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Egyptian Regional Human Rights Authority
Report of Findings
15-110-9013
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 (Chester):

1. **A patient's rights were inappropriately restricted.**
2. **A patient received inadequate medical treatment.**
3. **A patient is not being served in the least restrictive environment.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2 et al.) 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, an HRA team 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 was not allowed to have a pencil without staff being right beside him and that he had not been given a restriction of rights form explaining why he couldn't have a pencil independently. He also stated that every night for 3 weeks staff were doing room "shake downs" and would throw his clothes on the floor. He stated it had "eased up some" the last couple of weeks since the HRA became involved.

The recipient was also concerned that his medical needs were not being met. He explained that he had been in a car accident where his mother was driving, just prior to his admission at Chester. He had neck and shoulder pain as a result of this accident, but could not get a doctor at Chester to examine him to ensure everything was ok. He also explained that he is a "brittle diabetic" and his blood sugar is not easily controlled. A few weeks ago his sugar levels had bottomed out and there was no orange juice on his living unit therefore, he started hiding a piece of candy in his desk drawer in case that

happened again. He admitted to cutting the center of a book out and using that as a hiding place for his candy.

The recipient's final concern was that he was not being served in the least restrictive environment. He stated that he signed papers to admit himself to Chester because his therapist was going to help him with a placement in the community at a residential facility that had already accepted him, but that did not happen. He stated that the staff had reported that he was refusing medications and that was non-compliance with treatment so he could not be discharged. He stated that he had only refused medications one day because his medication had been changed and he did not recognize the doctor who ordered the change. He stated that he is not a violent person; however the emergency medical technician (EMT) who treated him after the car accident had said that the recipient threatened a judge, but the recipient did not remember doing so.

B. Mother: The HRA spoke with the recipient's mother via telephone. She stated that her son was found Not Guilty by Reason of Insanity (NGRI) and was supposed to be transferred from the county jail to another state operated facility but instead was transferred to Chester. She stated that he had two charges of not registering to which he pled guilty and he was supposed to "receive a deal" in exchange for his guilty plea of 6 months; however, he instead was sentenced to 5 years. She stated that the community residential facility had accepted her son for placement, but when she contacted by the jail, she was told that he was going to prison instead. She was also concerned about his health due to him being a brittle diabetic and she explained that they had recently been in a car accident in which she was the driver and her son had some injuries to his neck and back as a result that she felt were not being addressed at Chester even though she had contacted staff there and provided the medical records documenting the injuries. She explained that the only treatment he received was to be given Motrin for the pain, which he contended is not much help. She agreed to send the HRA copies of these medical records which are detailed later in this report. Her final concern involved a package of items she had sent to the recipient which would not all fit into his allotted storage space and he was told he had to return it or throw it away. She said the facility was not clear on the amount of items she could send and tried to have the social worker hold his items but the social worker would not agree to do so.

B. Chairman: The HRA made inquiries with the Chairman of the Human Rights Committee at Chester about the recipient's mother's concerns and to ensure that the medical information had been given to the treatment team for the recipient. The chairman stated that the team had received the medical information regarding his diabetes and they had also discussed with the mother how important it was for her to comply with the treatment recommendations for his diet due to the serious health consequences associated with hyperglycemia. He stated that the mother does not always send diabetic friendly snacks and instead sends sugary snacks which are against his doctor's orders for his diet and a detriment to his health. The treatment team explained to him that they have had multiple conversations with his mother regarding contents and sizes of packages being sent into the facility for the recipient. The chairman also explained that the recipient had been refusing to have his blood sugar levels checked occasionally and had attempted to hide

high sugar content items in property that he has altered for that purpose (i.e. sugar packets in a hollowed out paperback book). The chairman explained that Chester does not store patient's property in the therapist's office and does not pay to ship items. However, the team can address these issues with the mother and see what could be worked out. The chairman also explained that the recipient is housed on the medium security unit at Chester and at the time of our interview, they were exploring other placement options for him.

A couple of weeks later, the HRA followed up with the chairman on these issues as further complaints continued to be received. The chairman explained that the recipient is NGRI and has a theim date of March, 2019 and therefore cannot be discharged from a Department of Human Services (DHS) facility until that time. He explained that the recipient was refusing medications periodically including his insulin; he was refusing food and does not believe he has a mental illness. He also explained that the recipient's room had been "shaken down" January 30th due to his blood sugars being in the upper 300-400 range. Therefore, staff were concerned that he had hidden more sugary snacks in his room. He explained that the recipient tries to control his diabetes on his own instead of how the doctor recommends it which results in extreme highs and lows in his blood sugar levels. He also stated that the recipient appeared to be psychotic when the chairman visited with him because he believed that he was a voluntary patient, but he is NGRI.

C. Nurse: The nurse stated that the recipient's blood sugars are very hard to control; he has extreme highs and lows ranging from 60-260 or higher and has insulin on a sliding scale. His sugars are checked four times per day unless it is needed more frequently. He also has a standing order for Glucagon which is kept on the unit in case he "bottoms out" along with juice and milk. The nurse said if they get down to a couple of juices on the unit, they call and get more so that they do not run out. There are a few patients on the unit with diabetes. The doctor has him on a FE [failure to eat] protocol so that a doctor is contacted if he refuses meals four or more times and he also is on meal monitoring and staff document what and how much he eats. His vitals are checked at every shift. The nurse stated that the recipient's mother brought in candy, snack pies and sugary snacks or those high in carbohydrates which are not in compliance with his diabetic diet. The therapist spoke to his mother about his diet but it did not seem to help. She stated that the recipient took sugar packets and will try to get other recipients' commissary items.

D. Therapist: The HRA also interviewed the recipient's therapist who stated she had asked the recipient's mother several times not to bring in sweets and regular soft drinks due to his dietary restrictions. She said it became a battle between her and the mother because the recipient would say that his mother allows him to have these things and the therapist and doctor were trying to enforce the dietary restrictions. She stated that his blood sugar becomes high and presents as psychosis. When this happens, she has witnessed him talking to the vents and stated that he becomes violent. She stated that the recipient understands what he is supposed to eat, but chooses the wrong food and then gets upset when his blood sugars are "out of whack." She did state that prior to him being found NGRI, she had spoken to the community residential placement, which is supervised

apartments but also has 24 hour care in the office. She said the recipient would not sign the admission papers due to him not wanting 24 hour supervision, medication being administered to him and he did not want the programming they offered. She stated that when he was in jail, he refused his medication and became worse. However, once he went to court and pled guilty and was found NGRI, he was placed at Chester on the medium secure unit. Although, at the time of the HRA's interview with the therapist, the recipient had been transferred to another state operated facility.

The therapist also stated that he was on a pencil restriction for a short period of time but that restriction was not renewed. The restriction was put into place because he placed an eraser in the outlet to "prevent gas from coming in". She stated he also had his glasses restricted due to using them to cut out pages in a book in his room to make a hiding place to "stash" things such as sugar packets, jelly etc... This also led to the pencil restriction to prevent him from using a pencil to cut pages. After room "shake downs" prevented him from hiding things in his book, he started hiding packets in the bathroom under paper towels. When questioned about his medical treatment for his back pain, she stated that she knew he received pain medication for it, but that is all that was ordered by the doctor.

II. Clinical Chart Review:

A. Report for Court: The initial 30 day treatment plan report for court listed the recipient's current legal status as Not Guilty by Reason of Insanity (NGRI). His "NGRI Date" was listed as 11/10/10 and his "Max Out Date" was listed as 3/10/2019. His Diagnosis is listed as Axis I: Schizoaffective Disorder, Bipolar type; Axis II: No diagnosis; Axis III: Insulin Dependent, DM [diabetes mellitus]; Reported CVA [cerebral vascular accident] by history; and, Reported Seizure Disorder by history. Under "Problems Impending Conditional Discharge" it stated that the recipient was in need of treatment for his mental illness on an in-patient basis and listed his "significant psychiatric history" which included several private hospitalizations beginning at age 17 or 18 and outpatient treatment. It also listed a history of auditory and visual hallucinations of voices giving him commands and telling him what will happen in the future. The report continued by saying "his thinking becomes delusional and these delusions are paranoid in nature. His difficulties here appeared to be due not only to a schizophrenic process, but also due to past CVA and severe Type 1 diabetes. When [recipient's] sugar levels are high, he will present with confusion, psychotic like symptoms including hallucinations, a delusional thought process, and verbal and physical aggression. [Recipient] has a long history of medication noncompliance."

B. Treatment Plan Reviews (TPRs): The 3 day TPR dated 12/12/14 stated in the discussion section that the recipient had stated "My attorney said that after the psychiatrist examined me and realizes that I am not a dangerous person then you can send me to program for about 2 months and then find me an apartment in the community." His emergency preferences were listed as 1) seclusion 2) medication and 3) FLR [full leather restraints]. However, in the emergency intervention/rights section the order of preference was listed as 1) emergency medication 2) seclusion and 3) restraint. The HRA did find two face sheets in the chart, one dated 5/20/14 and the other dated 12/11/14, both stated the order of preference as 1) medication 2) seclusion and 3) restraint. The continuity of care information section did state that when the

recipient is discharged, community linkage will be facilitated with the community agency to which the recipient had stated he was supposed to move. The criteria for separation was listed as 1) A genuine, sincere desire for transfer and willingness to cooperate with the receiving facility 2) compliance with prescribed medication 3) Active participation in recommended programs 4) absence of physically aggressive behaviors 5) absence of sexually inappropriate behaviors 5) absence of behaviors that are self-destructive to patient and/or behaviors that pose an imminent threat to the safety of the facility and community which include, but are not limited to physical harm to himself or others and 7) follow the sex offender registration rules.

The 12/29/14 TPR's discussion section stated that the recipient signed the TPR indicating he was not in agreement with his goals. He was upset about the way his hearing turned out. He stated that his attorney told him that he would be at Chester until an evaluation was done indicating he was not dangerous and then he would be placed in the community. He informed his treatment team that he was going to appeal his case. The TPR stated that "he has been exhibiting symptoms of psychosis e.g. talking to himself; he is very paranoid; delusional thought process; thinking is loose and tangential and he has great difficulty keeping on one subject. He has been non-compliant with the rules of the facility." This section continued by reaffirming and describing the pencil restriction and justification for same as well as the incident of shaving his glasses down. The recipient stated that he would cooperate with treatment. In the extent to which benefitting from treatment section it was explained that the recipient believed he was at Chester with the intention of being evaluated for his risk of dangerousness and then he was to be transferred to the community. His therapist explained the process, but it was stated that the recipient becomes upset when it is discussed. The recipient had problems with peers on the unit and was calling them names. It also described that the recipient took a pair of eye glasses and scraped them on the floor until the arms of the glasses were shaved down. The facility believed that he was going to use them as a weapon; the recipient denied this, however he could not explain why he did so. This section also documented that he was on pencil restriction because he used a pencil to carve out the center of a book for the purpose of hiding items in the book. He had been taking sugar packets and hiding them in his room. When staff found them, he began hiding them in the bathroom. He was put on the failure to eat protocol because he became upset and stopped eating. He explained that he had stopped eating because he wanted to see the doctor. The therapist's notes in the treatment/goals section stated that the recipient's mood was labile. "He gets mad over the slightest things not going his way. When angry his thoughts are loose and tangential. He jumps from one subject to another and is very difficult to follow. He makes threat after threat towards staff and peers…"

The 1/30/15 TPR documented in the discussion section that the recipient had refused psychotropic medication 5 times that month and has been exhibiting symptoms of psychosis such as talking to himself, paranoia, delusional thought process and difficulty keeping on one subject. While discussing why he was refusing to take his medication, the recipient responded "I was having a rash on my butt and I think I'm getting dementia and I figured you know how to handle people like this." The recipient later stated "I have worked in bars and I know what you people do. You go to the bathroom and come back and they have put something in your drink. The treatment you are trying to give me is not helpful and safe, bad drug, bad drug, bad drug, bad drug. I see TV. I read things. You want to give me Risperidone and that gives you breasts. You've already made your opinion of me. I need to write things down about what you're doing,

call/contact people and get back into court. I don't have to be compliant with treatment. I haven't had schizophrenia for 7 years and I'm not crazy." The therapist's notes in the problem/goals section state that the recipient "is not open to discussing reason for admission and mental illness at this point. He is very angry and keeps saying that he plans to appeal his case and will leave CMHC. He will not agree to take his medication and continues to state that there is nothing wrong with him and he does not belong here."

The 2/24/15 TPR documented in the discussion section that the recipient had refused medications 25 times between mid-December, 2014 and the end of February, 2015. The treatment team discussed his noncompliance with medication and the recipient's response was that he was not taking that and he wanted Geodon. He again stated that he had not had schizophrenia for 7 years and did not need medication. The treatment team also discussed his uncontrolled diabetes and his diet with him. The recipient refused to discuss this stating "you've already made your opinion of me, are we through?" The team discussed his mother bringing pop-tarts when she comes for visits and also buying candy out of the vending machines during her visits for him. The team discussed limiting his non-diabetic foods but the doctor stated that his food could not be restricted as he has a right to eat them. The team decided that when he visits with his mother, everything he eats will be written down and placed in his file. The response to medication section noted that he had been on observe with mouth check for his medication compliance but that he had "just started taking medication." There were no reports of aggressive behaviors, but it was noted that he had been observed "talking to vents and is paranoid."

The recipient was transferred to another less restrictive state hospital on March 3, 2015 therefore, the February TPR was the last one that was completed prior to his discharge.

C. Restriction of Rights Forms (ROR): A ROR form dated 12/26/14 through 1/26/15 restricted the recipient to supervised pencil use. The reason listed is "patient used his pencil to carve out pages of a book to hold numerous items of contraband."

D...Progress Notes: A 12/12/14 nursing note stated that the recipient said the doctor ordered Bengay for his neck pain, but when the nurse checked, there was not an order but she called and received a temporary order for him. On 12/14/14 a nursing note documented that he woke up at 3:45 a.m. complaining of a shaky feeling. Blood glucose level was check and was a 47. The nurse gave him a carton of orange juice and graham crackers. Rechecked at 4:00 a.m. and it had risen to a 94. The doctor and nurse were notified and another order was received from the doctor to eat a banana now. It was offered and accepted. On 12/14/14 he complained of neck pain as 6 out of 10 and was given Acetaminophen 650 mg. An hour later his pain was rated at 2 out of 10. There were several other entries similar to this one documenting that he was given Acetaminophen and Bengay; when questioned, he rated the pain at a lower level indicating that the medication was effective. There were at least 19 medication refusals documented in case notes from December, 2014 through February 2015. On 12/17/15 the therapist documented that the recipient had refused his morning medication on 12/13, 12/14 & 12/15. A 12/19/14 physician's note documented the recipient was seen for left knee pain and requested a knee brace. He also complained of shoulder and neck pain. The doctor's note stated "no deformity noted, gait stead and goes to gym has PRN Ibuprofen and Ben-Gay available;" the diagnosis was

arthritis in left knee and he also ordered a diet of "no desserts, sub [substitute] with fruit monitor BS qid [blood sugars 4 times daily] Return in 3 months." He was also given a "soft knee support" for his left knee. There were several case notes documenting the wide range of highs and lows that the recipient experienced and treatment given. One example was on 12/21/14 at 2:15 a.m. he complained of feeling like he was "bottoming out" on his blood glucose level (BGL). An Accu check revealed BGL of 45 and a recheck of 48. He was given juice and milk and the doctor was notified who ordered graham crackers and a recheck in 30 minutes. At 2:45 a.m., his Accu check showed a BGL of 139. Then, a nursing note documented an Accu check at 7:30 a.m. showing a BGL of 304. The doctor was again notified and 9 units of insulin were administered. At 7:00 a.m. on 12/22/14 his BGL was back down to 48 with a recheck registering at 47. The doctor was notified, juice was given and he ate his breakfast. On 12/22/14 an X-ray note documented that a chest X-ray and EKG were completed. On 12/24/14 an STA note documented that the recipient was found with a drink packet in his room making a glass with water. The STA 2 was notified and ordered a room shakedown be conducted "to remove items of contraband. STA's recovered 10 packets of sweet n low, 6 packets of instant coffee, an extra pencil, a ripped up t-shirt bottom and a book with 360 pages cut out of it that was square shaped, commonly used to conceal contraband; rec [recipient] also had a non-issue plastic cup and full length shoe strings. All items were confiscated and referred to treatment team for review."

On 12/25/24 the recipient refused his Ziprasidone medication. The nurse discussed the importance of taking medication but the recipient walked away. The doctor was notified of refusal. A therapist note dated 12/26/14 documented that the therapist had been advised of the contraband found due to a room shake down as well as a book with the middle cut out. The therapist documented that at the morning meeting it was discussed to talk with security staff about a pencil restriction. The recipient denied using a pencil to tear the book and would not tell the writer what he had used. Another shakedown was conducted and his glasses were found with one of the ear pieces sharpened. The recipient then admitted to using the pencil to tear up the book. The Unit Director "signed a supervised pencil restriction on this date. Security staff removed the glasses from his room. This writer ordered some plastic framed glasses from personal property for patient to use on the unit."

On 12/26/14 a nursing note documented that the recipient "returned from a visit [with an] Accu check of 434/427 called Dr. [name] she ordered to just give the 10 units of Lispro now. 10 units Lispro given…" The next STA note dated 12/26/14 documented that the recipient "made a comment to staff about having contraband in his room. I instructed staff to conduct a shakedown. Staff recovered a partially eaten Milky Way candy bar and a partially eaten chocolate covered marshmallow. Rec. also had an extra pencil concealed in his pocket of hanging shirt." After the shakedown, it was reported to the STAII that the recipient "threatened a female staff by saying 'you're going down.' He then pointed his hand at her as if he was shooting a gun and said 'boom.'" A 12/30/14 nursing note documented that the recipient requested Motrin for generalized discomfort. It was noted that the dosage had been increased from 400 mg to 600 mg and the nurse would need to go to the pharmacy to get it. The recipient requested the 400 mg and it was later noted that the recipient reported that it was effective.

On 1/3/15 a physician's note documented that the recipient had been started on Glucerna and since then, his blood sugars have increased to the 300s in the morning. It was also reported to

the doctor that staff "continues to find sugar packets in patient's room and hidden in bathroom, given candy bars and desserts by mother on visit. Patient has been instructed on importance of compliance with controlling blood sugars with diet and medications…" The therapist note dated 1/2/15 documented that the recipient was hiding sugar packets to use later and that since his room is being "shook down" on a regular basis "he appears to be hiding them in the bathroom underneath the paper towels. According to nursing staff, he has had high blood sugars on a regular basis due to his noncompliance. His mother also continues to bring him inappropriate food for his diet during visits. This writer was informed that the patient does not have any plastic glasses in his property but he has been referred for optometry. His restriction for pencil supervision was reviewed and continued on this date by his treatment team"

A 1/5/15 therapist note stated that the recipient stated he was "putting pieces of erasers in his outlet to keep 4 ohlm gas from seeping into his room." He became upset that he was being questioned and requested to be transferred to another state facility and then left the room. Notes in January stated that the doctor asked to be contacted when the recipients BGL is 400 or over. On 1/17/15 his BGL was at 491 and then later at 500. The doctor was notified and an order for Lispro Insulin was given. On 1/20/15 it was documented in a nursing note that the recipient was refusing medications, Accu checks and Insulin and he stated that it was due to him fasting. The therapist met with him later that same day and her note on 1/20/15 documented that the recipient had been refusing his medication and said it was due to his back hurting too bad for him to get up and get them. It was noted that in the past, nurses have brought his medication to his door. The therapist also discussed with him that he had been "exhibiting signs of psychosis i.e. talking to himself, mumbling all day long, very paranoid and guarded." The doctor ordered mouth checks to ensure medication compliance. Later in the day on 1/20/15 a nursing note documented that he requested PRN [as needed] Ibuprofen and Menthol ointment for his neck pain which was given. A nursing note on 1/21/15 documented that the recipient was observed talking into the air vent and responding to internal stimuli for several minutes. On 1/30/15 the recipient again refused medications and meals.

E…Medical Referrals: The only referral found in the recipient's chart involving neck pain was dated 3/10/14 prior to his admission to Chester. The recipient was referred to neurosurgery for neck pain and an abnormal MRI of the neck. In the records that the recipient's mother provided to the HRA, there were several documentations about the recipient's brittle diabetes and treatment prescribed for that. One doctor from a community hospital had written a letter dated 10/21/14 stating that the recipient "*suffers from very brittle Type I diabetes mellitus. For this reason he often has hypoglycemia (very low blood sugars). If he does not receive food or glucose immediately, these low blood sugars lead to him being confused. During this time he becomes disoriented, confused and agitated. He cannot control his behavior when this happens.*" Another document dated 3/17/14 showed that the recipient had been treated for a "minor head injury" with staples being placed to close the laceration and ordered him to return in 10 days for the removal of the staples. Radiology records dated 5/19/14 documented a head injury and found "*mild kyphosis of cervical spine. Vertebral body heights are normal. No fracture. There is mildly decreased disc height at C4-C5 and C5-C6 and severely decreased disc height at C6-C7 with endplate remodeling*" The specific disc injuries were documented as bulging discs, some had mild osteoarthritis and the C6-C7 had severe bilateral osteoarthritis. The impression was documented as "*no fracture, severe lower cervical spondylosis of the*

lumbar spine." The thoracic spine radiology report findings were *"prominent degenerative disc disease at C6-7"* and *"slight scoliosis."* There was a medication list from the community hospital showing that a new prescription was given for Tramadol "every 6 hours as needed for pain". However, it was not dated and did not indicate if it was an ongoing medication or just short term due to the car accident.

III...Facility Policies:

The *Patient Request for Referrals* policy states *"Patients, their families, or guardian may request referrals to various treatment components within the Chester Mental Health Center or to community service providers. When deemed appropriate, staff shall assist in facilitating referrals for services which the Chester Mental Health Center does not provide."*

The *Patient Personal Property* policy states *"Patients who reside at Chester Mental Health Center shall be permitted to receive, possess and use personal property and shall be provided with storage space for such property items. Limits to storage space have been established and specified in this policy. Possession and use of certain property may be prohibited or restricted by the Hospital Administrator and or the treatment team to protect the patient and or others from harm… Items determined by the treatment team to be a danger to the patient or others or to be detrimental to treatment goals may be prohibited or restricted through the restriction of rights process documented on form IL462-2004 M (formerly MHDD-4)…Some property items have been identified as "contraband" for patients due to the item being potentially harmful or subject to potential abuse and to protect the patient and others from harm as determined by the Hospital Administrator. Completion of Restriction of Rights is not required in this instance…the following items are prohibited for use and are considered contraband items and will be placed in personal storage or the patient may send to his family/friend at the patient's expense. Completion of Restriction of Rights is not required in this instance. 1.) Items that in staff's judgment could reasonably be used or fashioned into a weapon, particularly glass or metal items (i.e. jewelry)…11.) Pens of any type and pencils over 3 inches long."*

The *Patient Handbook* states in its "visits" section *"for the safety and security of patients, staff and visitors, food and beverages may not be brought into the visiting areas. Visitors may purchase food and beverage items from vending machines located in the visiting room. When available, visitors may order food and beverage items from local vendors and request delivery to the facility during the visit. A list of vendors who will deliver to the facility will be maintained in the control center/visiting room. All food and beverages must be consumed during the visit. Any leftovers will be disposed of or returned with the visitor. No food or beverages will be allowed to be taken back to the unit. All patients are encouraged to adhere to their prescribed diets. If your visitor brings you clothing, shoes, money, or personal property, it will be processed according to facility procedure."*

According to the *Transfer Recommendation of NGRI and Involuntary Criminal Patients Procedure*, all transfers are to be in accordance with the Mental Health Code requirement of treatment in the least restrictive setting. Transfers begin with a determination by the treatment team and then a transfer recommendation is made by the psychiatrist. The therapist then addresses any transfer issues.

The facility Treatment Plan Procedure states that the section of the treatment plan that addresses Criteria for Separation is to "Describe the criteria that must be met before the patient can be transferred to another facility or be returned to court."

The Patient Rights Procedure states that the recipient is to "…be provided with adequate and humane care and services in the least restrictive environment pursuant to an individual treatment plan."

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."*

With regard to transfers between state-operated facilities, the Code (405 ILCS 5/2-707) states *"The facility director of any Department facility may transfer a client to another Department facility if he determines that the transfer is appropriate and consistent with the habilitation needs of the client. An appropriate facility which is close to the client's place of residence shall be preferred unless the client requests otherwise or unless compelling reasons exist for preferring another facility."*

The Code (405 ILCS 5/2-100) requires 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 5/2-104) provides that *"Every recipient who resides in a mental health or developmental disabilities facility shall be permitted to receive, possess and use personal property and shall be provided with a reasonable amount of storage space therefor, except in the circumstances and under the conditions provided in this Section.*

(a) Possession and use of certain classes of property may be restricted by the facility director when necessary to protect the recipient or others from harm, provided that notice of such restriction shall be given to all recipients upon admission.

(b) The professional responsible for overseeing the implementation of a recipient's services plan may, with the approval of the facility director, restrict the right to property when necessary to protect such recipient or others from harm.

(c) When a recipient is discharged from the mental health or developmental disabilities facility, all of his lawful personal property which is in the custody of the facility shall be returned to him."

Conclusion

The complaint alleged that a patient's rights were inappropriately restricted, when he was not allowed to have a pencil. There was also concern that a patient received inadequate medical treatment when his neck and back pain were not appropriately treated. The final allegation was that a patient was not being served in the least restrictive environment.

Upon review, it was discovered that the patient's pencil was restricted due to him using it to cut out the center of a book to store candy and sugar packets which were prohibited items. The recipient admitted to the HRA that he had done this, but stated it was due to no juice being on the unit when his blood sugar "bottomed out." Although it was well documented in his chart that the patient had uncontrolled diabetes with extreme highs and lows in his blood sugar levels, the nurses on the unit had stated that when they get down to 1 or 2 juices on the unit, they request more so as to not run out since there were a few patients on the unit with diabetes. The nurse also stated that this recipient had a prescription for Glucagon which was kept on the unit for this recipient. It was also well documented in his chart that the recipient would often consume sugary snacks that his mother brought in for him which would cause his blood sugar levels to become unstable. Therefore, that allegation is **unsubstantiated.**

The next concern was that the recipient's back and neck pain due to a recent car accident was not being addressed by the facility. The HRA reviewed medical documents confirming that the recipient had some scoliosis, bulging discs and osteoarthritis based on previous medical exams prior to his admission to Chester. While at Chester there were case notes documenting that the recipient had asked for Tylenol or Motrin for back, neck and knee pain which he was given upon request. A follow up case note was there for each time pain medication was given that documents the recipient stating that his pain rating on a scale of 1-10 was always lower after pain medication was given. The HRA found no documentation in which the recipient requested any other treatment for his back and neck pain that he was denied. Therefore the allegation is **unsubstantiated.**

The final allegation was that the recipient was not being served in the least restrictive environment. The recipient was under the impression that he was admitted to Chester to be assessed for dangerousness and that after he was proven to not be a danger to others, he would be discharged to a community residential setting. He also stated that he had only refused medication once and that staff were stating that he was non-compliant with medication which is why he could not be transferred to a less secure setting. The report to the Court stated "his thinking becomes delusional and these delusions are paranoid in nature" and also stated that this was due partly to his uncontrolled blood sugar levels that caused him to become delusional when not controlled. This statement was confirmed by another physician outside of Chester prior to his admission who stated in a letter that the recipient "becomes disoriented, confused and agitated. He cannot control his behavior when this happens." The majority of the recipient's chart focused on the recipient's blood sugar levels being too high or too low and also noted that he spoke to vents and had other delusions when this occurred. Therefore, the allegation is **unsubstantiated**. The HRA offers the following suggestion:

The criteria for separation in the TPR was listed as 1) A genuine, sincere desire for transfer and willingness to cooperate with the receiving facility 2) compliance with prescribed medication 3) Active participation in recommended programs 4) absence of physically aggressive behaviors 5) absence of sexually inappropriate behaviors 6) absence of behaviors that are self-destructive to patient and/or behaviors that pose an imminent threat to the safety of the facility and community which include, but are not limited to physical harm to himself or others and 7) follow the sex offender registration rules.

The HRA contends that criteria 2 and 3 conflicts with the recipient's right to refuse and his transfer should not be restricted based on those two being met if the other criteria have been met. Also, criteria 1 could prove to be hard to measure and perhaps "*indicates agreement with transfer*" would suffice instead. The HRA contends that the focus for transfer should be on reducing aggressive, self-destructive and sexually inappropriate behaviors rather than eliminating altogether to allow for "bad days" if the overall picture is one of improvement. The HRA acknowledges that since this investigation began, the recipient has since been transferred and offers the suggestion for future treatment plans on other patients as well.