shall be followed to prevent injuries to the recipient in the seclusion room. Seclusion rooms shall be adequately lighted, heated, and furnished. If a door is locked, someone with a key shall be in constant attendance nearby. (g) Whenever seclusion is used, the recipient shall be advised of his right, pursuant to Sections 2-200 and 2-201 of this Code, to have any person of his choosing, including the Guardianship and Advocacy Commission notified of the seclusion. A person who is under guardianship may request that any person of his choosing be notified of the seclusion whether or not the guardian approves of the notice. Whenever the Guardianship and Advocacy Commission is notified that a recipient has been secluded, it shall contact that recipient to determine the circumstances of the seclusion and whether further action is warranted"

Summary

The allegation was that the recipient was placed into seclusion based on false information. The recipient contends that his statement "it must suck to be your kids" was mistakenly interpreted as a threat against a staff member's family which was the reason he was

put into seclusion. The chart documentation indicated that the recipient was "slamming doors and making threats" therefore, his first emergency preference, seclusion, was utilized.

Conclusion

Since the case notes did not document specifically what verbal threats were being made, it was difficult for the HRA to determine if the recipient's account of what was said was accurate or misunderstood. However, it was documented by different staff members that the reason for seclusion was the fact that he slammed his bedroom door and was verbally aggressive. The post-episode debriefing also noted that the recipient understood why he was in seclusion and that he showed no signs of physical or psychological effects and stated that he was fine. Therefore, the allegation is **unsubstantiated**. The following suggestion is made.

1. When it is necessary for emergency preferences to be utilized, staff should document what specific threats are being made or what physically aggressive behavior is occurring rather than making general statements such as verbal threats or acting aggressively.

Allegations 3 and 4: A recipient's property was restricted without a legitimate reason and there was an inadequate OIG investigative process of staff abuse

I. Interviews:

A. Recipient - The recipient informed the team that he had filed several reports through both the internal complaint process through the Human Rights and Ethics Committee (HREC) and the Office of Inspector General (OIG) however, he was not questioned promptly regarding the allegations. He said that he had completed approximately 20-30 complaint forms involving allegations of abuse, inquiries as to why he is still UST, telephone access, property restrictions (adult magazines) and unsanitary living conditions. One complaint involved another recipient (recipient 2) being abused on his unit. The recipient called the OIG and they took down the information, but no one ever came to speak with him. He has asked for copies of his complaints to ensure that the OIG received them, but stated he never received any. The recipient also stated that his therapist told him he "would never get his adult magazines back" and that an STA made the statement that he deserved to have his magazines taken because he had so many and that he got himself into this mess by reporting it and stated that he deserved to be on red level.

B. Recipient 2 – The HRA questioned the recipient named as the victim of abuse on his unit. He informed the HRA that 1½ - 2 weeks ago he was questioned about 5 staff members "jumping on him" but he said that never happened. He said there are 2 other recipients with the same last name as him but both have been released. He said it was possible that one of them could have been the subject of the investigation, but he is not sure. The HRA asked if he had witnessed any abuse on his unit by staff members and he replied that he has not.

C. Chairman - The HRA also questioned the Chairman of the Human Rights and Ethics Committee (HREC) to see if he had received complaints from this recipient. He said that he had received a few but not the amount as reported to the HRA by the recipient. The Chairman agreed to look into the matter and later informed the HRA that he did eventually receive all of the complaint forms.

II. Chart Review

A. Information Report- The HRA reviewed an information report completed by the HREC Chairperson dated 2/7/14. The report stated that on 2/6/13 he received 23 copies of human rights complaint forms from this recipient and also noted that the complaints were from the timeframe of November, 2013 through December, 2013. It also stated that the recipient "alleges that the complaint copies were in a bag with other personal property (men's magazines) in his therapist's office since his 12/23/13 shakedown. [Recipient] states the original complaint forms were submitted during the respective timeframes according to CMHC [Chester mental health center] policy. The Human Rights Committee received none of the original complaint forms. On 2/7/14 the complaints were processed." The report then listed the specific complaints that required OIG reporting. Those listed included the following:

- 11/26/13 allegation of mental abuse when a staff acting as the "mailman" made a derogatory remark about the adult magazines he received in the mail;
- 12/20/13 allegation of theft (2 adult magazines);
- 12/23/13 allegation of theft (2 more adult magazines) and mental abuse involving a staff allegedly saying "you deserve to have your magazines stolen";
- 12/23/13 allegation of theft which occurred on 12/22/13 or 12/21/13 (2 adult magazines, receipts, bank statements, phone card number, credit card number and copies of human rights written complaints);
- 12/23/13 allegation of theft (a rosary and all adult magazines) after a room search;
- 12/26/13 allegation that a 12/18/13 complaint was never received by the HREC and included an allegation of mental abuse in which a STA said "I hope you choke on it [candy] and die."
- 12/30/13 allegation that the recipient is not receiving confirmation that HREC complaints are being received;
- 12/30/13 allegation of property destruction (Playboy business card) on the basis of it being restricted.

The report concluded with a statement that the recipient's chart was reviewed and "one restriction of rights was written on 12/23/13 for 'patient may not have pornographic material due to allowing other patients to view magazines.' ROR [restriction of rights] form stipulates that material will be stored in personal property. ROR form indicates that 'individual wished no one be notified of this notice' However, [Recipient's] mother is his guardian. There was no evidence discovered that indicates the guardian was notified."

B. Complaint Forms – The HRA reviewed 31 HREC complaint forms completed by the recipient. The complaint allegations ranged from mental abuse, verbal threats, inaccurate

diagnosis, telephone use and restriction of property (adult magazines). The complaints allege that staff members either ignore his complaints or tell him he deserves to have the things happen to him. Per the HREC chairman, those complaints that were appropriate for an OIG investigation were forwarded to the OIG.

C. Memo dated 3/20/14 - The HRA questioned the HREC Chairman as to what action was taken when it was discovered that the complaint forms were not received by the HREC in a timely fashion. A copy of a memo from the HREC Chairman to the Therapist was provided and reviewed by the HRA. This memo summarized that the restriction began on 12/23/13 when the recipient gave some "adult magazines" to another recipient "as a gift" and that a room shakedown resulted from this infraction along with a restriction of property and a level drop (Chester operates on a level system for behavior, red level for behavioral infractions and restrictions, green level when a recipient is following rules and has had no infractions.) This memo also noted that the recipient's legal guardian was not notified of the restriction "for a significant amount of time" and that his HREC complaints "were intercepted and egregiously delayed." This memo also noted that this recipient was "initially assessed as a medium patient and as such would have been afforded a daily review of his level and this infraction would have been met with verbal redirection of behavior only." As of the date of this memo, it was noted that the recipient's property restriction continued with an additional 30 days restriction being renewed on that date. The Chairman stated that he had also recommended to the Therapist via email on 2/25/14 that limited access to the adult magazines be reintroduced to the recipient "in order to truly determine if he can abide by the unit rules." The HRA confirmed in his forensic pre-placement evaluation that his recommended placement was "Chester MHC (medium unit)." However, his date of admission to CMHC was 8/30/13 and the medium unit did not open until 3/3/14 so he was admitted to a maximum secure unit. At the conclusion of the HRA's investigation, the recipient was still residing on the maximum secure unit.

D. Restriction of Rights Forms – The HRA reviewed restriction of rights (ROR) forms dated 12/23/13, 1/21/14 and 2/20/14. The restriction of rights form for the period of 12/23/13 to 1/23/14 indicated that "patient may not have pornographic material due to allowing other patients to view magazines (will be stored in personal property)." The form stated that the restriction is "to be reviewed weekly" and a box next to "individual wished no one be notified of this Notice (Exception: Guardian must always be notified)" was marked. The Therapist and Facility Director both signed this form. The ROR form for the period of 1/21/14 to 2/21/14 stated the reason for the restriction verbatim as the previous ROR form had described. It again stated that the restriction was to be reviewed weekly by the treatment team. The same box was marked stating he wished no one to be notified and the form was signed by both the Therapist and Facility Director. The final ROR form reviewed was for the period of 2/20/14 to 3/20/14 and was identical to the previous two forms, with the exception of the timeframes for the restriction being updated. This form was also signed by the Therapist and Facility Director.

The HRA was informed that as of March 26, 2014 the recipient had received all or most of his property, including the adult magazines.

E. OIG Reports

The HRA reviewed 6 OIG reports dated from December, 2013 through March, 2014. The first complaint that was investigated alleged an incident of mental abuse that was received on 12/19/13. Specifically, that a STA stated to the recipient that "he hoped he would choke and die on candy he received in the mail." That allegation was unsubstantiated due to the STA accused denying the allegation, another STA denied hearing the comment being made and the unit manager stating that there was a "very argumentative" exchange between that STA and the recipient during that timeframe, but there was no mention of any threats. This specific incident matched the 12/26/13 incident included in the list from the HREC of cases that were referred to the OIG for investigation.

The next complaint the OIG investigated was received on 1/31/14. This mental abuse allegation involved another STA and alleged that the STA took three bags of chips belonging to the recipient and threw them in the garbage. This allegation was unfounded due to the fact that the STA said he found the chips and attempted to find the owner but when he could not, they were placed in the nurse's station. The chips were given to the therapist so she could review the rules with the recipient and return the chips. No one observed the chips in the garbage can and there was no evidence on the facility video recording. This complaint also did not match any of those included in the list from the HREC of cases that were referred to the OIG for investigation.

Another complaint was received on 2/7/14 and alleged mental abuse involving the STA in the 12/19/13 report. The allegation was that this STA called the recipient a "sexual predator" and also repeated the allegation that the statement "I hope you choke…and die on candy" was made. This complaint was unsubstantiated and it was noted that this allegedly occurred on 12/18/14.

The fourth complaint was reported on 2/7/14 and alleged neglect in that another STA did not intervene when a recipient made a verbal threat to this recipient allegedly occurring on 11/30/13. This allegation of neglect was unfounded due to a statement made by the accused STA stating that another recipient chased this recipient but that staff intervened**. It was noted that the recipient did not report the incident in a timely manner which denied the investigator the ability to collect timely evidence including a video recording to support or contradict the allegation.**

The fifth complaint was received on 2/25/14 and involved an allegation of mental abuse in that a STA allegedly made a threat that if the recipient returned to Chester he would be shot. This allegation was unfounded due to the STA denying that he made the statement as well as another STA who was present on the shift. The OIG also reviewed behavioral data reports that were written on that day stating that the recipient was using profanity and threatening staff members. This did not match any of the complaints included in the HREC list of those turned over to OIG.

The final complaint reviewed was received on 3/7/14 and alleged mental abuse involving a social worker who allegedly made inappropriate comments about the mail the recipient received. This incident allegedly occurred on 2/28/14. This allegation was unfounded due to the fact that the social worker denied making the statement and the unit manager also denied hearing the comment. It was also determined that the recipient had a restriction of rights at that time concerning the possession of pornographic magazines which is why he was being monitored when opening mail. This complaint did not match any of those listed in the HREC's list of complaints turned over to OIG.

The HRA requested a list of OIG complaints that were received that involved this recipient for the timeframe of November and December, 2013. The facility investigator provided a list of complaints that were dated 1/31/14 through the present time and totaling 18 complaints of which 12 were determined to be "non-reportable" by the OIG intake and 6 were opened for investigation. Of the 6 cases that were opened, 2 investigations had been completed at the time of this report, both were unfounded.

A letter dated 2/3/14 from the recipient to the HREC chairperson was also reviewed in which the recipient was requesting copies of his complaint forms, psychiatrist tests, treatment plan reviews (TPRs), disciplinary reports and also requesting that copies be sent to his mother who is his legal guardian. The HRA inquired with the HREC Chairperson who stated that he had been trying to resolve the recipient's request to receive the chart copies since February and had just received acknowledgement that staff were in the process of complying (as of 4/8/14).

III. Facility Policies

Reporting and Resolving Complaints Policy RI.03.03.00.01 states "It is the policy of Chester Mental Health Center that patients, families, significant others, and other interested parties have open recourse and opportunity to identify and resolve concerns and complaints concerning treatment, other services, or conditions at Chester Mental Health Center." The policy explains that abuse, neglect, financial exploitation or sexual abuse will be reported to the OIG. For non-OIG complaints the unit manager is to attempt to address all complaints for corrective action. The levels of resolution are listed as follows: recipients are encouraged to address concerns with unit personnel first; staff receiving complaints will attempt to resolve the complaint at the unit level with the involvement of the treatment team, unit leadership and the unit quality council if indicated; if the complaint is not addressed or resolved within 3 days, the recipient is encouraged to file a HREC complaint form. The complaint form is sent to the quality assessment and improvement (QA&I) office and **within 2 days** the QA&I will deliver a written acknowledgement that the complaint has been received. The policy outlines which complaints are sent directly to the hospital administrator and which complaints are sent to the HREC to review, investigate and make recommendations for a resolution to the complaint. **Within 5 days of receipt**, the HREC should conduct an initial review including an interview with the recipient. After the initial review, the reviewer will close the complaint as invalid, resolve the case or refer it to the full committee membership for further review. If referring to full committee for review, the complaint is either closed as

resolved or invalid, forwarded to the unit director for further action or forwarded to the hospital administrator. **Within 10 days of receipt**, the unit director or hospital administrator will forward their findings back to the HREC for closure as resolved or if the committee disagrees with the findings, a meeting can be scheduled and must take place within 10 days. After conclusion of the case, the original complaint is filed with the HREC and copies are furnished to the unit director and complainant.

Policy RI .01.01.02.01 Patient Rights details the procedure for restriction of rights. For non - emergency restriction of rights "A restriction of a patient's rights should be based on clinical assessment of the patient and/or the situation. A Notice Regarding Restricted Rights of Individuals (IL462-2004M) will be issued to restrict the patient's rights. If any of the patient's rights as described in Section I. of this procedure are restricted then a Restriction of Rights of Individuals (IL462-2004M) will be initiated. This includes when a patient is restrained, secluded and/or subject to a physical hold. The Unit Director or designee will ensure that the initiation of the restriction is reported, discussed, and approved at the Facility Morning meeting. When a Restriction of Rights is implemented and reviewed by the treatment team – emergency or non-emergency they will ensure the restriction form is approved and signed by the Facility Director or designee. When the Restriction of Rights involves mail, access to the patient's room, or telephone, the form IL 462-2004M must be signed by the Facility Director or designee prior to initiation of the restriction…All patients have the right to their personal property. If the patient's clinical condition warrants removal of personal property or limiting access to specific personal property then it will be considered a restriction…If a patient is restricted from accessing his personal property, a restriction of rights has to be issued. The notification of the restriction must indicate where his property will be stored during the restriction and whether or not he will be allowed access to it. If a patient's access is limited in any way to communication tools, for example; supervised pencil use and supervised calls, a restriction of rights must be given to the patient."

Security/Privileging on the Medium Security Unit Policy EC.04.01.00.01 defines the medium security forensic facility as "A facility within DHS where forensic patients have been found Unfit to Stand Trail (UST), Extended Unfit to Stand Trial (UST EXT), Not Guilty by Reason of Insanity (NGRI), or Not Not Guilty (NNG) by the court system and are sent to a DHS facility to address their fitness or treatment needs. Patients designated to be sent to a medium security unit do not meet the Red Flag Criteria for consideration of Maximum Security Placement." The policy states that "The Medium Security Unit at Chester Mental Health Center will function and operate as a separate and distinct unit from the Maximum Security units within the facility. **The Governing Body at CMHC will make every effort to provide a separation of the two populations within the facility**. Where mixing of these two populations is required then measures will be taken to provide as safe of an environment as possible in which to co –exist."

IV. Statutes

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-104) guarantees that "Every recipient who resides in a mental health or developmental disabilities facility

shall be permitted to receive, possess and use personal property and shall be provided with a reasonable amount of storage space therefore, except in the circumstances and under the conditions provided in this Section. (a) Possession and use of certain classes of property may be restricted by the facility director **when necessary to protect the recipient or others from harm**, provided that notice of such restriction shall be given to all recipients upon admission. (b) The professional responsible for overseeing the implementation of a recipient's services plan may, with the approval of the facility director, restrict the right to property when necessary to protect such recipient or others from harm. (c) When a recipient is discharged from the mental health or developmental disabilities facility, all of his lawful personal property which is in the custody of the facility shall be returned to him."

The Code (405 ILCS 5/2-201) states that "Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefore to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian…(5) the recipient's substitute decision maker, if any. The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefore in the recipient's record."

The Code (405 ILCS 5/2-102) states that 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."

The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4) provides that "The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof: (1) the parent or guardian of a recipient who is under 12 years of age; (2) the recipient if he is 12 years of age or older…(4) the guardian of a recipient who is 18 years or older…Assistance in interpreting the record may be provided without charge and shall be provided if the person inspecting the record is under 18 years of age. However, access may in no way be denied or limited if the person inspecting the record refuses the assistance. A reasonable fee may be charged for duplication of a record. However, when requested to do so in writing by any indigent recipient, the custodian of the records shall provide at no charge to the recipient, or to the Guardianship and Advocacy Commission, the agency designated by the Governor under Section 1 of the Protection and Advocacy for Developmentally Disabled Persons Act1 or

to any other not-for-profit agency whose primary purpose is to provide free legal services or advocacy for the indigent and who has received written authorization from the recipient under Section 5 of this Act to receive his records, one copy of any records in its possession whose disclosure is authorized under this Act. (c) Any person entitled to access to a record under this Section may submit a written statement concerning any disputed or new information, which statement shall be entered into the record. Whenever any disputed part of a record is disclosed, any submitted statement relating thereto shall accompany the disclosed part. Additionally, any person entitled to access may request modification of any part of the record which he believes is incorrect or misleading. If the request is refused, the person may seek a court order to compel modification. (d) Whenever access or modification is requested, the request and any action taken thereon shall be noted in the recipient's record."

The Administrative Code (59 IL ADC 110.30) provides that "Individuals may possess a reasonable amount of personal property for personal use under the following conditions: 1) Possession and use of certain classes of property may be restricted by the facility director when necessary to protect the recipient or others from harm, provided that notice of such restriction shall be given to all recipients upon admission so long as the restriction does not otherwise conflict with the rights provided in this Section...Staff shall post a list of contraband and restricted items in a common area of the unit…. 3) Property must be approved by the individual's treatment team prior to use. Any personal property that the treatment team determines, in the exercise of its professional judgment, may pose harm to the individual or to others shall be restricted. Property shall not be restricted on political, philosophical or religious grounds. Property intended as a medically reasonable accommodation of a known disability shall not be restricted except when determined by a physician and the treatment team, in exercise of the their professional judgment, that the accommodation may pose harm to the individual or others. A restriction of rights shall be issued in accordance with the Mental Health and Developmental Disabilities Code [405 ILCS 5/2-201] within 48 hours. **When the restriction of rights is issued, the treatment team member shall inform the individual of his/her ability to request a review under subsection (a)(5).** The individual will have the option of placing the personal property in storage or returning it to its place of origin…Contraband: Notwithstanding any other Section of this Part, any property that is determined to be contraband shall not be allowed in any State operated facility…**Sexually explicit material shall not be listed as a contraband item**. An individual's access to such materials may be restricted in accordance with subsection (a)(3). **Public display or sharing of sexually explicit materials may result in the confiscation and restriction of those items as provided in subsection (a)(3).** e) Restrictions on an individual's right to possess personal property shall not be imposed as punishment, in response to an individual declining to take medication, or in response to a failure to undergo other treatment recommended by an individual's treatment team. However, if an individual's clinical situation changes, the individual's treatment team may reconsider the possession of property in accordance with this Section. f) This Section applies to all adult individuals admitted to a Department mental health facility. g) The facility director shall conduct training on this Section at least once a year and a written record of such training will be made.

The Code of Federal Regulations (42 CFR 482.13) provides that "(2) the hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. **The grievance process must include a mechanism for timely referral of patient concerns** regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum: (i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital. (ii) The grievance process must specify time frames for review of the grievance and the provision of a response. (iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion…d) Standard: Confidentiality of patient records. (1) The patient has the right to the confidentiality of his or her clinical records. (2) **The patient has the right to access information contained in his or her clinical records within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits."**

The Illinois Administrative Code (59 IL ADC 50.30) states that "a) Availability of OIG: 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. b) Responsibility of OIG for receiving the report: 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…f) Authorized representative: 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]; 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…. G) OIG may determine what further action, if

any, is necessary to protect the safety of any individual, secure the scene of the alleged incident, preserve the evidence and maintain the integrity of the investigation. Such action may include immediate emergency referrals (such as medical or housing services), the notification of law enforcement officials, requesting hospital services or contacting the Department or other State agencies for assistance."

The Administrative Code (59 IL ADC 50.50) also states that "Depending on the nature of the allegation, an investigation shall consist of, but not be limited to, the following procedures whether done by OIG, the community agency or the facility: 1) Ensure that the victim is not in imminent danger; 2) Protect the integrity of the investigation at all times; 3) Secure the scene of the incident; 4) Identify and separate witnesses; 5) Preserve and secure all evidence; 6) Obtain statements from persons involved including victims, alleged perpetrators, and witnesses by face-to-face interviews, in writing, or by telephone; and 7) Obtain copies of pertinent documents relating to the investigation, i.e., progress notes, incident or injury reports, patient or resident records, photographs, etc…**No person shall interfere with or obstruct an OIG interview or investigation**… Facilities and community agencies shall obtain and provide OIG with all written statements and any requested documents **in a timely manner**."

Summary

The allegation of property being restricted without a legitimate reason was based on the recipient's pornographic magazines being restricted. According to the Administrative Code (59 IL ADC 110.30) sexually explicit material shall not be listed as a contraband item. Upon investigation, it was learned that the recipient had access to his magazines until he shared them with another recipient, which is listed in the patient handbook as prohibited. The recipient was issued restriction of rights notices, but it did not appear that they were sent to his legal guardian in a timely fashion.

Conclusion

The restriction of rights notices revealed that the recipient's magazines were restricted for a legitimate reason, sharing with another recipient. Therefore the allegation is **unsubstantiated.** However, there were a few things the HRA discovered throughout the course of this investigation which were concerning and the following **suggestions** are offered.

1. The restriction of rights forms stated that the restriction on the recipient's magazines would be reviewed weekly by the treatment team. However, based on the restriction of rights forms found in the chart, it appears it was being reviewed only monthly and the HRA found no documentation in the TPRs that it was discussed at the treatment meetings. Also, the HREC recommended to the therapist in February that "limited access to the adult magazines be reintroduced to the recipient in order to truly determine if he can abide by the unit rules." The HRA learned that the recipient received his magazines back sometime in March, which was approximately 3 months after the initial restriction. Administration should review facility policy regarding

restriction of rights with staff to ensure proper procedures are being followed and that property is not being restricted indefinitely.

2. Policies regarding guardian contact should be reviewed with staff to ensure that guardians are properly notified when restriction of rights are issued even if the recipient states he wishes no one be contacted.

3. Another concern was that the forensic pre-placement evaluation stated specifically that this recipient should be admitted to Chester's medium unit and at the time of this report, he still resided on the maximum security unit. The HRA understands that at the time of his admission, the medium unit had not yet opened, but does question why he was not transferred to the medium unit once it opened since he was assessed as a being in need of a medium secure setting at Chester Mental Health. The HRA suggests that the administration review this case, and others that may have similar situations, to determine if recipients are being served in the least restrictive setting per Chester policy EC.04.01.00.01 and the Mental Health Code (405 ILCS 5/2-102).

4. Finally, it was concerning that the recipient seemed to have such difficulty gaining access to his records. It was documented that the recipient had requested copies of his complaint forms, psychiatrist tests, TPRs, disciplinary reports and also requested that copies be sent to his mother who is his legal guardian. When the HRA inquired as to if access had been granted, it was discovered that the HREC Chairperson had been trying to resolve the recipient's request since February and had just received acknowledgement that staff were *in the process* of complying as of 4/8/14. The HRA suggests that administration review facility policies regarding access to patient records as well as Federal Regulations (42 CFR 482.13) with staff to ensure delays do not occur in the future.

Summary

The allegation of inadequate OIG investigative process was based on statements that multiple complaint forms were completed and never followed up on. During the course of the investigation the HRA learned that there were approximately 23 Human Rights complaint forms that were completed and turned into staff members in November and December, 2013 but the Human Rights Committee did not receive these complaint forms until February, 2014. Some of these complaints warranted OIG reporting and were reported to the OIG once received by the Human Rights Committee. However, due to the lapse in time from the incident to when it was received by the OIG, it was difficult to do a thorough investigation as noted in the OIG report detailed above.

Conclusion

Due to the delay in time from when the Human Rights complaint forms were completed and the time the Human Rights Committee actually received the complaints, some of which were OIG reportable and which also prevented an adequate OIG investigation to be completed, the allegation of an inadequate OIG investigative process is **substantiated**. The HRA makes the following recommendations:

1. Staff should be retrained in Chester policy *Reporting and Resolving Complaints Policy RI.03.03.00.01* as well as the *Illinois Administrative Code Rule 50* and reminded that all allegations of abuse, neglect or exploitation should be immediately reported to the OIG to determine if the allegation warrants an OIG investigation.

2. Administration should review facility policies relating to filing grievances/complaint reporting and determine if any revisions are necessary to ensure timely reporting as required by 42 CFR 482.13 in order to avoid delays in grievance reporting and subsequent OIG investigations in the future.

Allegation 5: Unsanitary living conditions

I… Interviews

A. Recipient: The recipient informed the HRA that his living conditions are "unsanitary" due to the fact that he finds spiders in his bedroom at least twice a week that bite him in his sleep. The recipient alleged that he has found "over 30 spiders in 4 months." He stated that he has asked CMHC to spray his desk and living unit but they refuse to spray his room. The recipient also stated that he developed a skin disease in November or December, 2013 after he was moved into another room against his will. The staff told him that he had to move because another recipient had to be in a room with the water shut off and where this recipient currently was, the water could not be turned off. The recipient stated that the "skin disease" was on his knuckles, the same place as this recipient whose room he was moved into. He stated that the doctor gave him some kind of cream but it did not help.

B. Housekeeping Inquiries: The HRA communicated with the housekeeping supervisors and reviewed staff memos and instructions on housekeeping duties for each shift. The housekeeping staff dust, wipe down walls, dust mop, scrub toilet & sink, wet mop the floor and disinfect the patient rooms. It was estimated that 20 minutes is spent on each patient's room. The estimated time spent on cleaning each module is based on the number of staff working. With one staff member it takes approximately 12 hours, with two, 6 hours and with four staff members, it takes approximately 3 hours. The module includes patient rooms, hallways, day room, showers, nurse's station, offices and the "stem area" which includes offices, doctor's room and break room. There are two shifts for housekeeping 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. The Team was provided with a housekeeping schedule showing that each day during first shift, Unit A has 2-3 staff; Unit B has 1-2 staff; Unit C has 1-2 staff and the infirmary has 1 staff. Second shift has 3-4 staff scheduled each day with the exception of Wednesdays when there are 2 staff members. There were also 4 staff members listed as "relief".

C. Facility Engineer: The HRA interviewed the facility engineer over the phone about pest control at the facility. A pest control company comes twice each month on set days to spray all the common areas of the facility such as hallways, dining room, kitchen, etc. If the engineer receives specific reports of problem areas, the pest control company also treats those areas in addition to the regular areas. Prior to the pest control's visit, the engineer sends out emails inquiring if there are any specific issues that need to be addressed and treated during their visit. The engineer also said that in July of 2014 this recipient's living unit was treated as a specific problem area. The engineer said that she personally inspects all patient areas twice a year and said that direct care staff persons are also inspecting the rooms on a regular basis during the course of their normal job duties. If any pest problems occur, they are reported to her and then treated when the pest control comes for their regular visit.

II. Chart Information

A The TPRs are outlined above under Allegation 1. The HRA found no documentation in the discussion sections indicating that the recipient voiced concerns about his living unit or room assignment.

B. Medication Administration Record (MAR): The MAR for October, 2013 showed that the recipient was provided with a triple antibiotic ointment cream for one week for treatment of "insect bite." The November, 2013 MAR documented another triple antibiotic ointment cream which was prescribed for 7 days "for insect bites." The December, 2013 MAR showed that a hydrocortisone cream was prescribed for "skin irritation" on his elbow and wrist. Sulfamethoxazole/trimethoprim was also prescribed for 10 days but no reason was given. Drugs.com indicates that this medication is prescribed for treating infections caused by certain bacteria and is usually given as an injection.

III. Tour of the Facility: The HRA toured the facility including the living units. The units appeared to be clean. There were no odors indicating the units are not being cleaned regularly. There were no signs of insects of any kind on the living units.

IV. Statutes:

The Code (405 ILCS 5/2-102) states that 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."

Summary

The allegation was that the living units are unsanitary. Specifically, the complaint alleges that there are spiders in the recipient's room and that requests to have his room sprayed have been disregarded. According to the MAR, the recipient was treated with an antibacterial cream for "insect bites". A phone conversation with the facility engineer revealed that there was a pest problem on this unit, but the facility took steps to resolve it and had the unit treated as soon as it became aware of the problem. Additionally, the facility has regular pest control treatments twice each month by a professional company.

Conclusion

Based on a review of the housekeeping schedule, list of duties and the number of staff on each shift along with the estimate of how much time it takes staff to clean each module, there are adequate staff on each shift to be able to accomplish the duties assigned. Also, it was discovered that the facility has regular pest control treatments twice a month to prevent a problem with insects. During a tour of the facility, the Team did not observe any unsanitary living conditions. Therefore, the allegation that unit conditions are unsanitary is **unsubstantiated**. No suggestions are made.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

STATE OF ILLINOIS
Pat Quinn, Governor

DEPARTMENT OF HUMAN SERVICES
Chester Mental Health Center Post Office Box 31 Chester, Illinois 62233

December 31, 2014

Chairperson
Regional Human Rights Authority
#7 Cottage Drive
Anna, IL 62906

Re: Case # 14-110-9012

Dear

Thank you for your thorough investigation and report regarding the above mentioned case. We appreciate the opportunity to review such allegations and correct any violations or deficiencies that are found.

This correspondence is in response to the following substantiated finding of a rights violation:

Inadequate OIG Investigative Process.
Recommendations were as follows:

> Due to the delay in time from when the Human Rights complaint forms were completed and the time the Human Rights Committee actually received the complaints, some of which were OIG reportable and which also prevented an adequate OIG investigation to be completed, the allegation of an inadequate OIG investigative process is substantiated. The HRA makes the following recommendations:
>
> 1. Staff should be retrained in Chester policy *Reporting and Resolving Complaints Policy RI.03.03.00.01* as well as the *Illinois Administrative Code Rule 50* and reminded that all allegations of abuse, neglect or exploitation should be immediately reported to the OIG to determine if the allegation warrants an OIG investigation.
>
> 2. Administration should review facility policies relating to filing grievances/complaint reporting and determine if any revisions are necessary to ensure timely reporting as required by 42 CFR 482.13 in order to avoid delays in grievance reporting and subsequent OIG investigations in the future.

Facility Response/Explanation/Action:

1. Chester Administration reviewed this case both prior to HRA's investigation, and after receipt of the HRA's report. The following information was found:

   - In January 2014, the Patient and Human Rights Chair informed the Director of Clinical Operations that he did not think the human rights complaints forms were being forwarded

to him. A patient had told the Chair that the patient had completed about 30 complaint forms and that he had not received written follow-up.

- The Human Rights Chairperson confirmed he had not received any complaint forms.
- The next day, the Director of Clinical Operations met with the Unit Director, therapist, and Unit Manager and asked if any of them had received these written complaints in question. They all stated they had not received any.
- The therapist suggested to the patient that he go through a storage box that the patient had that he stored magazines and papers in.
- When they searched the box, they found a stack of complaints that appeared to be originals, not copies, in this box.
- The complaint forms were promptly turned in to the Human Rights Chair.
- Once the complaints were turned in, they were reviewed and submitted to the Human Rights Committee or OIG as appropriate in a timely fashion.

Based on the evidence above, we are not able to prove that any staff ever received these documents prior to the date they were found in the patient's storage or that staff was negligent in processing the complaints. It is the Administration's belief that if staff had received the complaint forms at the time they were written, they would have handled them according to procedure, therefore, **Administration does not feel re-training of any staff is warranted at this time.**

2. Chester Administration reviewed the facility policies relating to filing grievances/complaint reporting and found the following:
   - Chester's policy RI.03.03.00.01 and the Illinois Administrative Code Rule 50 are explicit in the expectation that all allegations of abuse, neglect or exploitation should be immediately reported to OIG.
   - The current policy (RI.03.03.00.01) is in sync with the current Rule 50.
   - All staff are required to complete training on this policy and Rule 50 upon hire, as well as annually.

Therefore, **no changes are recommended for this policy or any other complaint process.**

Please feel free to contact me if you have any other questions or concerns in regards to this case.

Sincerely,

Acting Hospital Administrator
Chester Mental Health Center

cc: Associate Director for Hospital Operations
Quality Improvement Coordinator