FOR IMMEDIATE RELEASE

North Suburban Regional Human Rights Authority
Report of Findings
HRA #18-100-9003
Elgin Mental Health Center

Introduction

The North Suburban Regional Human Rights Authority (HRA) opened this investigation regarding Elgin Mental Health Center (EMHC), Forensic Treatment Program (FTP) after receiving a complaint of alleged rights violations. The complaint accepted for investigation alleged that at least once a week the unit has no clean towels and it runs out of soap; staff members do not always have time to monitor hygiene tasks such as shaving; the unit was without ample showers for some time; a broken window in the dayroom was boarded up which presented a safety matter; and packages dropped off during visitation can take days before the patient receives the package.

The rights of patients receiving services at EMHC are protected by the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5).

Patients receiving services at EMHC's Forensic Treatment Program have been remanded by Illinois County Courts to the Illinois Department of Human Services (DHS) under statutes finding them Unfit to Stand Trial (UST) and Not Guilty by Reason of Insanity (NGRI). Placement evaluations determine the most appropriate inpatient or outpatient setting for forensic treatment based on a number of factors including age, gender, mental health diagnosis, and security need. Unless a person is specifically ordered to receive services in an outpatient setting, court ordered referrals under state forensic statutes call for placement in a secure inpatient setting. The Forensic Treatment Program has approximately 315 beds.

Methodology

To pursue this investigation, the HRA met with EMHC personnel to discuss the allegations raised in this complaint. Also reviewed were facility policies relevant to the allegation.

Allegation: at least once a week the unit has no clean towels and it runs out of soap.

Findings

At the site visit, Center personnel stated that the unit has an ample supply of both clean towels and soap. Should one or the other item run out, the staff can contact the AOD (Administrator on Duty) to get additional supplies or staff members can go to another unit for the needed items. All linens are laundered three times per week. The HRA toured the unit and observed the supply closets. One closet contained a large shelved-cart that contained clean towels and bedding supplies. Next to that closet was the hygiene closet that contained soap, toothpaste, toothbrushes, mouthwash, etc. Each patient is given a small container of liquid soap that is poured from gallon containers. The soap is an all-purpose product, used as shampoo and body wash. In addition, patients can purchase their own hygiene products. These personal products are kept in a separate locked area. The unit has community meetings held two times per day. When asked, the

Center personnel interviewed stated that she had not heard of this complaint during any community meetings.

The Center's Linens policy states that the Central Linen Distribution Section of the Central Support Services shall be responsible for collecting soiled linens and distributing clean linens to units for facility use. Clean linens shall be distributed to units and service areas on a set schedule, with a predetermined level for each inventory item and using a cart system. Delivery schedules for each area shall be determined by past and current usage. The policy states that the Central Linen Distribution Section shall have scheduled work hours of 7:30 a.m.-11:30 a.m. Monday through Friday. If linens are needed at other times, the Central Dietary/Stores Building has linens available.

Conclusion

The Mental Health Code calls for adequate and humane care pursuant to an individual service plan. (405 ILCS 5/2-102a). Based on the information obtained, the HRA found no evidence to support the allegation that once a week the unit has no clean towels and it runs out of soap.

Allegation: staff members do not always have time to monitor hygiene tasks such as shaving

Findings

Center personnel explained that male patients have the opportunity to shave daily Monday-Friday. A staff member must be present to observe the process for safety reasons. Shaving was not an option on the weekends because staffing levels are lower than during the week days. It was stated that about a week prior to the site visit (late October 2017), patients requested that shaving be allowed on the weekends. She stated that staff members have been instructed to accommodate this request if it is safe to do so.

Conclusion

The Mental Health Code calls for adequate and humane care pursuant to an individual service plan. (405 ILCS 5/2-102a). Since staff members must monitor hygiene tasks such as shaving, it is reasonable to assume that from time to time, this might not occur due to low staff levels or other pressing matters occurring on the unit. And, shaving was not offered on the weekends because it was determined there were not sufficient staff members readily available to monitor this task. However, we trust that staff members will make every effort to ensure that all hygiene needs are met as quickly as possible. The allegation is unsubstantiated.

Allegation: the unit was without ample showers for some time

Findings

Center personnel explained and the HRA observed the three shower stalls for patient use. The unit has scheduled shower times three times per day. It was stated that at no time were any of the showers broken or out of order. It was offered that one stall had low pressure, but it was still useable.

Conclusion

The Mental Health Code calls for adequate and humane care pursuant to an individual service plan. (405 ILCS 5/2-102a). Based on the information obtained, the HRA found no evidence to support the allegation that the unit was without ample showers for some time.

Allegation: a broken window in the dayroom was boarded up which presented a safety matter

Findings

It was explained that a window in the dayroom had been broken by another patient throwing a chair at it. The window is safety glass, thus the glass cracked verses shattered. It was explained that Center maintenance personnel boarded-up the window immediately and it was boarded up for about a month since the replacement window needed to be ordered. Center personnel stated that the OIG (Office of Inspector General) investigated the safety issue of the boarded up window and saw no safety breach. The window had been replaced at the time of the HRA visit.

Conclusion

The Mental Health Code calls for adequate and humane care pursuant to an individual service plan. (405 ILCS 5/2-102a). A window in the dayroom was boarded up; since the HRA did not observe this, we have no evidence to determine if it presented a safety concern. We defer to the OIG investigation.

Allegation: packages dropped off during visitation can take days before the patient receives the package.

Findings

At the site visit, it was stated that Center Security must inspect all packages and the contents before the patient can receive the package. This process might take a day or two, but typically no longer than that.

When the package arrives either by the Stores Department or during visitation, Security personnel record the consumer's name and notify the unit that a package has arrived for the consumer. The consumer retrieves the package in the FTP visitation area, where the consumer, a unit staff member and Security observe the consumer open the package. If the consumer is unable to leave the unit, the package will be taken to the unit.

The Center's Patient Mail policy states (in part) that "if mail is a package, Security contacts the unit to inform that a package has arrived for him/her. Patients with packages are notified when Security is available to assist in opening, to proceed to the Visitation Room. Packages must be opened in the presence of a Security Officer and STA [Security Therapy Aide]".

Conclusion

The Mental Health Code calls for adequate and humane care pursuant to an individual service plan. (405 ILCS 5/2-102a).

Since all packages must be inspected by Security personnel, it might take a few days before the patient receives the package; it is concluded that this is not a substantiated allegation.

RESPONSE

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

Bruce Rauner, Governor • James T. Dimas, Secretary

Division of Mental Health/Elgin Mental Health Center
RECOVERY IS OUR VISION
Recovery is a Personal Journey of Hope, Growth, Choice, and Change

January 2, 2018

Ms. Patricia Getchell- Chairperson
North Suburban Regional Human Rights Authority
9511 Harrison Street, W-300
Des Plaines, IL 60016-1565

Re: HRA #18-100-9003

Dear Ms. Getchell:

Thank you for your thorough review. We are happy to hear these allegations were unsubstantiated. Elgin Mental Health Center recognizes and understands the need to have even the basic amenities available to our patients. The Facility feels personal hygiene is a very important step in recovery and so it is part of each patient's individual plan. We also strive to identify and address any safety hazards on the unit, but wait times for special orders are beyond our control.

The Facility continues to review our mail/packages procedures, always looking for ways to streamline and make the process easier for everyone.

Please feel free to include our response with any public release of your Report of Findings.

Sincerely,

Brian Dawson, B.S.
Hospital Administrator

BD/TZ/aw