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Egyptian Regional Human Rights Authority
Report of Findings
11-110-9017
Chester Mental Health Center
March 29, 2011

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Chester Mental Health Center, a state-operated mental health facility located in Chester. The facility, which is the most restrictive mental health center in the state, provides services for approximately 240 recipients. The specific allegation is as follows:

A recipient at Chester Mental Health Center was inappropriately placed in restraints.

Statutes

If substantiated, the allegation would be a violation of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-108 and 405 ILCS 5/2-201).

Section 5/2-108 states, "Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for staff."

Section 5/2-201 of the Code states, "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 the 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 right of persons with developmental disabilities and amending the Acts therein named 'approved September 20, 1985, if either is so designated; and (5) the recipient's substitute decision maker, if any. The professional shall be responsible for promptly recording such restriction or use of restraints or seclusion and the reason therefore in the recipient's record."

Complaint Information

According to the a complaint registered via letter to the Egyptian Regional Human Rights Authority, staff members at Chester Mental Health placed a recipient at the facility into restraints without a valid reason. Information indicated that the recipient was not involved in any activity which would be considered harmful to self or others. Additionally, there were numerous allegations regarding Security Therapy Aides (STAs) abusing the recipient. When the complaint was received the allegations pertinent to the abuse were reported to the Illinois Department of Human Services, Office of the Inspector General (OIG), the agency designated to investigate allegations of abuse at state-operated mental health facilities.

Investigation Information

To investigate the allegation, the HRA Investigation Team (Team), consisting of two HRA members and the HRA Coordinator (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 a Representative (Representative) from the facility's Human Rights Committee. The Authority reviewed information from the recipient's clinical chart with his written authorization, the facility's restraint policy, and an Illinois Department of Human Services Program Directive.

I: Interviews:

A: Recipient:

When the Team spoke with the recipient about the allegation, he stated that he had a verbal altercation with another recipient after the recipient called him "cesspool". The recipient denied any physical violence associated with the incident; however, staff members placed him in physical restraints after the incident occurred. The recipient could not provide the exact date of the restraint episode, but stated that he believed that it occurred, "a couple of weeks ago".

The recipient stated that he was also inappropriately placed on a water restriction protocol. He informed the Team that he does not have any problems which would warrant restriction of his water intake.

B: Representative:

According to the Representative, recipients are only placed in restraints for self protection or the protection of others. The Representative stated that the facility has a written policy that is in accordance with the Code's requirements.

The Representative stated that all of the information pertinent to any restraint application, as well as any recordings pertinent to water restriction would be documented in the recipient's clinical chart. With the recipient's written authorization, copies of the requested information from the recipient's clinical chart were provided to the HRA.

II: Clinical Chart Review:

A: Treatment Plan Reviews (TPRs):

Documentation in the recipient's 10/27/10 TPR indicated that the 50-year-old was admitted to the facility in May 1994 as Unfit to Stand Trial (UST). His legal status was changed to Not Guilty by Reason of Insanity in August 1996 and a Theim date of "natural life" was given.

According to the record, the recipient had received five Behavior Data Reports (BDRs) with zero episodes requiring restraints for the reporting period of 09/27/10 to 10/27/10. However, the record indicated that the restraint applications were necessary on 09/15/10 and 09/26/10 due to the recipient attacking staff members. Documentation indicated that the BDRs were issued for inappropriate sexual behavior, verbal threats toward staff and peers, and being excessively loud and disruptive.

The recipient's problem areas were listed as follows: 1) psychotic symptoms; 2) aggression; 3) water intoxication; 4) predatory sexual behavior; 5) hepatic disorder, and 6) hyperlipidemia.

The recipient's diagnoses were listed as follows: AXIS I: Schizoaffective Disorder, Bipolar Type, History of Poly-substance Abuse: AXIS II: Antisocial Personality Disorder; AXIS III: Hepatitis C Positive, Idiopathic Polydipsia, High Ammonia Levels, Dyslipidemia since 09/28/06 controlled with treatment; AXIS IV: NGRI since 08/29/96 for Aggravate /Criminal Sexual Assault, Theim date of natural life, Attempted Murder, concurrent life sentences in IDOC (Illinois Department of Corrections).

The recipient's medications were listed as follows: 1) Olanzapine 30 mg HS (at bedtime) for psychosis (increased on 10/27/10); 2) Topiramate 100 mg AM and 300 Mg HS for mood lability; 3) VPA (Valproic Acid) Syrup 2,000 mg AM and 5 PM for mood lability; 4) Clonazepam 3 mg TID (three times daily) for anxiety/agitation; and 5) Haloperidol 10 mg and Lorazepam 2 mg PRN (as needed) for anxiety/agitation.

Individualized habilitation goals were listed in the TPR to address each problem area. To address the recipient's psychotic symptoms the following objectives were listed: 1) take medications as prescribed; 2) report a decrease in side effects from the medications; 3) demonstrate an understanding of the medications; and 4) no longer display speech or behaviors indicative of delusion, such as extreme distrust.

In order for the recipient to cope with his anger in a socially acceptable and a less aggressive manner, the following objectives were listed in the 10/27/10 TPR: 1) follow unit rules and routines; and 2) reinforce appropriate social behaviors by offering behavioral support with a consistent reward system and clear expectations of the recipient's behaviors in areas of daily living skills, impulse management, program activities and medical interventions. Documentation indicated that the recipient was currently on red level after being involved in inappropriate sexual behavior. The Red Level is the lowest level of allowed activities in the facility's Level System Procedure.

Documentation indicated the recipient's problem area regarding water intoxication would be addressed by closely monitoring his fluid intake and weighing him twice daily.

Objectives to address the recipient's predatory sexual behaviors included the following: 1) take medications as prescribed; 2) to refrain from any sexually inappropriate behaviors on the module; to learn how to appropriately handle his sexual impulses and aggression. Documentation indicated that the recipient received BDRs for inappropriate sexual behaviors on 01/19/10, 02/14/10, 03/02/10, 04/07/10, 07/22/10, 08/23/10, 08/25/10, 09/27/10 and 1/27/10.

Medication, nutrition education, exercise, weight maintenance, and being compliant with labs were objectives listed to address the recipient's elevated serum cholesterol and triglycerides.

In the Extent to Which Benefitting from Treatment Section of the 10/27/10 TPR, documentation indicated that the recipient's behaviors had not significantly changed during the reporting period. However, he did not have any restraint applications due to physical aggression during the reporting period. The record indicated that the last episodes of restraints on 09/15/10 and 09/26/10 appeared to be related to his excessive fluid intake.

Documentation in the recipient's 11/22/10 TPR indicated that the recipient had received five BDRs with zero episodes requiring restraints during the reporting period from 10/2/7/10 to 11/22/10. The five BDR's consisted of not following directions, cursing and verbal threats towards staff and peers, excessive noise and disrupting behaviors, excessive fluid intake, not staying out of other recipients' rooms, trading, manipulating others, and inappropriate sexual behaviors.

Additional documentation in the 11/22/10 TPR indicated that excessive water intake causes the recipient to become very agitated and aggressive. According to record, the recipient's last episodes of restraints were two periods ago on 09/15/10 when he voided 950 cc's of fluid within four hours and on 09/26/10 when he voided 750 cc's in a two hour period. The record indicated that medical staff related that a normal amount of urine voided would be 30 cc's per hour.

Recordings in the Emergency Intervention/Rights Section indicated that in accordance with the Code, the recipient was informed of the circumstances under which the law permits the use of emergency forced medication, restraint or seclusion. Should any of these circumstances arise, the recipient's only stated preference was listed as emergency medications. The record indicated that the recipient had not listed any additional preferences for emergency treatment at

previous TPR meetings, and after staff's encouragement at the 11/22/10 meeting continued to decline making additional preferences.

According to the recipient's Personal Safety Plan when he is in a crisis staff should instruct him to read a book, write a letter, think positive thoughts, go to a dark room, take a shower, talk to staff, become involved in other activities, or listen to music. Documentation in the Plan indicated that staff should allow the recipient to have personal space.

B: Progress Notes:

Documentation in a 09/15/10 Progress Note indicated that the recipient became angry and attempted to strike a staff member with his fist. The incident occurred at 1:35 PM while the recipient was in the gym. According to the record, a physical hold was implemented; however, his aggression toward staff continued. Due to the recipient's continued physically aggressive actions toward others, he was escorted to the restraint room and placed in 4 point restraints. The record indicated that the recipient's vital signs were assessed, and he was thoroughly examined. The Registered Nurse (RN) completing the progress Note indicated that no injuries were noted, and the recipient did not voice any complaints regarding injury. Additional documentation indicated that the after the restraints were applied the recipient was provided with Restriction Notices, and a urinal was placed at his bedside.

In a 2 PM Progress Note on 09/15/10, a facility physician recorded that while the recipient was in the gym he became agitated and attempted to hit a staff member with his fist. When verbal redirection and a physical hold did not calm him, he was placed in restraints for the protection of self and others.

A Security Therapy Aide (STA) recorded at 2:35 PM on 09/15/10 that the recipient was placed in a physical hold after he attempted to strike an activity worker while he was in the gym. The recipient was escorted to Unit C-3 and placed in four point restriction for the safety of all.

A facility physician recorded at 5:45 PM on 09/15/10 that the recipient had poor insight into his behaviors, continued to be agitated, argumentative, and blamed staff members for his maladaptive behaviors. Therefore, he should remain in restraints for the protection of self and others.

At 9:45 PM on 09/15/10, an RN recorded that the recipient was clam, cooperative, able to discuss the incident and take responsibility for his actions. The recipient was no longer considered a threat to his and/or others' safety. The RN documented that the recipient returned to his room after being released from restraints. Additional recordings indicated that the recipient voided 1750 cc urinary output while he was in restraints.

An RN recorded at 10:45 PM on 09/15/10 that the recipient was resting quietly after the restraint episode.

According 09/26/10 documentation by a facility RN, the recipient made an unprovoked attack on staff at 11:05 AM. After the incident, a physical hold was applied and emergency

medication offered; however, the recipient refused the medication. When the recipient's aggressive behaviors continued, he was placed in restraints for the safety of all. The record indicated that an old laceration above the recipient's left eye was re-opened during the restraint application and a small amount of blood was noticed.

A facility Psychiatrist recorded at 11:50 AM that the recipient was placed in full leather restraints after he was very angry and agitated, refused to go to his room and approached staff in a threatening manner.

An RN recorded in a 09/26/10 Progress Note that the recipient had a small injured area above the left eye which was cleaned with water. After cleansing the area, steri-strips and a band-aid were applied. The recipient was offered ice for placement on the injured area; however, he refused. The RN documented that the recipient denied any reaction to the light, pain in the eye, headache or any vision problems. The RN recorded that the recipient was provided with a Restriction of Rights Notice for the physical hold as well as the 4-point restraints.

In a 09/26/10 Progress Note at 1:15 PM, the RN recorded that the recipient ate 80% of his lunch, drank 240 cc of liquid and voided 750 cc of urine. The RN documented that the recipient remained argumentative, restless and continued to pull at the restraints. According to the RN, the recipient was reminded of the criteria for release from the restraints.

A facility psychiatrist recorded in a 3 PM progress note that the recipient remained agitated, argumentative, loud and uncooperative; therefore, he had failed to meet the release criteria. The psychiatrist ordered that the recipient's electrolytes be evaluated due to the diagnosis of water intoxication.

An RN and a STA documented at 7:15 PM the recipient had met the criteria for release from the restraints. The recipient was able to answer questions in a calm manner following the release.

C: Restraint Records:

1) Restraint I

Documentation in an Order for Physical Hold indicated that the recipient attacked an activity staff member without an apparent reason. He was placed in a physical hold at 1:35 PM on 09/15/10. The record indicated that he was transferred from the hold into handcuffs at 1:40 PM and then into restraints at 1:45 PM. The record indicated that there was no physical or mental distress noted during the physical hold.

The recipient was provided with a Restriction of Rights Notice for the hold. The reason listed for the restrictive measure was the recipient attempted to attack a staff member. According to documentation the Notice was delivered in person, and the recipient did not wish to have any one notified of the hold.

An Order for metal cuffs was instituted at 1:40 PM on 09/15/10. The specific reason listed for the cuffs was listed as the recipient was highly aggressive with staff trying to hit a staff member with his fist. He continued his aggressive behaviors with staff during the physical hold making containment very difficult. Therefore, metal cuffs were utilized to assist containment and to provide safe transport back to the unit. The Order was issued for up to 10 minutes; however, the recipient was in the cuffs for a period of 5 minutes. He was released from the cuffs when the transport was completed, and he was placed in 4-point restraints.

The record indicated that the recipient was given a Restriction of Rights Notice for the application of the metal cuffs which commenced at 1:40 PM and ended at 1:45 PM on 09/15/10. The reason listed for restriction was that cuffs were needed for transport due to the recipient's continued struggling and attempts to fight staff. According to the documentation, the Notice was delivered in person, and the recipient did not wish to have anyone notified.

An Order for Restraint began at 1:45 PM when the recipient was released from the metal cuffs. The specific behavior requiring restraint was listed as the recipient attempted to hit a staff member with his fist while in the facility gym. When his aggression continued after the physical hold and metal cuff application, placement in restraints was necessary. The Order was issued for up to 4 hours in order to allow the recipient time to calm himself and to gain control of his impulses. The criteria for release from the restraints was listed as follows: 1) to become calm, cooperative and appropriate during reviews; and 2) to no longer make verbal threats, yell, curse or display anger for a period of 60 minutes.

An RN recorded an examination of the recipient at 1:45 PM, and a facility physician examined him at 2 PM. Both medical professionals assessed that the restraint application did not pose any undue risk to the recipient in light of his physical and medical status and verified their examination and assessment by signing the Order.

Documentation in the Restraint Flowsheet indicated that post application the recipient's body was searched by an RN. The RN determined that restraints were properly applied and the individual was properly positioned. A determination was made that the room environment was appropriate, and the recipient was wearing proper clothing for the restraint. The record indicated that the RN informed the recipient of the reason for the restraint, the release criteria and provided him with a Restriction Notice pertinent to the restraint.

Additional documentation in the Flowsheets indicated that the recipient was continually observed, and his behaviors were documented in 15-minute increments. An RN checked circulation in all four extremities, released his limbs, checked vital signs and offered fluid and toileting hourly. He was given an evening meal at 4:15 PM, and the record indicated that he ate 100% of the items served. His medical and physical statuses were also evaluated hourly by the RN.

The record indicated that the recipient did not reach the established release criteria when the initial Restraint Order expired; therefore, a second Order was issued at 5:45 PM. Documentation indicated that attempts at redirection, empathic listening and reassurance failed to calm the recipient. The release criteria remained the same as listed in the initial Order.

Documentation indicated that the recipient was examined by an RN and a facility physician at 5:45 PM. Both medical professionals determined that the restraints did not pose an undue risk to the recipient. Documentation in the Flowsheets associated with the second Order indicated that the recipient met the release criteria at 9:45 PM.

Documentation in a Post-Episode Debriefing indicated that an RN conducted a debriefing with the recipient after he was released from the restraints at 9:45 PM on 09/15/11. According to the documentation, the recipient was able to identify stressors occurring prior to the restraint and to verbalize an understating of the causes and consequences of his behaviors. The RN recorded that the recipient was encouraged to discuss his feelings related to the restraint, and he stated that he was aware that he could request staff assistance prior to the escalation of his anxiety. Additional documentation indicated that the recipient expressed that staff could not have helped him to remain in control in the situation which led to the restraint, and he was unable to identify method(s) to control his aggressive behaviors. The RN recorded that the reasons why previously identified early interventions were not employed were discussed with the recipient. The RN recorded that the recipient did not receive any physical injury during the restraint episode. It was determined that his physical well-being and his privacy needs had been addressed during the restraint.

A Restriction of Rights Notice was given to the recipient for the 8 hour restraint episode which began at 1:45 PM and ended at 9:45 PM. The reason for the restraint application was listed as the recipient made a random attack towards staff. Documentation indicated that the recipient was delivered to the recipient in person, and he did not wish to have anyone notified of the restraint.

Additional recordings in a Formal Debriefing Follow Up Interim Treatment Plan indicated that a social worker, mental health administrator and an RN met on 09/16/10 to discuss the recipient's restraint. Documentation indicated that the recipient was placed in restraints after he attempted to strike an activity staff member with his fists. The record indicated that a STA intervened and prevented the recipient from striking the activity worker. As a result of the recipient's actions, he was placed in a physical hold. During the hold he fought with staff and struggled to the point that the use of metal handcuffs was necessary in order to transport the recipient to an area where restraints could be applied. According to the clinical review it was not clear what led the recipient to be involved in the behaviors since he had not been in restraints since 06/01/10. The Team determined that this appeared to be an isolated event rather than deterioration in the recipient's mental condition. No TPR modifications were suggested after the information was analyzed.

<u>Restraint 2:</u>

According to documentation, the recipient came toward staff yelling and cursing. When he was asked to calm down and go to this room, he refused and became physically aggressive toward the staff members. The record indicated that the recipient was placed in a physical hold at 11:05 AM on 09/26/10 after the physical aggression began. According to documentation, an Order for Physical Hold was completed at 11:05 AM on 09/26/10. Documentation indicated that

a facility physician and an RN examined the recipient at 11:05 AM and determined that the physical hold did not pose an undue risk to the recipient's health.

The recipient was provided with a Restriction of Rights Notice for the Physical Hold, which was implemented at 11:05 AM and ceased at 11:15 AM on 09/26/10. Aggression towards staff by trying to hit them with his fist was listed as the reason for the hold. Documentation indicated that medication, the recipient's preferred intervention, was offered during the physical hold; however, the recipient refused the medication. According to the record, the Notice was delivered to the recipient in person, and he expressed that he did not want anyone notified of the hold.

An Order for Restraint was implemented at 11:15 AM on 09/26/10 when the recipient's aggressive behaviors continued. Documentation indicated that the recipient was offered medication during the physical hold; however, he refused. The record revealed that behavioral interventions, such as redirection, verbal support and conflict resolution were implemented. When the attempts failed and his behaviors continued, the recipient was placed in restraints for the safety of all.

The Order for Restraint was issued for up to 4 hours with 1 hour reviews. The Release Criteria was listed as follows: 1) to be calm, cooperative and appropriate during reviews; 2) to not show any signs of anger, such as yelling, cursing, threatening, and pulling on restraints for a period of 60 minutes.

Documentation indicated that a facility physician and an RN examined the recipient at 11:15 AM. Both professionals assessed that the restraint application did not pose an undue risk to the recipient.

Documentation in Restraint Flowsheets indicated that post application of the restraint, the recipient's body was searched. An RN conducting the evaluation determined the following: 1) The room environment was appropriate; 2) He was wearing proper clothing for the restraint; 3) He was properly positioned; and 4) The restraints were properly applied. The RN informed the recipient of the reason for the restraint and the criteria for release from the restraints. The recipient was provide with a Restriction of Rights Notice for the restraint episode.

According to recordings in the Restraint Flowsheets, the recipient was continually monitored and his behaviors recorded in 15-minute increments. He was offered toileting and fluids on an hourly basis. An RN checked his circulation, released his limbs, took his vital signs and assessed his physical status hourly. He was provided with a noon meal at 12:15 PM; however, no receipt of the evening meal was documented. According to the record, the recipient did not meet the criteria for release from restraints until 7:15 PM, a period of time that an evening meal was scheduled to be served.

A Restriction of Rights Notice was given to the recipient for the 8 hour restraint which began at 11:15 AM and ended at 7:15 PM on 09/26/11. The reason listed for the restriction was the recipient continued to be combative and refused medication, his choice of emergency intervention. Due to the level of his continued aggression, he was placed in restraints for the

safety of all. The record indicated that the Notice was delivered to the recipient in person, and he expressed that he did not wish to have anyone notified of the restraint application.

An RN conducted a Post-Episode Debriefing with the recipient when he was released from the restraints at 7:15 PM on 09/26/10. According to the documentation the recipient was able to identify stressors occurring prior to the restraint, to verbalize an understanding of the causes and consequences of his aggressive behaviors, and to identify methods to control the behaviors. The record indicated that the recipient expressed that he felt that staff could have helped him to remain in control, and he stated that he was aware that he could request assistance from staff prior to escalation of his anxiety. The RN documented that the recipient was encouraged to discuss his feelings related to the restraint episode. Documentation indicated that the recipient received an injury during the restraint process and an injury report was completed. The RN determined that the recipient's physical well-being and privacy needs had been addressed during the restraint.

Documentation indicated that the Treatment Team met on 09/27/10 to discuss the recipient's 09/27/10 Restraint episode. After discussing the events associated with the restraint, the Team determined that the recipient's behaviors had not changed significantly to show evidence of clinical de-compensation. No treatment changes were recommended.

D: Additional Documentation

The HRA observed Restriction Notices pertinent to the restriction of water to the sink and toilet in the recipient's room due to his diagnosis of water intoxication. The documentation indicated that the restrictions were reviewed every 30 days to determine the appropriateness. The recipient was provided with a Restriction Notice for every 30 day period of the restriction.

III: Facility Policy and Program/Policy Directives:

A: Use of Restraint and Seclusion (Containment) in Mental Health Facilities Policy (Policy)

The Policy Statement is listed as follows, "Chester Mental Health Center uses restraint and seclusion only as a therapeutic measure to prevent an individual from causing physical harm to himself or others and follows the Department of Human Services Program Directive 02.02.06.030.

B...Illinois Department of Human Services Program Directive 02.02.06.030 (Directive)

The Policy Statement in the Directive is as follows, "It is the policy of the Department of Human Services, Mental Health (DHS/MH) that the use of restraint or seclusion be limited to emergencies in which there is an imminent risk to an individual harming himself or herself, other patients, or staff. This directive is the primary directive for the use of restraint and seclusion in mental health facilities. It is consistent with the requirements of the Mental Health and Developmental Disabilities Code. It supersedes any previous DHS or mental health facility procedure. For clinical and administrative reasons the DHS may have chosen in this directive to

exceed MHDD Code of Joint Commission on Accreditation of Health Care Organization (JCAHO) requirements; therefore this directive takes precedence.

Neither restraint nor seclusion may ever be used to punish or discipline an individual or as a convenience to staff. The least restrictive intervention that is safe and effective for a given individual will be used. It is the role of leadership to create a physical, social, or cultural environment in which the approach to restraint and seclusion protects the individual's health and safety; preserves his or her dignity, rights, and well-being; and minimizes the risks to staff and others. Limiting restraint and seclusion use to clinically-appropriate and alternative strategies is the role of all staff. An approach to restraint and seclusion utilization that focuses on reduction while striving to assure the safety of the individual, other patients, and staff requires planning, thoughtful education, and continuous efforts at performance improvement.

The circumstances that result in the use of restraint or seclusion are complex. Consequently, the strategies for reducing and eliminating restraint and seclusion may be multi-faceted and incorporate multiple points of view, including those patients, consumers, and staff at all levels of the organization. It is the position of DHS/MH that the goal of reduced restraint and seclusion utilization be approached through a broad range of strategies for enhancing positive behaviors, preventing destructive behaviors, and limiting the circumstances that may necessitate the use of restraint or seclusion. These include, but are not limited to:

1. the use of nonphysical interventions as preferred interventions for both patients and staff:
2. the implementation of staff training based upon nationally-recognized training program in conflict de-escalation and prevention;
3. the inclusion of the consumer perspective on the restraint and seclusion experience and perceived opportunities for reducing utilization; and
4. effective assessment and treatment."

Summary

According to the recipient whose rights were alleged to have been violated, he was placed in restraints without a valid reason for their use. However, documentation in the recipient's clinical chart indicated that the recipient was placed in restraints on 09/15/10 and 09/26/10 after he attacked staff members. The record indicated that prior to restraint applications, the recipient was placed in physical holds and when his aggressive behaviors accelerated, it was necessary for him to be placed in restraints for self protection and the protection of others. Facility Policy and an Illinois Department of Human Services Program Directive reviewed were in accordance with the Code's requirements which mandates that restraint only be used as a therapeutic measure to prevent an individual from causing physical harm to self or others.

Conclusion

Based on the information obtained during the course of the investigation, the allegation that the recipient was inappropriately placed in restraints is unsubstantiated. No recommendations are issued.

Comment and Suggestion

The Authority acknowledges that the recipient met the criteria for placement in restraints for both September 2010 restraint applications. However, according to documentation in Flowsheets associated with the 09/26/10, the recipient was not provided with an evening meal during his restraint, which is a Code requirement. Therefore, the Authority fervently suggests the following:

1. Facility staff should ensure that during a restraint episode a recipient is provided with a meal at each scheduled meal time and appropriate documentation be completed pertinent to the offering/acceptance in the Flowsheets.