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Egyptian Regional Human Rights Authority
Report of Findings
16-110-9007
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 allegation concerning Chester Mental Health Center:

1. **A recipient was inappropriately restricted from rehabilitation classes.**

If found substantiated, the allegation represents a violation 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, the HRA interviewed the recipient, reviewed the recipient's record with consent, and examined pertinent policies and mandates.

I. Interviews:

Recipient: The HRA met with the recipient in August. He stated that in March he had quit taking his medications in order to talk to his attorney more clearly however, he had still been allowed to attend rehabilitation classes. In July he was prevented from attending classes. A charge aide and a nurse had told him that he could not go to school because he was not taking his medications. The reason given by the charge aide was that 2 instructors from rehabilitation classes had stated that they did not want him in school when he is off his medications. The recipient did not believe this statement and was of the opinion that he and his instructors had a good relationship and he did not believe that they would have said that. At his treatment plan review (TPR) meeting his therapist and psychiatrist stated that if he continues to refuse medications they were going to Petition the Court to obtain an Order for Court enforced medications. The recipient stated that he had no aggressive behaviors to justify a Petition being filed as he did not believe he met criteria since he had not been aggressive. The recipient stated that he had previously told his treatment team that he was going to fast March through August and only eat 1-2 times per day and was also going to "go off his medications" in order to prepare for a meeting with his lawyer. He stated he was drinking plenty of water during this timeframe. However, he stated that in order to compromise he began taking his medications again in June but then stopped again in July. He has not been allowed to attend rehabilitation classes since the

end of June. When he asks about this during his TPR meetings, he is told that security staff and school instructors do not want him in class unless he is taking medications. He was also concerned, because he prefers the injectible form of his medication and did not trust the oral medication was the same as the injectible. He stated that staff had told him there was a shortage of the injectible form and they may have to give him the oral form instead. The recipient stated that he would refuse the pill form and would only take the injectible form.

B. Vocational Rehabilitation Instructor: The HRA interviewed one of the recipient's instructors in rehabilitation classes. The instructor stated that he had known the recipient for several years and felt like they had a good rapport. He stated that the recipient is never aggressive even when he is off of his medication. He explained that when the recipient is not taking his medications, his paranoia increases but he is not aggressive and therefore, would not be a problem in class. The instructor stated that he personally does not have a problem with the recipient attending classes regardless of whether or not he is medication compliant at the time. He stated that he believes other instructors would have the same opinion but could not speak for them and stated that the decision for the recipient to not attend rehabilitation classes was made on the living unit not from the rehabilitation department.

C. Human Rights Chairperson: The HRA inquired with the Chairperson regarding the allegation that the recipient was being "punished" for refusing his medications. The Chairperson followed up with the therapist and notified the HRA that the recipient had not been penalized for refusing medication but remained on yellow level "due to the resistance and irritability of the medication situation." He was refusing medications that had been court ordered. However, she explained that he had also been assigned a new doctor that he was not adjusting to very well because his former doctor was assigned to another unit for coverage. The team had met and was exploring options for when there is no longer a supply of the injectable form of his medication, which he prefers over oral medication.

The HRA also inquired as to whether or not rehabilitation classes would be considered treatment or an off unit privilege that could be withheld due to behaviors, etc. The HRA was informed that rehabilitation classes are considered an off unit privilege and provided a copy of a policy that governs rehabilitation services modification which is outlined below. The HRA met with the Facility Administrator and the Director of Clinical Operations to clarify why Rehabilitation/Education would be considered a privilege and not treatment. The explanation given was that Clinical Therapy/Active Treatment is conducted on the unit by Nurses, Activity Therapists and Social Workers (Licensed professionals). Rehabilitation/Education is conducted by educators/vocational rehabilitation professionals and therefore is considered a privilege to attend since the classes include topics such as library, art, horticulture and activities of daily living (ADL). Some Art therapy is done on the unit when the treatment team considers it therapy for certain individuals but it is not typically considered active treatment. Groups for patients with intellectual disabilities for ADLs can come to the unit if those patients refuse to go to rehabilitation classes or if they do not have privileging levels.

II. Clinical Chart Review

A. Treatment Plan Reviews (TPRs): TPRs for July through September were reviewed. The 7/28/15 TPR stated that as of 7/26/15 the recipient had refused psychotropic medication. Security staff reported several instances of suspicious behaviors such as *"cheeking his medications"*. The treatment team noted his continued denial of all symptoms of his mental illness and increased exacerbations of psychosis and mood, non-compliance and escalating aggressive outbursts. It was noted that the recipient attended this meeting and presented as visibly agitated and accusing staff of purposely attempting to hurt him. It was noted that he had received several behavioral data reports (BDRs) for *"not following directions, threatening, cursing, demanding and bizarre behaviors and at times becoming loud and disruptive."* This TPR also documented that due to his ***"level of unpredictability and psychotic agitation has prevented temporarily his participation in psychosocial rehab classes."*** According to this TPR, the recipient had refused medication from 3/19/15 through 5/28/15 and then again starting 7/26/15. One vocational instructor had noted that he was presenting to class with toilet paper and Kleenex stuck in his nostrils. Another instructor had also noted that the recipient had "deteriorated a lot" in the last month noting the same behaviors of stuffing nostrils and ears and covering his mouth with a rag. This instructor noted that he has taken the recipient out of all but one class due to non-attendance and a large waiting list for the classes. The coordinating therapist documented the same "bizarre behaviors" of the recipient and noted that he had been refusing meals and supplements due to his belief that he was being poisoned. The recipient had also become *"belligerent with staff refusing to follow routine module requests, inciting peers to refuse treatments, accusing staff of a coordinated plot to kill him, becoming visibly agitated during his TPR's and visibly angry in an accusatory manner which has led to unpredictability and volatile behaviors. TX interventions by experienced staff, along with daily staff re-assurances and de-escalation has thus far prevented containment of the patient given his clinical deterioration resulting in suffering."* The STA documented 7 BDRs being issued this reporting period for *"bizarre behavior, not following directions and excessive noise."* The nurse noted that the recipient was currently 10 pounds under his ideal body weight and had lost 2 pounds this reporting period. "*Dietary is aware of the weight loss and is monitoring him."*

The 8/25/15 TPR reaffirmed continued exacerbations of positive symptoms of his mental illness such as paranoid delusional beliefs, and being "consumed by fear" and noted 21 BDRs this reporting period. It was again documented that the *"patient's level of unpredictability and psychotic agitation has continued, requiring, for the safety of all, to temporarily suspend his participation in psychosocial rehab classes."* The TPR noted that a Petition for enforced medication has been filed in the county court with a hearing date of 9/2/15. One vocational instructor noted that the recipient *"did not attend class this review period due to his medication refusals on the unit."* The other vocational instructor noted that the recipient was dropped from class to make room for other patients who had been waiting to be enrolled.

Finally, the 9/22/15 TPR noted that he was on court enforced medication during this review period and had 1 BDR issued. The nurse documented that the recipient was on Olanzapine three times a day, Benztropine at hour of sleep and Lorazepam every 6 hours for agitation. It was also noted that he resumed taking oral medications on 9/11/15. One vocational instructor had noted that the recipient had started attending his classes again and was pleasant. It was also noted that he did not attend any art therapy sessions or recreation activities.

B. Progress Notes: A nursing note on 7/30/15 documented that the recipient was sitting on the floor with a cloth held in his hand over his mouth and nose to keep the "gas" out. A few hours later it was documented that he was across from the nurses' station with toilet paper in his ears and a cloth over his mouth. He stated since they would not let him go to school he is refusing to take his medicine. He also stated they have poison in the food, water and air. When the nurse attempted to reason with him and explain the importance of taking medication, the recipient walked away. The recipient drank his ensure but refused to eat anything or take any of his medications stating the food tasted like poison. On 7/31/15 it was documented that he refused medications and ensure drink stating it had medication in it. He also refused all his medication at the hour of sleep that day but drank his ensure. Medication refusal was documented for both morning and evening medication 8/1/15 through at least 8/7/15 stating he would not take them until the end of October, when asked why he stated "it's just the day I've picked."

A therapist note dated 8/3/15 stated that she had just taken over his case as the previous therapist had transferred to another unit. At the time of the transfer the recipient was noted to have had a "*decline in clinical functioning mostly triggered by his refusal to accept psychotropic medication from March 15th – May 28th, 2015.*" The therapist continued the note by indicating reasons that may have contributed to the medication refusal, including securing services of a private lawyer. It was noted that he had declined significantly from his baseline which was evidenced by bizarre behaviors including stuffing his ears with paper, extreme mood irritability, extreme paranoia, grandiosity and verbally challenging of others, interrupted sleep and eating patterns, extreme religious preoccupation, stating that all staff will die and accusing staff of being devils. It was noted that in early June he re-initiated psychotropic medication compliance, but never attained the same level of clinical stability as before his refusal. It was also noted that the recipient intensified his threats of harm towards staff and had become verbally aggressive and experienced delusions of being poisoned by Chester staff through the ventilation system. The therapist was of the opinion that he was suffering extensively, required enforced medication to prevent further deterioration and suffering and stated *"this clinician along with Unit [name] treatment team endorses for the psychiatrist to initiate a petition to [county] court…[recipient] has intruded and exacerbated other patients resulting in treatment failure for his peers…the patient is psychiatrically and behaviorally unstable, requiring close monitoring in his unit environment; denotes no insight, mood is angry; shows signs of physical agitation; uncooperative; thought process is delusional/paranoid. Signs of psychosis were elicited daily. The patient refuses use of PRN medication. Based on significant current deterioration, [Recipient] has been deemed by his TX team as unpredictable and his outside module activities suspended until clinical stability defined as: increased predictability; absences of threats of violence; no exacerbation of psychotic symptoms i.e. extreme paranoid statements, bizarre behaviors; normalization (previous baseline) of his sleep and eating patterns. Clinical evaluation of the patient's progress is performed daily by the TX team members during the Unit [name] morning meetings. The patient will re-initiate his daily routine activities as soon as his TX team deems him safe to leave the unit."*

Another therapist note dated 9/2/15 documented that the Petition for court enforced medication was approved by the Court. The therapist noted that the recipient had experienced a decline in clinical functioning which was triggered by his refusal to accept psychotropic medication from

March 15-May 28, 2015 and again from July 26, 2015 to the date of this note. It was documented that he had decompensated greatly from his baseline. The goal of having court enforced medication is listed as to "*prevent potential volatile situations and allow for the patient's prompt recovery from this regressive state. [Recipient] indicated that he wanted to receive all his psychotropic medication by shots, no oral dose was welcome. After much discussion, a plan for enforcement was outlined. The patient will be closely monitored in his unit environment. His outside module activities will be reinitiated when his behavior is stable, that is, the Tx team is able to assess: increased predictability; absence of threats of violence; no exacerbation of psychotic symptoms are deems him safe to leave the unit." [sic]* A Social Worker note dated 10/26/15 was entered by a different therapist than the previous note. This therapist stated *"He continues to have persecutory delusions of being poisoned by CMHC staff through the ventilation system. He continues to pack his nostrils, ears and carries a cloth covering his mouth when he leaves the unit. He is currently on Court enforced medication to assist in his recovery. He is also very active in Rehab/Education programming…"*

C. Petition and Court Order: The Petition for Administration of Enforced Medication dated 8/21/15 gives some history and lists the recipient's legal status as "involuntary Criminal" with a Theim date of 2023. The hospital course section noted that he had taken medication from 2013 until March of 2015 when he stopped medications because he *"felt that he didn't need them and following an incident of him being in seclusion for the behaviors of lying under the bed and refusing to come out on 5/28/15, he started taking his medications spontaneously, then he decided not to be on the medication since 7/26/15 then he displayed deterioration in his behaviors and became extremely paranoid."* The basis for the Petition was listed as argumentative behaviors with staff, paranoid delusions, and bizarre behaviors which have resulted in him suffering from a weight loss of 30 pounds in 4 months. The Petition also noted the recipient's impaired insight and judgment affecting his ability to recognize treatment needs and make a reasoned decision regarding his treatment.

The HRA reviewed the Order for Administration of Authorized Involuntary Treatment that was file marked September 2, 2015 and ordered the recipient to receive involuntary treatment in the form of psychotropic medication. The Order listed the following medications to be given: Olanzapine, Haloperidol, Haloperidol-D, Lithium, Benztropine, Venlafaxine and Lorazepam. The Order did not specify whether medication had to be in oral form or injectible form. The Order was not specific as to the reason for court enforced medication and appeared to be a form Order. The Order stated that the Court found that the recipient*"1. Has a serious mental illness 2. Exhibits any one of the following: a) deterioration of his ability to function; b) suffering; or c) threatening behavior. 3. The illness or disability has existed for a period marked by the continuing presence of the symptoms set forth in item (2) above, or the repeated episodic occurrences of these symptoms and 4. The benefits of the treatment will outweigh the harm and 5. The individual lacks the capacity to make a reasoned decision about treatment and 6. Other less restrictive services were explored and found inappropriate; and 7. Testing and procedures essential for the safe and effective administration of treatment and 8. A good faith attempt was made to determine whether the individual has executed a Power of Attorney for Health Care or a declaration of mental health treatment 9. The Respondent received information about the benefits/side effects of the treatments and their alternatives. 10. The Respondent is a person*

subject to Involuntary Administration of Psychotropic Medication pursuant to Illinois Compiled Statutes 405 ILSC 5/2-107.1."

D. Medication Administration Record (MAR): The MARs for July, August and September were reviewed. July MAR showed that the recipient took Olanzapine twice daily, Amitriptyline once daily, Venlafaxine XR once daily and Lovastatin once daily. There were 2 instances on July 29th & 30th when it appeared the medications were not given, but it does not indicate if it was due to refusal, the days have circles with no staff initials indicating it was given. In August the MAR documented Lovastatin being given daily with 15 days of it not being given. The other previous medications listed on the July MAR were not listed on this MAR. The September MAR had a handwritten note indicating that the recipient was on Court Enforced medication as of 9/2/15. Haloperidol (injectible) was given September 3rd through the 11th. Haloperidol PO (oral) was given September 5th and 6th and again the 11th through the 15th. Olanzapine was given twice daily from September 16th through the 30th, Benztropine (injectible) was given September 3rd through 11th with 12th through the 15th not being given. Benztropine (oral) was given September 5th and 6th and again the 11th through the 30th. The Lovastatin was only given 8 times throughout the month.

E. Patient Movement Charts: The HRA reviewed patient movement charts for July, August and September. These movement charts are kept on the unit and log when patients move off of the unit to various activities and to rehabilitation classes. The July movement charts documented that the recipient attended school daily through July 29th. His name was marked off the list for July 30th which was a Thursday. The month of August shows no movement of this recipient off of the unit for any activities. The month of September documented that the patient was moved from the unit to Court on September 2nd. The next movement occurred on September 17th when he was off unit to attend rehabilitation classes again. The recipient continued attending classes daily for the remainder of the month.

F. Level Charts: Chester operates on a Level system for participation which is set up to reinforce adaptive social behaviors. Green "Quality of Life" is the highest level with the least amount of restrictions. Yellow "Stabilize" is the mid-level for which there are a few restrictions on this level and finally, Red "Protect from harm" level is the most restrictive level patients can be on. Before moving patients, staff must check the level sheets to see what activities in which patients are allowed to participate. This recipient was on yellow level in September. The level sheet for 9/4/15 lists the reason as "manipulating, threatening, bizarre, non-compliant." A level sheet for 9/8/15 lists the reason for yellow level as "med non-compliant, bizarre, paranoid." Both state "no school" beside his name as well.

III...Facility Policies:

TX .01.02.00.04 Level System Procedure policy states that "*Patients at Chester Mental Health Center will be reviewed and placed on a designated level of participation based upon the level system criteria. All patients will follow the level system procedure unless the patients' treatment team determines they need an individualized approach to the level system."* The policy continues by stating that the purpose of this policy is "*to reinforce adaptive social behaviors through increased opportunities for positive preferred activities."* The policy also provides that

level placement does not automatically preclude a patient's participation in groups/rehabilitation classes and states that the treatment team determines each patient's level of participation in the rehabilitation area. The three levels are described in this policy as follows:

Level Red - Protect from Harm

Activities allowed:	Church	Yard (Civil)
	Dining Room	
	Gym	
	On-Unit Activities	
	Commissary - once per week	
	Birthday Party	
	Cook-outs	

Level Yellow - Stabilize

Activities allowed:	Church
	Dining Room
	Gym
	On-Unit Activities
	Commissary - twice per week
	Birthday Party
	Cook-outs
	Treatment Mall
	Library
	Inter-Unit Activity
	Feature Film
	Veteran's Party
	Eligible to serve on Consumer Advisory Council
	Yard

Level Green - Quality of Life

Activities allowed:	Church	Library	Increased opportunities for treatment mall	
	Dining Room		Inter-unit Activity	
	Gym		Feature Film	Cook-outs
	On-Unit Activities		Veteran's party	
	Game Room		Commissary - twice per week	
	Birthday Party		CAPS Room	
	Special Monthly activity			
	Eligible to serve on Consumer Advisory Council			

RI .01.01.02.01 Patient Rights: The Patient Rights policy states *"It is the policy of Chester Mental Health Center (CMHC) to respect the rights of patients and not to abridge said rights without cause and without due process. Restrictions, as such, should have a clinical rationale and serve to facilitate a therapeutic treatment setting. Each patient admitted to Chester Mental Health Center shall be treated with respect and shall be ensured of all rights under Sections 2-100 to 2-111 of the Mental Health and Developmental Disabilities Code. Restrictions of rights and corresponding rationale shall be properly documented in the patient's clinical records."*

This policy states that a patient has the right to *"be provided with adequate and humane care and services in the least restrictive environment pursuant to an individual treatment plan…*
A. Non - Emergency Restriction of Rights

1. A restriction of a patient's rights should be based on clinical assessment of the patient and/or the situation. A Notice Regarding Restricted Rights of Individuals (IL462-2004M) will be issued to restrict the patient's rights.

2. If any of the patient's rights as described in Section I. of this procedure are restricted then a Restriction of Rights of Individuals (IL462-2004M) will be initiated. This includes when a patient is restrained, secluded and/or subject to a physical hold.

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

4. When a Restriction of Rights is implemented and reviewed by the treatment team – emergency or non-emergency they will ensure the restriction form is approved and signed by the Facility Director or designee. When the Restriction of Rights involves mail, access to the patient's room, or telephone, the form IL 462-2004M must be signed by the Facility Director or designee prior to initiation of the restriction.

B. Emergency Restriction of Rights

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

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

PF.01.02.01.04 Rehabilitation Services Modification of Provided Services policy states that it is to *"provide quality patient care, the Rehabilitation Services Department provides educational and vocational programming regardless of age, disability, or dysfunction. Certain situations may require modification in a patient's educational or vocational programming."* The policy continues by saying that a program can be modified due to a patient mastering all phases of a certain program or due to presenting problems such as refusing 50% of scheduled programming or **exhibiting inappropriate behavior**. The following guidelines are outlined as requirements that must be adhered to when reviewing presenting problems for modification of programming:
"1. The patient cannot be automatically removed totally from programming as a result of a presenting problem…3. If the presenting problem involves inappropriate behavior while in programming the patient is put on hold (suspended) from programming. This means that a patient is limited from programming pending review by the treatment Team in consultation with Rehabilitation Services staff. The patient maintains his enrollment status and returns to regular programming consistent with the decision made by the Treatment Team and Rehabilitation Services staff." The policy continues by outlining the reintegration to rehabilitation classes procedure that is to be followed if the suspension from class is the decision of the Rehabilitation Department; however, there are no reintegration procedures when the suspension is the decision

of the unit staff or Treatment Team. The remainder of the policy governs modifications for Special Education for age-eligible patients as per Administrative Code 226.

Statutes

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

The Code (405 ILCS 5/2-102) states *"A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan."*

The Code (405 ILCS 5/2-107) provides that "*(a) 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. (b) Psychotropic medication or electroconvulsive therapy may be administered under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record."*

The Code (405 ILCS 5/2-201) states that *"(a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to:*
(1) The recipient and, if such recipient is a minor or under guardianship, his parent or guardian;
(2) A person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice;
(3) The facility director;

(4) the Guardianship and Advocacy Commission, or the agency designated under "An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named", approved September 20, 1985,1 if either is so designated; and
(5) The recipient's substitute decision maker, if any.

The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefore in the recipient's record.
(b) The facility director shall maintain a file of all notices of restrictions of rights, or the use of restraint or seclusion for the past 3 years. The facility director shall allow the Guardianship and Advocacy Commission, the agency designated by the Governor under Section 1 of 'An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named,' approved September 20, 1985, and the Department to examine and copy such records upon request. Records obtained under this Section shall not be further disclosed except pursuant to written authorization of the recipient under Section 5 of the Mental Health and Developmental Disabilities Confidentiality Act"

Conclusion

The allegation was that a recipient was inappropriately restricted from rehabilitation classes due to refusing medication. The recipient was of the opinion that the unit staff had restricted him from attending classes as a punishment for refusing medications. The HRA reviewed unit movement forms which documented that he was restricted from attending classes from July 30th through September 17th. The recipient had refused psychotropic medication from March 19th through May 28th and then again beginning July 26th. He also fasted some during these timeframes stating that it was all in preparation for a meeting with his attorney. The facility filed a Petition for court enforced medication. The reasons cited for a Petition being filed were his clinical deterioration resulting in suffering from a weight loss of 30 pounds in 4 months, refusing meals and supplements due to his belief that he was being poisoned, bizarre behaviors of stuffing tissues into his nostrils and ears and covering his mouth and nose with a rag due to his paranoia that he was being poisoned through the ventilation system. The Order for court enforced medication was signed on September 2nd. It was documented in the chart that the treatment team had met with him in July and concluded during his TPR meeting that he would be temporarily prevented from participation in rehabilitation classes and that all his off module activities would be suspended until stability could be regained. This was due to his level of unpredictability and psychotic agitation requiring daily reassurance and de-escalation by staff. This was reviewed and reaffirmed during the August TPR meeting. The September TPR documented a significant decrease in behavioral reports (down from 21 to 1 for the reporting period) and the recipient was returned to rehabilitation classes during the month of September. Although the recipient was not physically aggressive, there was documentation that the recipient was psychiatrically and behaviorally unstable, making verbal threats to staff, requiring close monitoring in his unit environment, displaying mood instability and signs of physical agitation and was described as unpredictable which required daily de-escalation and reassurance from unit staff. There was also documentation that he was experiencing extreme paranoia which inhibited his daily functioning. Therefore, the allegation is **unsubstantiated.** The HRA offers the following suggestions:

1. Chester Policy *PF.01.02.01.04 Rehabilitation Services Modification of Provided Services* states that a patient's programming can be modified due to a patient exhibiting inappropriate behavior. If such behavior results in the rehabilitation department suspending a patient from classes, there is a reintegration protocol to be following so that a patient can return to classes as soon as possible and not be suspended indefinitely. However, this policy does not include any provisions for when unit staff or the treatment team suspends participation in classes. The HRA suggests that the policy be reviewed and revised if necessary to include more frequent review of the suspension than at monthly treatment meetings.

2. Chester *Policy TX .01.02.00.04 Level System Procedure* provides that level placement does not automatically preclude a patient's participation in groups/rehabilitation classes and states that the treatment team determines each patient's level of participation in the rehabilitation area. It continues to state that when a patient engages in a maladaptive behavior, the Staff observing the behavior will determine if a change in the patient's level is warranted and if it has been determined that a change to a lower level is appropriate, the Staff will document the problematic behavior using a Behavior Data Sheet. The unit therapists review the BDRs every morning and indicate any restrictions from rehabilitation classes. A level sheet for this recipient dated 9/8/15 lists the reason for yellow level as "med non-compliant, bizarre, paranoid" The HRA questioned whether medication non-compliance, bizarre and paranoid behavior should have warranted a restriction from rehabilitation classes and suggests that criteria for class restriction be reviewed with unit staff and therapists. The policy provides specific criteria to be met in order for a patient to advance in the level system but not for a reduction. The HRA suggests this be reviewed also and the policy be revised to include specific criteria for a decrease in levels to provide a more consistent approach to class restriction and level decreases.

3. There were 2 instances when it appeared, based on the MAR sheets, that the medications were not given to the recipient in this case. It did not indicate on the MAR form if the medication was not given due to refusal or some other reason. The days had circles with no staff initials indicating it was given so the assumption of the HRA was that medication was refused. However, the HRA suggests that some indication of why a medication was not given should be noted on the form either by writing "R" or "REF".