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Egyptian Regional Human Rights Authority
Report of Findings
15-110-9011
Chester Mental Health Center

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

1. **A patient was inappropriately restricted to his unit.**
2. **The facility failed to protect a patient from harm.**
3. **A patient received inadequate medical care.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2 et al. & 5/3-211), the Code of Federal Regulations (42 CFR 482.13) and Chester policies.

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

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

I. Interviews:

A. Recipient: The Recipient informed the HRA that he has been on unit restriction for approximately 4 months, other than going to the cafeteria, due to receiving an envelope in the mail that contained a razor blade. He denied knowing that a razor blade was being sent to him and said the letter was from his 10 year old son who would have no reason to send a razor blade to him. The recipient also stated that a “charge aide” opened the letter but he did not know the staff person’s name. The envelope had tape on it which made him suspicious. He said that whenever he brings up his unit restriction and when that will be lifted during his treatment meetings, staff just change the subject and do not answer him. He also stated that restriction of rights forms are given for one month time periods.

Another concern he had was an ongoing conflict with another patient. The recipient stated that this peer had “attacked him” 8 times in the past and was recently moved from another module to his for no apparent reason. He stated that during a medication pass approximately 3

weeks prior to our interview, around 8:20 p.m. next to the nurse's cage, the peer attacked him. Then, around the end of September or the beginning of October, he was being escorted from module 1 to 3 on his unit around meal time. The peer was "waiting" on module 3 and hit him in the face a couple of times. He alleged that a security therapy aide (STA) held him while this peer was allowed to hit him. The STA grabbed the recipient's arm, twisted it and told him that he did not stop when they asked him to so they put him in restraints. This was the day after the peer attacked him while on module 1 when he was eating a snack by the nurse's cage. He alleged that a STA held him and not the peer which allowed the peer to continue hitting him. The unit director and another staff person had told him that he should be able to defend himself and would not get in trouble for doing so, but he "ended up" in restraints nonetheless. He stated that he had filed an Office of Inspector General (OIG) complaint and the OIG liaison had come to see him but he did not know the outcome of the investigation yet.

The HRA reviewed the OIG report on this incident which occurred September 26, 2014. The OIG determined the allegation to be unfounded. It was stated in the report that the two peers had been involved in multiple physical altercations. It was documented that this particular incident began with the peer attacking the recipient. Staff intervened to redirect both of them; however the recipient kept fighting and had to be placed in restraints. The peer had sustained a scratch to his face and the recipient had no documented injuries. However, two months later, the recipient stated he had a broken finger because of that incident. It was also stated in the OIG report that the recipient waited 2 months to report the allegation which hindered the investigator's efforts in gathering evidence in a timely manner.

The recipient's final concern was that the nurses on his unit were not letting him use his rescue inhaler when requested even though he had a doctor's order to use it as needed. He said that after being refused his inhaler for the past few weeks, he has finally just quit asking and he has had to strain to breathe due to not having access to his inhaler. The reason he was given for denying him use of his inhaler from one nurse was that he could only have it after he had been to the gym or presented as short of breath. She stated that he "didn't look like he needed it." Another nurse told him that his pulse was too high to have the inhaler and then checked his oxygen level with a "pulsox" [pulse oximeter] and said it was fine so she refused to give him the inhaler. The recipient stated that he did not have problems accessing his inhaler until he moved from one module to another.

B. Recipient 2: The HRA also received a complaint from another recipient who lived on the same unit as the recipient in this case. He has an order for an inhaler and had a similar complaint as the recipient saying that the nurses on his unit will deny him access to his inhaler upon request at times. The HRA relayed this information to the Chairman of the Human Rights and Ethics Committee at Chester so the matter could be looked into right away. The Chairman spoke with a Registered Nurse on the unit. Her response was "*per documentation in [recipient 2's] chart, [recipient 2] only asked for prn [as needed] Cogentin, which he has no order for prn only scheduled, if at any time any patient is in respiratory distress or complains of respiratory problems the nursing staff immediately responds and treats the patient accordingly. When speaking with [3 nurse's names] the nurses on the unit yesterday and today, they stated he never requested his inhaler yesterday or today.*"

C. Nurse 1: The HRA interviewed one nurse on his unit who stated that every day at the same time the recipient requested his inhaler even when he did not go to the gym. She stated that Albuterol raises your heart rate somewhat and that the recipient's heart rate is "on the verge of being high." If the recipient requested Albuterol, she would give it to him when his "symptoms indicated it was needed." She would listen to his chest, check his oxygen level with a "pulsox" and if there was no indication, she would just follow up and monitor him closer but would not allow him to use the inhaler due to the risk of increased heart rate. She stated that most patients do not ask for their inhaler when it is not needed but she felt like this patient did for some reason, maybe for the "high" feeling. She stated that there are 2-3 out of the 36 on the unit that use inhalers.

D. Nurse 2: The HRA interviewed a second nurse from this same unit who stated that Albuterol can raise a person's heart rate but "not that much." If a patient is in any kind of respiratory distress, his heart rate is most likely somewhat elevated already. She stated that if a patient asks for his inhaler, she gives it to him if he has a doctor's order for it. She stated that even if a patient does not have obvious signs of breathing distress, if he asks for his inhaler and has an order for it, she will give it to him because she cannot tell how a person is feeling and can only go by that person's report of how he is feeling. She made the statement that she would not want to be the one to say a person did not need an inhaler and then have something happen because she denied it.

According to WebMD, a fast heartbeat is a "common side effect" of Albuterol that is "less severe."

E. Security Therapy Aide (STA): The STA named as the one who allegedly held the recipient while his peer hit him was questioned regarding both the mail the recipient received with the razor blade and the incident with the peer. The STA said that usually a Unit Manager or an STA II opens the mail in front of the recipients. He did not know who opened this particular piece of mail. When questioned about the altercation between the two patients, the STA said that this recipient had conflicts with several other recipients and was moved several times due to that fact. The peer involved in this incident with him also had conflicts with several recipients, but the STA did not believe that he was moved as much as the recipient was. The STA also stated that for the most part, when the recipient was on his module, he kept quiet except when he was scheduled for court. When he knew a court date was coming up (for fitness hearing) he would intentionally do something that would keep him at Chester. He eventually was placed on 2:1 supervision for aggression and self-injurious behavior prior to his last scheduled court date to prevent him from causing harm to himself or others and he was found fit and transferred to the county jail from that court hearing.

When questioned why the peer was moved to the same unit as the recipient, his response was that when there are conflicts, staff try to separate peers but the way the units are designed, certain populations (UST, NGRI, Civil) are housed on certain units and there are only so many places you can move them when they have conflicts with several other patients. They try to separate them as best as they can but stated that if they were going to fight with another peer, there are other "opportunities" such as when they go to the gym or the dining room where patients are required to move together.

F. Therapist: The HRA also interviewed the recipient's therapist who stated that a Psychiatrist at Chester had found the recipient fit to stand trial and he was transported to Court. His attorney "got a second opinion from another Psychiatrist" who disagreed with Chester's Psychiatrist and sent the recipient back to Chester to finish treatment to attain fitness. The Therapist believed that the recipient's issues were more "behavioral" than "subsequent to psychosis." At the time of our interview, the recipient was on unit restriction for both elopement risk and because he fought with a peer on another unit who has a history of aggressive behavior, however the therapist stated that there have been no problems with the recipient since he has been on his current unit.

II. Clinical Chart Review

A. Treatment Plan Reviews (TPRs): The 5/21/14 (21 Day) TPR stated in the *discussion section* that the recipient mentioned concerns about a peer who "seems to have problems with him" and noted that the recipient "has shown no behavioral problems." It was documented that the recipient had scored a passing grade on the fitness exam and that he "may be recommended as Fit to return to court within the next review period." The recipient signed his TPR.

The 7/10/14 TPR again noted that the recipient had scored a 95% on the Fitness Exam and is able to state his charges clearly. It was documented that he returned to court on 6/24/14 and told the examiner that he heard voices and has schizophrenia.

In the 8/4/14 TPR, it is noted that when the recipient went to court on 6/24/14, he had a Fitness Evaluation with Forensic Clinical Services and the doctor stated that he remained Unfit to Stand Trial. The treatment team at Chester all agreed that the recipient "not only understands the court system, he is aware of his charges and he is able to cooperate and assist his attorney in his own defense. [Recipient] is observed 24 hours per day at Chester with no indication he is responding to internal stimuli. He is able to perform tasks independently with no deficits noted. He follows direction with one prompt, no physical aggression and no verbal threats reported. He manages his funds and his writing skills are above average." The recipient signed his TPR but did not indicate whether or not he agreed with it. It was noted in the *response to medication section* that the recipient was on unit restriction due to receiving an envelope with a razor blade along with a letter written by his 10 year old son. The recipient "was unable to provide any explanation."

A 9/2/14 TPR did note in the *discussion section* that the recipient "became verbally aggressive toward his psychiatrist during his review and had to be removed from the room." It also documented that he had at least one physical altercation with a peer that month; no details were described in the TPR.

The *discussion section* of the 9/29/14 TPR stated that the recipient refused to attend his meeting "because of an increase in aggressive behavior this period, he stated that he did not want to be confronted by the treatment team." It was noted in the *response to medication* section that at his 9/2/14 TPR, he became abruptly angry, explosive

(verbally) and accused the writer for blaming him for his charges. The team decided to discontinue further discussion and later that afternoon he caused physical injury to a lower functioning patient. It was noted that was his third incident for the "last few weeks." His clinical condition was described as "characterological and behavioral, indicative of antisocial personality traits. He has not given any indication outside of his self-report, to experience symptoms of psychosis, either positive or negative. He has not been observed to be responding to internal stimuli nor has he indicated to have delusional thought content." It documented 3 physical altercations with peers that month which resulted in 2 restraints and 3 physical holds, but no other details were provided. The *response to medication section* noted

Finally, the 10/27/14 TPR was reviewed. The *discussion section* documented that he had not exhibited any aggression that reporting period and had exhibited no response to internal stimuli or indicated that he had any delusional thought content. The *response to medication section* noted that he refused to attend his TPR and stated that "his lack of cooperation is intentional and purposeful. He is not interested in working with his aggression towards other peers. His aggression is simple aggression unrelated to psychosis." There was no mention on whether or not the recipient was still on unit restriction.

B. Medication Orders: The HRA reviewed medication orders dated 3/27/14 for Albuterol 2 puffs every 6 hours PRN (as needed) for shortness of breath; Beclomethasone inhaler 2 puffs every 12 hours; Fluticasone inhaler daily and Diphenhydramine PO (orally) daily PRN for allergies. Beginning on 4/22/14, the Albuterol order states PRN daily and Diphenhydramine order continued, but the HRA found no order for Beclomethasone or Fluticasone inhaler. The orders for Albuterol and Diphenhydramine continued through 10/2/14. A new order dated 10/6/14 prescribed Albuterol 2 puffs every 8 hours PRN a note on the order stated "clarification of albuterol inhaler: 2 puffs q 8 hours prn" The last order reviewed was dated 1/14/15. The Medication Administration Records (MAR) for September and October were reviewed. September's MAR documented that Albuterol was given 17 times usually given between 1:00 and 3:00 p.m. with one being given at 7:30 a.m. October's MAR documented 2 days that Albuterol was given and then a note is written stating "frequency D'd" [decreased] on October 6th.

C. Restriction of Rights (ROR): The HRA reviewed Notices Regarding Restricted Rights of Individuals beginning 7/25/14 with the last one reviewed continuing through 1/17/15 [the recipient was discharged on 1/6/15]. All restricted the recipient to his unit and also required shakedowns of person and room twice a day. The reason for restriction was listed as "*pencil and toothbrush supervision. Shakedown person and room BID [twice] daily. Patient received a razor blade in the mail on 7/25/14.*" The restrictions were signed by the Unit Manager with the exception being the 11/19/14-12/19/14 ROR being signed by a registered nurse and the Acting Facility Administrator. That restriction listed the reason as "*unit restriction except dining room, shakedown BID pencil and toothbrush supervision. Pt had razor blade sent into facility in mail. Pt to remain on unit restriction except may go to dining room, remains on shakedowns BID and supervision for pencil and toothbrush usage to maintain safety of all on [illegible]*". That ROR did not list the date of the razor blade coming in the mail.

D. Injury Reports: A 4/1/14 injury report documented that the recipient was "spontaneously attacked by peer and punched in top left ear. No injury apparent, but tenderness present." On 5/3/14 an injury report documented that the recipient "was hit multiple times by peer; he had slight redness to right ear, right neck. Pulled lip down and slightly [illegible] area bottom lower lip. On 5/17/14 another report stated "allegedly choked by peer. Inspected neck area, 0 redness or injury seen." A 9/27/14 injury report indicated that something happened but was not very specific. It stated "no injuries seen at this time as full body check was done." Under the "what happened per patient section" the recipient stated "he attacked me last night and I was defending myself today." On 10/1/14 another report documented that the recipient "used right hand to hit patient [initials and identification number]." The recipient stated "he attacked me" and the patient initials listed matched the name of the patient that the recipient told the HRA he had altercations with in which staff allegedly held him and allowed him to be hit by the peer. All 5 injury reports listed this same patient identification number and initials as the "aggressor" of the incidents.

E. Nursing Summaries: The 8/10/14-9/4/14 summary documented that his Albuterol inhaler was utilized on 9/3 and 9/4. On 8/19 the recipient "physically assaulted a peer by walking into the peer's room and striking him in the face." On 9/3 he physically assaulted a peer by "spontaneously attacking peer causing injury." It was noted that he is taking no psychotropic medication and refused PRN medication during periods of agitation and aggression. However he did participate in medication education on 3 dates.

The 9/4/14-9/18/14 nursing summary documented that the recipient was seen on 9/9/14 in the asthma clinic and that he requested and received Albuterol inhaler 8 times during that timeframe. It was also noted that the recipient was involved in a physical altercation with a peer and required a physical hold to separate them.

The 9/18/14-10/18/14 nursing summary documented that he requested and received his inhaler 10 times during the reporting period. It was noted that he was involved in a physical altercation with a peer and required a physical hold and full leather restraints on 9/27, 10/1 and 10/13 and documented the unit restriction "due to receiving a razor blade in the mail." The recipient was prescribed and began treatment using Olanzapine twice a day and also received Lorazepam PRN 1 time for agitation. Seclusion was utilized on 10/13.

The 11/17/14-12/16/14 nursing summary documented that the patient refused his inhaler once during the reporting period. It was noted that the recipient required no interventions for behavior management during the review period and that he was "generally calm and cooperative."

F. Progress Notes: The case notes reviewed from 7/3/14 to 1/3/15 documented that the recipient requested and received his inhaler 14 times between July and October all on different days. It was not documented that he requested the inhaler more than once per day. On 9/9/14 the recipient was seen in the asthma clinic and was given a pneumonia vaccine, no changes to his inhaler order were noted. On 10/2/14 a nursing note stated the following "recip. [recipient] sent STA staff to tell this nurse recip 'short of breath and needing inhaler.' Recip has been asking every day for Albuterol inhaler at same time. This writer went to assess recip. Recip standing at

door, recip. Not rapidly breathing no blueness to lips, no wheezing heard at this time. Cannot find any justification as to giving Albuterol inhaler. Spoke with Dr. [name] and Dr. [name] wanted O2 sat [oxygen saturation], assessment of pulse and listening to recip lungs and report back findings." An entry 8 minutes later stated "Recip standing at stem door with STA staff, not displaying any shortness of breath, O2 sat 98% on room air, no blueness of lips, not hyperventilating, lungs clear, no wheezing seen or heard. Recip heart rate registering 128 bpm [beats per minute] at this time. Explained to recip that Albuterol increases heart rate. Recip. Heart rate already high that recip is not displaying and s/s [signs or symptoms] of shortness of breath or diff [difficulty] breathing. Explained and reassured that O2 sat is 98% and that's a very good sign. While trying to give education to recip, recip became agitated and wanting to argue. Explained that I was just trying to assess need for inhaler and would report findings to Dr. [name] and if Dr. [name] thought recip needed Albuterol, this writer would come in and give inhaler. Recip yelled 'this is bullshit, I've had asthma my whole life." Another entry 2 minutes later stated "spoke with Dr. [name] and reported findings. Dr. [name] stated 'with heart rate that high, cannot give Albuterol due to that increasing heart rate even more. Sounds like this may be behavioral please let treatment team know of what's happening.' This writer explained we will keep a close eye on recip and any changes will be reported immediately and action will be taken. Offered recip PRN and recip refused. Will cont. to monitor, placed recip on Dr. [name's] line to assess on Monday 10/6/14. Reported to recip therapist [name] also spoke with Dr. [name] about what's happening will cont. to monitor." An hour and 45 minutes later another nursing note stated "patient c/o [complained of] SOB [shortness of breath], requesting PRN albuterol inhaler. RN checked heart rate which was 62. BP 120/78. Notified Dr. [name] and informed him of above. Stated it was ok to give patient his inhaler. Used albuterol inhaler. Pt. had no other complaints no shortness of breath observed." On 10/3/14 another nurse documented "Pt. requested Albuterol. No SOB noted. Lungs clear. O2 sat 96% pulse 90. Reports no physical activity at this time. Encouraged to use inhaler when SOB and having problems with breathing. Encouraged to increase fluid intake." On 10/6/14 a medical doctor's note stated "[illegible] Albuterol inhaler frequency since pt using too frequently and becoming tachycardic" A nursing note that same day stated "new order for PRN Albuterol inhaler D'd to 2 puffs q 8 hours…"

A 7/25/14 Social Worker note stated "During mail distribution today a letter address to [Recipient] from his son was opened and a razor blade was enclosed with the letter. Patient was interviewed about the letter. He stated he knew nothing about the razor blade. He stated 'why would someone send something in here when they search everything.' Patient explained his son is 10 years old, lives with the child's grandmother (the mother's mother). He stated he just wrote his son a letter today. The letter was pulled from the mail. [Recipient] gave permission for the letter to be opened. He told the treatment team the content of the letter and once this letter was opened, the content was confirmed. He wrote to his son about school, gangs and told him to report to his grandmother if any[one] touches him sexually. Due to the nature of the item being a razor blade, [recipient] was ask [sic] if he had any thoughts to harm himself or anyone else. He denied both. Concerns voiced about his son being depressed about his dad being here. Therapist asked family for them to check on the child. Patient placed on restriction." A Nursing note from this same date stated the doctor "gave order for unit restriction and shakedowns BID [twice daily] due to charge aid finding razor blade in a piece of mail. Recipient given Restriction of Rights."

A 8/5/14 Social Worker note included the following statement addressing peer to peer aggression "During the month of May 2014, a peer had targeted [Recipient] on several occasions attempted to physically attack [recipient.] [Recipient] was able to avoid the peer and redirect the peer until staff intervened." A 9/27/14 Nursing note stated "while eating breakfast attacked peer [identification number]. Placed in a physical hold. Patient continued to be aggressive with peer and staff. Placed in 4 pt restraints for safety to self and others…" The medical doctor's note this same date stated "while eating breakfast attacked peer and would not stop fighting. Five minute PH [physical hold] initiated at 0710 and FLR's initiated at 0715 for the safety of all." The STA II note of this same incident stated "recipient got into a physical altercation with a peer. Staff tried to redirect recipients away from each other, but recipient [recipient name] would not stop. Recipient [name] was placed in a physical hold at 0710 and escorted to restraint room where recipient was placed in 4 pt restraints at 0715 for the safety of all." On 10/1/14 a Nursing note documented that the recipient was "standing in [unit] hall during lunch line; was spontaneously attacked by peer [identification number]. [Recipient] began to aggress against peer in response to attack and punched peer [id number] multiple times. When directed by staff to stop [Recipient] continued assault. Was placed in physical hold at 1240 for safety of all; during hold recipient continued to fight and struggle. Didn't follow redirection/deescalate during physical hold. Required 4 pt restraints for safety of all [1245] Preference not followed [medication, seclusion, restraint] due to violent aggression of incident…given restriction of rights x 2…Recipient [name] refused offer of PRN medication X3…] The Psychiatry note this same date stated "pt seen in 4 pt restraints he was in an altercation with another peer 'he has attacked me 13 times…I have written a complaint against him…I have only been in restraints twice in 6 months' Client does not explain why other pt attacks him. Lying in bed in restraints looks comfortable. No PRN desired VS [vital signs] stable." On 12/3014 a Nursing note documents that 2 medical doctors ordered 2:1 observation due to "pt attacking spontaneously. Pt has attacked 2 random people in the last 2 days." It was also documented on this date that the Medical Director called and was informed of the recipient's recent behavior and the doctors' order which stated "he should be on 2:1 for aggression, he is to stay in seclusion until lock down and then house in quiet room and have [doctor name] assess for 2:1 for aggression." The Medical Director gave approval for the same. A Social Worker note on 1/2/15 documented that the recipient was leaving on 1/5/15 for court and that the recipient understood that he needed to be aggression free with no plans to retaliate against peers who "walk near him." The recipient was able to answer questions on UST test with 100% accuracy and stated he is fit to Stand Trial and will cooperate with Evaluation at Court. The 2:1 observation was to continue "for safety of those involved peers, staff on the treatment module."

III...Facility Policies:

The Patient Handbook states the following about mail delivery "*Your family and friends may write to you at [address]. Letters will come directly to you. All of your mail will be opened in your presence by a staff member and will be checked for contraband...*"

RI .01.01.02.01 Patient Rights: The Patient Rights policy states "*It is the policy of Chester Mental Health Center (CMHC) to respect the rights of patients and not to abridge said rights without cause and without due process. Restrictions, as such, should have a clinical rationale and serve to facilitate a therapeutic treatment setting. Each patient admitted to*

Chester Mental Health Center shall be treated with respect and shall be ensured of all rights under Sections 2-100 to 2-111 of the Mental Health and Developmental Disabilities Code. Restrictions of rights and corresponding rationale shall be properly documented in the patient's clinical records." This policy states that a patient has the right to *"be provided with adequate and humane care and services in the least restrictive environment pursuant to an individual treatment plan…*

A. Non - Emergency Restriction of Rights

1. 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.

2. 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.

3. The Unit Director or designee will ensure that the initiation of the restriction is reported, discussed, and approved at the Facility Morning meeting.

4. 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.

B. Emergency Restriction of Rights

1. A restriction of a patient's rights should be based on an assessment of the patient and/or the situation affecting the safety of the patient or others by clinical staff on duty who oversees the patient's treatment plan. A Notice Regarding Restricted Rights of Individuals (IL462-2004M) will be issued to temporarily restrict the patient's rights. A progress note will be documented in the patient's record showing justification for the restriction of rights and explanation of actions taken.

2. A restriction imposed during off hours as an emergency intervention shall be reviewed by the treatment team on the next working day to determine whether continuation is indicated. If continuation is indicated the form IL462-2004M must be signed by the Facility Director or designee."

Violence Risk, Risk to Harm to Others policy states the purpose is *"to establish a protocol for the assessment of risk factors leading to violence; reassessment of factors; initiate interventions to reduce risk of violence and provide staff education on proactive approaches to address patient violence."* The policy states that upon admission all patients will be screened for violence risk to determine the need for safety measures by completing the VRAT (violence risk assessment tool.) Low risk patients will be reviewed at the monthly treatment team meetings. Medium risk patients will have immediate safety measures implemented with documentation completed in the progress notes. High risk patients will have immediate safety measures implemented along with a problem list with appropriate violence prevention measures incorporated into the treatment plan with interventions to manage and reduce the risk of violence. The policy continues by stating *"when an incident of aggression/violence occurs, the treatment team will document the incident on the monthly patient to patient assault log, CMHC-786. Assault log information will be reported weekly on a designated day at the facility's*

morning meetings to provide unit leadership the opportunity to discuss trends and develop action plans. Patients identified as having up to 3 assaults within a 2 week timeframe will require immediate review for implementation of a new intervention to prevent further assaults."

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. 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 Code (405 ILCS 5/2-100) guarantees that "*no recipient of services shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the receipt of such services."*

The Code (405 ILCS 5/2-201) states that *"(a) 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 therefor to:*
(1) The recipient and, if such recipient is a minor or under guardianship, his parent or guardian;
(2) A person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice;
(3) The facility director;
(4) the Guardianship and Advocacy Commission, or the agency designated under "An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named", approved September 20, 1985,1 if either is so designated; and
(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 therefor in the recipient's record.
(b) The facility director shall maintain a file of all notices of restrictions of rights, or the use of restraint or seclusion for the past 3 years. The facility director shall allow the Guardianship and Advocacy Commission, the agency designated by the Governor under Section 1 of "An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named," approved September 20, 1985, and the Department to examine and copy such records upon request. Records obtained under this Section shall not be further disclosed except pursuant to written authorization of the recipient under Section 5 of the Mental Health and Developmental Disabilities Confidentiality Act"

The Code (405 ILCS 5/2-112) guarantees *"Freedom from abuse and neglect. Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect."*

The Code (405 ILCS 5/3-211) states under Resident as Perpetrator of Abuse that *"When an investigation of a report of suspected abuse of a recipient of services indicates, based upon credible evidence, that another recipient of services in a mental health or developmental disability facility is the perpetrator of the abuse, the condition of the recipient suspected of being the perpetrator shall be immediately evaluated to determine the most suitable therapy and placement, considering the safety of that recipient as well as the safety of other recipients of services and employees of the facility."*

The Code (405 ILCS 5/2-103) provides that *"Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation. The facility director shall ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible, and that space for visits is available. Writing materials, postage and telephone usage funds shall be provided in reasonable amounts to recipients who reside in Department facilities and who are unable to procure such items."*

The Code of Federal Regulations (42 CFR 482.13) guarantees care in a safe setting stating that *"(1) The patient has the right to personal privacy. (2) The patient has the right to receive care in a safe setting. (3) The patient has the right to be free from all forms of abuse or harassment."*

Conclusion

The recipient felt like the length of time of his unit restriction was excessive. The HRA found restrictions for 6 months (July 25, 2014 until the recipient was discharged January 6, 2015). Although the restrictions listed the reason for the restriction, the TPRs did not document that any discussion was ever held regarding his unit restriction or the length of time that it should continue. The case notes did not document if the restriction was ever reviewed by a treatment team or anyone else. The one ROR form that the Facility Administrator signed for the restriction was for the timeframe of 11/19/14-12/19/14 but did not list that the razor blade came in July, which was 4 months prior to this ROR form. Since the Facility Administrator did not sign previous ROR forms, it was unclear if she was aware of the previous restrictions, as required by the Mental Health & Developmental Disabilities Code (405 ILCS 5/2-201) or if she was aware of the length of time the recipient had been restricted previous to the form she signed. Chester's policy (RI .01.01.02.01 Patient Rights: The Patient Rights) also requires that *"the Unit Director or designee will ensure that the initiation of the restriction is reported, discussed, and approved at the Facility Morning meeting."* This policy also requires that "w*hen 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 [restriction of rights form] *must be signed by the Facility Director or designee prior to initiation of the restriction."* Although the HRA understands that a Unit Director could be a designee to sign the ROR forms, there was no documentation showing that the restriction was ever reviewed in morning meetings or in treatment plan meetings. Therefore, the allegation is **substantiated** and the following **recommendations** are made:

1. Administration should review Chester's restriction of rights policies/procedures and the Mental Health Code requirements with staff and ensure that when a patient's rights are restricted that a review of the restriction is occurring and is documented in the chart as required by (405 ILCS 5/2-201)

2. When restriction of rights are issued that restrict a patient to the unit, there should be an end date listed on the form as to when the patient can return to classes and activities (ie restricted for 2 weeks, 1 month etc... can gradually be introduced to classes, yard activities, dining hall etc…) and the restriction should be discussed at treatment meetings and documented on the TPR form to ensure that the patient is aware of what is expected of him in order to earn privileges back and when a particular restriction could be lifted and/or privileges reinstated. This will ensure that the patient is being involved in his treatment planning as required by the Mental Health Code (405 ILCS 5/2-102 and 405 ILCS 5/2-103) and that restrictions aren't being continued without review or being continued by a unilateral decision by one staff person.

The second allegation of failure to protect a recipient from harm was based on the recipient having multiple altercations with the same peer and that peer being moved to his unit even though they had a history of aggressive behavior towards one another. The recipient also stated that staff "held" him while the peer attacked him. According to case notes for the timeframe given by the recipient, there were two altercations. The first occurred at the end of September and listed the recipient as the aggressor and noted that when staff intervened, he did not stop aggressing against the peer. The second occurred at the beginning of October. The nursing note documented that the recipient was attacked by the peer and the recipient began to aggress against peer in response to attack. It was noted that again, when directed by staff to stop, the recipient continued fighting. Neither case note indicated that the peer continued to fight the recipient. Therefore, the allegation is **unsubstantiated**. The following **suggestion** is offered:

1. Although the HRA understands that the units at Chester are separated by legal status (Civil, UST, NGRI etc…) and options are limited as to how patients can be moved around the units, the STA interviewed stated that if peers want to fight, there are other "opportunities" such as when moving together to the dining room or group activities. The HRA suggests that increasing staff supervision and distance between peers that are known to have conflicts with each other during these times of movement might be beneficial in limiting peer to peer aggression.

The final allegation of inadequate medical care was in response to a complaint that the recipient was denied use of his inhaler when requested even though he had a PRN [as needed] order. The recipient stated that the problems accessing his inhaler did not occur until he moved

to another module. Case notes documented several times up until the beginning of October where the recipient asked for and received the Albuterol inhaler without any problems. It was not documented that the recipient ever asked for it more than once per day. However, beginning 10/2/14 a nurse began questioning the frequency in which the recipient was requesting his inhaler and a medical doctor was consulted and due to already having an increased heart rate, the recipient was denied use of his inhaler. It was documented again on 10/3/14 that another nurse also denied use of his inhaler and encouraged him to increase his fluid intake due to not having any signs or symptoms of respiratory distress. On 10/6/14 a new order was given for Albuterol inhaler every 8 hours.

Although it is beyond the scope of the HRA to decide which medication or dosage is appropriate for an individual, when the inhaler was denied on 10/2/14 and again on 10/3/14, the recipient still had an order for PRN Albuterol. One nurse interviewed stated that if there was an order she would give the medication if requested because she would not want to be the one to deny it and then have something happen. She also stated that Albuterol does increase heart rate but "not that much". WebMD listed increased heart rate as a common but "less severe" side effect of the medication. The second nurse interviewed contended that Albuterol increases the heart rate and possibly causes a "high" feeling and therefore, if a patient was not showing any signs or symptoms of respiratory distress and had an increased heart rate, she would not give the medication. The HRA questioned whether or not simply being in respiratory distress would cause a temporary increase in heart rate. Since at the time of the denial, the recipient had an order for Albuterol PRN, the allegation is **substantiated** and the following **recommendation** is made:

1. Administration should address the inconsistent following of physician orders for PRN Albuterol inhalers by nurses and determine if the inconsistencies exist with other medications as well and retrain as needed.

The following **suggestion** is also made:

1. The nurse documented that she consulted with the physician when she had concerns that the recipient was overusing his inhaler, however there was no documentation from the physician indicating that he or she authorized denial of the albuterol inhaler. It wasn't until 10/6/14 when the recipient had an appointment with the physician that a new order was given. The HRA suggests that in the future, a temporary order be placed in the chart for the nursing staff to follow until the patient can be seen by a doctor to avoid confusion.