FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
Chester Mental Health Center
12-110-9038

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 recipient is unable to access the care of medical specialists.
2. Staff do not behave in a professional manner when they laugh at a recipient and make inappropriate comments toward him.
3. A recipient's music was inappropriately taken from him.
4. A recipient was inappropriately locked out of his room.
5. A recipient was subjected to excessive restraint use.
6. A recipient was not allowed to use a phone for an entire month and the phone was treated as a reward rather than a right.
7. The recipient was subject to large doses of medication.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-100 et seq.) and Chester Mental Health Center policies. Chester Mental Health Center is a secure, inpatient mental health facility operated by the Illinois Department of Human Services. The facility has 240 beds.

To investigate the allegations, an HRA team interviewed a recipient who maintains his legal rights, interviewed facility representatives, reviewed a recipient's records with written consent and examined pertinent facility policies.

COMPLAINT STATEMENT

According to the complaint, a recipient had been at the facility for approximately six months when he began having issues. For one entire month, the recipient was allegedly not allowed to call anyone and the phone was used as a reward. The recipient reportedly has a history of seizures and cardiac issues but is unable to see specialists for these medical needs. The recipient is reportedly given large dosages of medication and subjected to excessive restraint use for 24 to 48 hours at a time. One restraint incident that occurred in February 2012 resulted in the recipient becoming unconscious. The complaint also stated that the recipient is subjected to rude behavior from staff, including being laughed at and being threatened that they would "smash his nuts and cut off his toes." The recipient is also reportedly locked out of his room.

FINDINGS

Interviews

In a July 2012 interview with the recipient, the HRA was informed by the recipient that he was recently placed in restraints for singing and dancing. He stated that he believes restraints are aggressively used by staff against him. He reported that he was placed in restraints in January until he passed out and the Department of Human Services, Office of the Inspector General (OIG) investigated. He reported that, at other times, he has been placed in restraints for spitting at staff and after threatening to kill himself. He stated on one occasion, staff rubbed a soiled sheet in his face after being restrained and another time he was left in soiled clothing. These incidents occurred on July 10th and July 11th of 2012. The recipient stated that he has a history of an enlarged heart and hypertension as well as a seizure disorder and he has not seen any specialists since his admission; he stated that his blood pressure increases when he is in restraints. The recipient reported that he was locked out of his room for kicking a door and the lock-out lasted for approximately one month. With regard to telephone use, the recipient reported that he can currently use the phone but he verified that he was not allowed to use it earlier in the year due to behaviors; he stated that he could not talk with anyone, including his mother. He also stated that staff monitored his calls. The recipient reported that his current medications make him drowsy and do not seem to help. With regard to staff behaviors, the recipient stated that while some staff are nice, others call him names, make fun of him and call him the "N word." The HRA reported these matters to the OIG and to facility administration. Facility administration reported that they reported to the OIG as well.

Later, the HRA met with the facility medical director who reported that medical specialists are sought if facility medical staff see a need; the director stated that there currently is nothing significant to warrant specialists for the recipient in this case. A facility therapist reported that the recipient is placed in restraints and given restrictions due to behaviors.

The HRA also had e-mail communication with the facility's assistant director of nursing who consulted with the clinical nurse manager, unit director and unit therapist as part of her response to the HRA's questions. According to the facility staff, the recipient's telephone access has never been restricted. The recipient has signed consent for his mother to talk with staff and the recipient has regular telephone contact with her as well. It was reported that at the time of the recipient's admission, the mother was contacting different staff on different shifts to obtain recipient information, and the treatment team determined that it might be best for the mother to talk to specific individuals for recipient updates; two staff persons were identified. The mother contacts staff approximately 1 to 2 times per week and has regular contact with the recipient via calling cards provided by the mother. Staff reported that they do not remember any incident in which the recipient passed out during a restraint episode; staff indicated that they conducted a review of the record to check on this and found nothing. With regard to the seizure issue, staff stated that the recipient was admitted with a diagnosis of "history of seizure disorder" and was admitted with and continues to take the medication, Dilantin, for seizures. His chart includes a seizure record and he is on the "seizure precautions list" for his unit; however, he has not had a seizure since admission and the dosage of Dilantin has been modified due to medication levels. Staff also reported that the recipient's access to music has never been restricted; music is listed in

his treatment plan as a means to distract him from self-injurious behaviors. With regard to medication side effects, staff indicated that there is no documentation of any side effects and the recipient frequently refuses his medication; the medications, Clozaril and Propranolol, were considered for the recipient but the physician declined. Staff indicated that the recipient's EKG at admission was within normal limits. Finally, staff reported that the recipient was either in full leather restraints or on special observation almost every other day during the first 3 to 4 months after his admission and that being in full leather restraints or on special observation limits a recipient's access to some things. For example, a recipient cannot talk on the phone or have access to his music if he is in full leather restraints or if he is in a quiet room. Staff also reported that when the recipient is informed he is being considered for transfer to another facility, his behaviors seem to increase; if transfer is not discussed, the behaviors stabilize.

Record Review

With the recipient's consent, the HRA examined the recipient's record. According to the record, the recipient was admitted to the facility from another state-operated facility on 11-03-11 due to aggression. Numerous assessments were completed at the time of admission and within a few months after admission. An electrocardiogram (ECG) was completed on 01-25-12 noting some abnormalities, including "Left Atrial Abnormality," "QRST Contour Abnormality consistent with Anteroseptal Infarct", and an "Abnormal ECG." The referrals for the ECG were made as part of a medical work-up to consider the administration of the medications of Propranolol and Clozaril which has not been prescribed. There has been no referral to a neurologist while at Chester.

A behavioral management plan was developed on 12-20-11 for self abusive and physically aggressive behaviors with the overall goals to exhibit adaptive social function without self abusive or aggressive behaviors. Replacement behaviors included adaptive social interaction, self-behavior monitoring/management and positive goal directed behaviors. A disruptive sleep pattern was identified in which the recipient slept during the day and was awake at night. Thus, he was locked out of his room from 8:30 a.m. to 11:30am, from 12 pm to 4:30 pm and then from 5 to 9 p.m. He was allowed to be in his room from 11:30 am to 12 pm, 4:30pm to 5 pm and from 9 pm until 8:30 am. There was no identified time span for the room lock out; instead there is a general objective to earn 75% of his reinforcement (encouragement from staff) for 3 months by July of 2012.

A functional assessment was completed on 01-11-12. According to the assessment, the recipient "…presents 'seizure-like' activity. In 2011, while at [the other state-operated facility] he exhibited behaviors such as 'shaking limbs …and was non-responsive.' Following the episode he underwent neurological evaluation including EEG and MRI. Evaluation results did not support a diagnosis of seizure disorder. The report stated 'A video EEG showed no epilepticum discharges and no focal slowing. The MRI showed no abnormal evidence of a mass effect, hemorrhage, or edema, and it was normal pre-and-post contract MRS.' Results suggested [the recipient] likely exhibits 'pseudo-seizures.'" The assessment further stated that "Due to the serious nature of the target behavior - especially the self-injurious behaviors, attention from staff occurs immediately following the behavior….The attention usually consists of staff prompting [the recipient] to discontinue hitting himself. On those occasions when he exhibits sustained self-injurious behavior, staff implement holding restraint which usually leads to 4-5 point restraint. Also,

when an injury is detected, [the recipient] receives attention from direct care, and medical staff….[The recipient] also appears to relish opportunities to report his injuries to his mother who then typically provides an emotional response. The assessment includes documentation of PRN (as needed) medication as well as restraint episodes. There were a total of 81 PRNs (as needed) from 08-17-11 to 19-13-11 and from 10-2511 to 12-11-11 in both Chester and the other state-operated facility; there were 39 episodes of "containment" during the same time frame. The assessment suggests that attention from staff, possible psychosis, attention from his mother and anxiety may contribute to the behaviors. Recommended interventions included contact with a limited number of staff, limited contact with his mother and a behavior plan with reinforcement for adaptive behaviors. Medications at the time included: Haldol 10 mg twice per day, Paroxetine 20mg per day, Benztropine .5 mg twice per day, Amitriptyline 50 mg at bedtime and Ativan 2mg in the a.m.; PRN medications included Olanzapine and Ativan.

A treatment plan dated 11-20-12 documented 5 restraint episodes for a total of 26 hours and 23 PRNs in October and 9 PRNs but no restraints during the month of November through 11-20-13. The treatment plan indicated goals to address disruptive behavior, self abusive behavior, physical aggression, psychiatric symptoms, substance abuse and pseudo seizure disorder. His Diagnosis included: Psychosis, Not Otherwise Specified (NOS); Personality Disorder, NOS; History of Seizure Disorder; History of Enlarged Heart per mother, etc. Medications were listed as Diazepam 5 mg four times per day, Chlorpromazine 300 mg twice per day and Desyrl 100 mg at night. His plan stated that "When [the recipient] begins exhibiting behaviors such as: tapping the wall; placing his foot against others; making spitting gestures, etc., ask him if he would be willing to take a PRN. If he declines the PRN, immediately ask the nurse to initiate emergency enforced medication. This step is necessary because the disruptive, repetitive behaviors are an early part of a behavior chain which leads to more serious behaviors (self-injuriousness and physical aggression) which are potentially harmful to [the recipient] and/or to others. [The recipient] has stated he finds being placed in restraints reinforcing. He often engages in target behaviors with the goal of being placed in restraint. If [the recipient] is placed in restraints, interact with him as little as is absolutely necessary. Do not show emotion or provide commentary on his behaviors. He enjoys this attention….The therapist will meet with [the recipient] in the morning, and again in the early afternoon in order to provide supportive interaction and individualized attention." The plan indicates an overall improvement in the recipient's behaviors and noted that the recipient does take Dilantin for seizures although no seizure activity was noted.

The HRA examined progress notes related to the complaints. On 07-01-12 at 1915, the recipient was placed in FLR for kicking recipient's room door to the point of injuring his toe and after verbal redirection failed. PRN medication of Haloperidol 5mg IM and restraints were continued. On 07-02-12 at 7:15 a.m., it was noted that the recipient had been in restraints for 12 hours after an incident with a peer and restraints were to be continued until the team could assess. "Pt calm but unable to verbalize he will not kick/slam door at this time." The recipient met restraint release criteria at 11:15 am and was released. At 11:55 a.m. "Pt offered PRN. Pt kicking door loudly, Pt refused to stop with much encouragement. Pt refused PRN … Pt constantly redirected to stop kicking door would not stop. When redirected Pt became explosively angry. Placed in physical hold. Fighting and struggling with staff while in physical hold. When escorted to the restraint room PT's behavior became more violent and aggressive kicking trash

can repeatedly…Pt. very aggressive. Pt. placed in 4 point FLRs…Release criteria explained to Pt. Restriction of rights given. A review was conducted by the physician at 4 pm and restraints were continued. He subsequently refused to respond to questions to meet release criteria, stating he didn't care. He later began yelling, spitting, and jerking and he was to remain in restraints and more PRN medication was given. He became incontinent at 2345 and the notes stated he was "cleaned and changed." He was released from restraints on 07-03-12 when he became calm; the physician ordered a Clozaril work up. The recipient was offered and accepted a PRN for walking around with his pants down. On 07-04-12 at 0740 the recipient was placed in 4 point restraints for kicking staff in the groin. The restraints were continued at 11:45 am noting that the recipient denied wrong doing, continued to be uncooperative, and spitting at staff. At 1415, he was thrashing on bed and agreed to take PRN. At 1515, the notes stated that he was calmer but verbalizing his desire to take out a peer's eyes. A review was conducted at 345 pm and due to exaggerated crying, release criteria not having been met and threats to staff and peers, restraints were continued. They were continued again at 1945 when he had not met release criteria. He was released at 2145 when he met release criteria. He was placed in restraints after refusing a PRN and verbal redirection for kicking a peer.

The HRA examined a DMHDD clinical note regarding the initial note indicating that the recipient has an allergy to Haldol. The note, dated 11-30-11, stated that the physician spoke to the recipient and his mother and both confirmed that the recipient does not have an allergy but may have experienced some past side effects; it was unclear to the HRA why an admission document referenced an allergy to Haldol. The HRA also examined an echocardiogram report completed 09-16-11 which was done at a Chicago medical center cardiology department. The study stated that the recipient's right and left atrial and ventricular sizes are normal; the aortic, mitral, tricuspid and pulmonic valves are normal; global normal left ventricular function is normal with an ejection fraction to be 55 to 60% and moderate concentric left ventricular hypertrophy.

The HRA saw no documentation of seizures, complaints of chest pain, reference to cardiac symptoms, telephone restrictions, music restrictions, complaints of medication side effects or documentation of staff to patient interactions. The record does indicate regular physician reviews of the recipient's status. When the recipient was in restraints or receiving PRN medication physician contact was daily or even more frequently depending on the continued need for restraint use. The recipient's medication did appear to change from admission to more recent treatment plan documentation. HRA interviews with the recipient, over the phone and in person, did not give the appearance that the recipient was overmedicated at the times of the interviews.

OIG Report

The HRA examined an Illinois Department of Human Services' Office of the Inspector General report regarding allegations that the recipient had been tormented by staff on a regular basis. According to the report, investigators met with the recipient on two different occasions and the recipient denied that staff were tormenting him. The report further stated that nothing in the recipient's record or treatment plan documented concerns on the part of the recipient. The report concluded that "the allegation of mental abuse is unfounded."

Policy Review

The facility maintains a policy in which facility physicians can request medical services that are "…not provided and are not within the professional expertise of the Chester Mental Health Center." A physician referral form is completed and then tracked. The policy also describes the consultation review process. A list of referral resources are listed within the policy and include neurologists and cardiologists through an area hospital.

The facility's Code of Conduct addresses staff to patient interactions and dictates that patients are to be treated with dignity, respect and courtesy.

The facility's Psychotropic Medication policy discusses the need for informed consent which includes providing the recipient or guardian with education on the medication being prescribed, including medication information sheets. The facility maintains a medication review panel.

Chester's restraint policy dictates that restraints are to be used for therapeutic purposes to prevent harm to the recipient or others. When used, treatment team members are to meet with the recipient to discuss release criteria and to determine if the criteria has been met when nursing conducts its evaluation. A clinician also determines if the recipient is at risk for self harm prior to releasing the restraints. When restraints have been in place for 12 hours or if there are 2 or more episodes of restraint use in 12 hours, psychiatric follow-up is to occur. Treatment teams will meet the day following the restraint episode to determine needed treatment plan revisions. A debriefing is also conducted with the recipient. Quality assurance reviews of restraint incidents and results are conducted and compiled into monthly reports for distribution to all direct care staff. The policy requires that reviews of the continued need for the restraint are to be conducted every 2 hours by a minimum of 3 staff, one of whom must be a clinician. Fifteen minute checks are to be documented. Restriction of rights forms are to be completed.

Chester's recipient rights policy dictates that recipients have full access to their rooms unless a clinical reason restricts access as documented in recipient treatment plans. Recipients are also to have access to their personal property unless a restriction is clinically indicated. If property is restricted then it is to be stored until access is allowed. The rights policy guarantees the right to telephone calls, communication and visits. In addition, recipient have the right to refuse medication and the right not to be restrained except as provides for in the Mental Health and Developmental Disabilities Code. Restrictions can occur "When in the judgment of a physician, a patient requires a restriction due to medical/physical reasons involving his safety or the safety of others…." Initial restriction orders are not to exceed 7 days without a new order and approval from the facility Medical Director. If a restriction continues for a month then monthly restriction renewals are required along with written justification. Weekly reviews of the restriction are to be conducted by the treatment team. Restrictions lasting more than a month must be approved by the facility director or designee.

The Illinois Department of Human Services Rights Statement includes the right to telephone communication unless to protect against harm and harassment, the right to be free from restraint unless needed to protect from harming self or others, the right to adequate and humane treatment pursuant to a treatment plan and the right for designated individuals to be noticed if a recipient's rights are restricted.

MANDATES

The Illinois Administrative Code regulations (59 Ill. Admin. Code 112.90) address the administration of psychotropic medications in Department of Human Services programs. According to the regulations, "No psychotropic medication … shall be prescribed for a recipient unless examinations have been conducted….." The regulations also state in the same section that the attending physician is to document the status of a recipient's condition and possible medication side effects at a minimum of once every 30 days.

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) guarantees the right to "…adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan." The facility is to consider the views of the recipient when developing the treatment plan, and if psychotropic medication is to be administered, the physician or designee is to provide the recipient with information about the medication, including the side effects, risks and benefits as well as any alternatives.

The Code guarantees in Section 5/2-103 the right to "…unimpeded, private and uncensored communication with persons of his choice by mail, telephone and visitation." Communication can be restricted "…only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission. When communications are restricted, the facility shall advise the recipient that he has the right to require the facility to notify the affected parties of the restriction, and to notify such affected party when the restrictions are no longer in effect."

According to Section 5/2-104, recipient can possess their own personal property provided that there is reasonable space. Also, certain classes of property can be restricted by the facility director to protect recipient and others from harm as long as all recipients are noticed at admission. Property can also be restricted to protect the recipient or others from harm.

Section 5/2-107.2 requires a treatment review panel to review medication that has been given to a recipient routinely for 3 months and then subsequently every 6 months. The recipient is to receive notice of the review, can participate in the review meeting and can inform the committee whether or not he wants to continue the treatment. If he refuses continued treatment, the treatment can be discontinued unless court ordered and absent an emergency.

Section 5/2-108 addresses restraints and states that "Restraint 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 restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for the staff….restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of restraint is justified to prevent the recipient from causing physical harm to himself or others. In no event may restraint 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 restraint 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 restraint and the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for that length of time. No order for restraint shall be valid for more than 16 hours. If further restraint is required, a new order must be issued pursuant to the requirements provided in this Section…. The facility director shall review all restraint orders daily and shall inquire into the reasons for the orders for restraint by any person who routinely orders them…..Restraint may be employed during all or part of one 24 hour period, the period commencing with the initial application of the restraint. However, once restraint has been employed during one 24 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…..Restraint shall be employed in a humane and therapeutic manner and the person being restrained shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. The qualified person shall maintain a record of the observations. Specifically, unless there is an immediate danger that the recipient will physically harm himself or others, restraint shall be loosely applied to permit freedom of movement. Further, the recipient shall be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the recipient or others.

Section 5/2-201 requires that when rights are restricted, notices of rights restrictions are to be issued to the recipient, any person designated by the recipient, the Guardianship and Advocacy Commission or a protection and advocacy agency, and any substitute decision maker.

Section 5/2-107 states the following: "An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services."

CONCLUSIONS

Complaint #1: A recipient is unable to access the care of medical specialists.

The complaint stated that the recipient is unable to access the care of medical specialists for a recipient's seizure and cardiac needs. Staff reported and the record reflects that the recipient has had no seizures at the facility but continues to receive seizure medication, be monitored for seizure activity and be subject to seizure protocol on his living unit. An MRI and EEG conducted at a prior facility in the same year as his admission to Chester indicated "no abnormal

evidence." An ECG completed as part of a medical work up for medication consideration indicated some "abnormalities" but staff reported that the test was within normal limits. An echocardiogram completed at a Chicago medical facility prior to Chester admission indicated mostly normal functioning. There was no record documentation of signs/symptoms related to cardiac distress which was reiterated in a meeting with the facility medical director. The medical director reported that, if warranted, referrals to medical specialists are made but no such referral is warranted in the recipient's case. The facility maintains a policy and list of resources for making referral to medical specialists. The Mental Health Code guarantees adequate and humane care and services pursuant to a treatment plan. The recipient's treatment plan includes goals and objectives related to seizure activity. Based on the evidence, the HRA does not substantiate the allegation that the recipient is unable to access the care of medical specialists.

Complaint #2: Staff do not behave in a professional manner when they laugh at a recipient and make inappropriate comments toward him.

The complaint stated and the recipient reported that staff make inappropriate comments toward him. The record did not indicate any reported concerns regarding staff behavior toward the recipient and an OIG investigation indicated that the recipient denied any complaints about staff mistreatment after having been approached by OIG investigators on two different occasions. The facility maintains a Code of Conduct and the Mental Health Code requires "humane treatment." Based on the available evidence, the HRA cannot substantiate the allegation but does suggest that the facility continue efforts to remind staff of the Code of Conduct.

Complaint #3: A recipient's music was inappropriately taken from him.

The staff reported that the recipient was never restricted from his music although his access may have been limited when in restraints and seclusion. Staff indicated that music is used as part of treatment planning. The recipient reported he was placed in restraints for singing and dancing. There was no record documentation of music being taken from the recipient, a music restriction or restraint use for singing and dancing. The HRA did find that music was listed as a possible distraction from aggressive behaviors. The facility's recipient rights policy indicates that recipients can access their personal property unless clinically indicated and restrictions can occur for reasons involving the safety of the recipient and others. The Mental Health Code guarantees access to personal property unless certain classes of property are restricted upon admission because they are identified as being potentially harmful to the recipient or others and property can be restricted after admission if an individual's property is deemed harmful to self or others. Based on the lack of evidence that the recipient's music was restricted, the HRA does not substantiate the complaint.

Complaint #4: A recipient was inappropriately locked out of his room.

The recipient reported and the record indicated that the recipient was locked out of his room. The recipient believed that he was locked out of his room for kicking a door while the record indicated that the recipient was locked out of his room due to his sleeping patterns. The lock out was included in the recipient's treatment plan although the objective for meeting the related goal/objective concerned the earning reinforcements (i.e. staff encouragement) which did not appear entirely consistent with improved sleeping patterns, the start date of January 2011 was prior to his admission at Chester, and then the completion date of July 2012 seemed to be an excessive time frame. The recipient reported, however, that the lock out lasted approximately

one month. Also of concern was the excessive amount of time the recipient was locked out of his room which totaled 11 ½ hours per day; he was allowed access over night and for brief intervals during the day. There was no evidence that the facility attempted alternatives to improving the recipient's sleep patterns before resorting to the room lock-out which appeared in his treatment plan dated 12-20-11, a little over one month after admission.

Chester's recipients' rights policy states that recipient are to have full access to their rooms unless a clinical reason restricts access as documented in the recipient's treatment plan.

The Mental Health Code guarantees adequate and humane care and treatment in the least restrictive environment pursuant to a treatment plan with input from the recipient.

Although the room lock-out was addressed in the recipient's treatment plan, the HRA contends that this approach was highly restrictive and without attempting less restrictive measures for improving the recipient's sleep patterns violates the principle of least restriction. Furthermore, the amount of time that the recipient was locked from his room totals almost half of a day which verges on the inhumane. And, the lack of consistency between the problem of irregular sleeping patterns and the goal of meeting 75% reinforcement (staff encouragement) along with the recipient's lack of understanding of the rationale for the lock-out even though he is a treatment team member leads the HRA to conclude that the treatment planning aspect of the lockout was insufficient. **Based on its findings, the HRA substantiates rights violations related to the room lock out in the areas of least restriction, treatment planning and recipient involvement in treatment planning and recommends the following:**

1. **Ensure that least restrictive approaches are considered when addressing behaviors by utilizing less restrictive alternatives, when possible, before moving toward more restrictive approaches. For disrupted sleep patterns, consider alternative, less restrictive approaches before considering a room lock-out. When a room lock-out is considered, review the number of hours a recipient is to be locked out.**

2. **Ensure that objectives are consistent with goals and that the time frames and criteria for achieving objectives are reasonable.**

3. **Ensure that recipients are aware of the treatment plan goals, objectives and rationale. Seek recipient participation in goal development as required by the Mental Health Code.**

<u>Complaint #5: A recipient was subjected to excessive restraint use.</u>

Staff reported and the record supports frequent restraint use for the recipient in this case particularly in the months following admission. The complaint stated that the recipient was restrained on one occasion until he became unconscious; however, the HRA found nothing in the record to support this. The record does indicate that restraints appeared to be used when the recipient was physically aggressive to staff, others or to himself; the recipient confirmed that he was restrained for aggression. The facility did maintain a behavior plan to help address the recipient's behaviors and restraint use has declined over the recipient's stay at the facility consistent with the recipient's improvement in behaviors. There were frequent nursing and

physician reviews of the restraint use along with release criteria which appeared to be followed. On one occasion, the recipient soiled himself and the record indicated that he was cleaned.

Chester's restraint policy which is consistent with the Mental Health Code states that restraints are only to be used for therapeutic purposes to prevent harm to the recipient or others. Based on the evidence that restraints were used to prevent harm to self or others, the HRA does not substantiate the complaint.

Complaint #6: A recipient was not allowed to use a phone for an entire month and the phone was treated as a reward rather than a right.

The complaint stated and the recipient indicated that he was not allowed to use the phone for about a month after admission. Staff reported and the record indicated that there has not been a telephone restriction placed on the recipient since admission. Staff did state that the recipient is unable to talk on the phone if in restraints or seclusion. The facility rights policy guarantees the right to telephone use unless there is a restriction due to reasons involving the safety of the recipient or others. The Mental Health Code guarantees the right to telephone communication unless a restriction is warranted to protect the recipient or others from harm, harassment or intimidation. Based on the findings, the HRA does not substantiate the allegation but offers the following suggestion:

> When a recipient is in restraints or seclusion and cannot respond to a call, consider a means to facilitate communication between the recipient and the caller (e.g. relay a message on behalf of the recipient, indicate that the caller can attempt to call back at a later time, etc.).

Complaint #7: The recipient was subject to large doses of medication.

The recipient reported that his medications make him feel drowsy at times. Staff reported that there have not been any problems with medication side effects and that the recipient refuses medications at time. Regular medication reviews are conducted through the monthly treatment planning process. A review was also conducted after a question came up about a medication allergy. In meetings with the HRA, the HRA did not find that the recipient appeared overmedicated. The HRA also noted that the recipient's medication has changed over the course of his stay and medication considered was declined by the physician after a medical work up. The facility's medication policy calls for informed consent with the provision of medication education. The HRA did find documentation on 11-20-12 that emergency medication is to be given to the recipient if he refuses a PRN medication. This documentation represents a violation of the Mental Health Code Section that allows a recipient to refuse medication and that emergency medication cannot be administered unless **"…necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available." Although the HRA does not find evidence to substantiate the complaint that the recipient was overmedicated, the HRA does find a rights violation regarding the documented statement that emergency medication is to be administered if the recipient refuses a PRN; the HRA contends that this rationale does not meet Mental Health Code criteria and recommends the following:**

1. **Ensure that emergency medication is only administered as required by the Mental Health Code. Review this requirement with facility physicians and staff.**

The HRA also noted that an allergy to Haldol was documented on the recipient's 11-03-11 admission paperwork although it appeared to be resolved as documented by a physician on 11-30-11. It was unclear to the HRA as to the timing of the allergy review and the initial administration of Haldol, thus, the HRA strongly suggests that the facility address and resolve any questions about allergies as soon as possible after admission.