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Egyptian Regional Human Rights Authority
Report of Findings
17-110-9003
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:

1. **Inappropriate seclusion of a recipient.**
2. **No restriction of rights form was given when property was restricted.**

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, the HRA interviewed the recipient and staff, reviewed the recipient's record with consent, and examined pertinent policies and mandates.

I. Interviews:

A. Recipient: The recipient told the HRA that he has problems with one or two STAs "antagonizing" him. He said that on July 15th one STA pulled him out of the lunch line for talking and took him to the seclusion room for 1 ½ hours. His emergency preferences are 1) Seclusion 2) Emergency Medication and 3) Restraints. Another example he gave was a room shake down that was conducted by this STA that antagonizes him. He said that he had requested that another STA conduct his room "shake down" due to him and this STA having problems to which the STA replied "you don't run anything here. We just played golf together the other day and he probably shredded your complaints." The recipient took this comment to mean that nothing was going to be done because the two STAs were friends. When his room was shaken down, they reportedly took his toothbrush and did not give him a restriction of rights (ROR) form stating why it was removed. He said he keeps his toothbrush in a clean sock to keep the germs off of it and they thought he was going to use it as a weapon.

B. STA 1: This STA was questioned regarding the room shake down and said that if it makes things easier, he would use a STA that a recipient does not have an issue with rather than one he does. However, this recipient complained frequently about all staff not just one in

particular so it made it difficult to accommodate his request for a different STA to conduct the room shake down. He stated that he did not remember confiscating a toothbrush, but it would have been taken if it was sharpened or broken to where it could be used as a weapon. When a toothbrush restriction is done, the toothbrush will be held in the nurse's station to use when needed, but the patient is not allowed to keep it in his room. Random shake downs of patient rooms are done both as a unit or module wide and are sporadic but can be specific to a person if there is a reason to conduct the search. The STA stated that this recipient is a higher functioning individual who has moments when he tries to bend the rules and he knows what he can get away with. He has a tendency to be more non-compliant with rules than to be compliant. He makes statements to the effect of "I don't have to listen to the rules" and would not cooperate with even small requests just to irritate others, both staff and peers. On the day he was placed in seclusion it was due to him being loud and threatening in the lines, not just for talking. He was threatening staff by saying that he was going to get them fired and was telling peers that his posse would come down and he would have someone else "take care of it." The STA said the recipient did not get along with peers. The STA denied making any comments about playing golf with another STA.

C. STA 2: This STA also worked on the unit with this recipient. He corroborated the first STA's comments that this recipient was typically non-compliant with rules and said that he often tries to "buck the system." He will comply eventually, but he takes his own time doing so. He wants to run things. The STA said he writes behavior reports (BDRs) frequently, sometimes daily mostly for non-compliance issues. The recipient would not follow module rules and has no respect for authority and even less respect for female staff members. He was described as "pushing the limits" and "manipulating the system." This recipient was on module 3 at the time of the room shake down. The module breakdown was described as follows: Module 1 is the quieter module, mostly lower functioning patients, it's more structured and there are "better patients." On module 2 there are more behavioral problems and patients of different functioning levels. Module 3 is "chaotic" and typically, patients with the most behavioral problems are housed there. This recipient was mostly housed on module 2. He had argued with a peer and was moved to module 3 but then the peer moved out so he was able to move back to module 2 from which he had been discharged. The STA explained that room shake downs occur monthly and sometimes twice a month and then as needed if something is suspected. This recipient's room was shaken down during a unit wide search of all three modules. His toothbrush edges were filed down and that is why it was taken and given to the charge aide and a restriction of rights form was completed. When a toothbrush is taken, a replacement is given to the nurses for patient use when needed and then collected by the nurses after they are finished using it. If anything is taken out of a room during a shake down, staff complete a form of anything that was taken, lists the room number and then what was found goes to the therapist with the patient's name on it and it is stored in the patient's property storage. This STA corroborated that the recipient had made threats in the lunch line to get staff fired and have his posse come down and "take care of" his peers. He made direct threats to peers often and did not "click" with his peers. He felt as though he was above them.

D. Human Rights Chairperson: The HRA questioned the chairperson about the difference between comfort room and seclusion room. It was explained that seclusion is for emergencies when there is a clear and present danger of an individual harming himself, other patients or staff.

When a seclusion room is being used for seclusion, the door to the room is locked. A staff member provides constant observation of the patient either directly or via video/audio monitor after the first hour of seclusion. If the unit RN agrees that using the seclusion room as a quiet room will allow closer clinical monitoring without jeopardizing the safety of the patient, then a patient can also request the seclusion room to be used as a quiet room to regain emotional control if he is not considered an imminent danger to self or others. For this use, the room door remains open. The comfort room is to provide a supportive, relaxed and calm environment in which patients can practice self-soothing emotional regulation skills. The comfort room is for the medium security unit and is not intended for those who have become so agitated that they pose a threat of physical harm to themselves, others or the room and its contents. When used as a comfort room, the door is also left open. A restriction of rights form is not required for the comfort or quiet room use of the seclusion room when the door remains open. However, if a patient is placed in seclusion with the door locked then a restriction of rights form is required.

II. Clinical Chart Review

A…Treatment Plan Reviews (TPRs): The initial TPR listed his primary diagnosis as Bipolar I Disorder, Manic with Psychotic Features and his secondary diagnosis as Antisocial Personality Disorder. He was found unfit to stand trial in April and was admitted to Chester in June. The 8/2/16 TPR documented that he had passed the fitness test and had a good understanding of his charges, but did not present with the ability to appropriately cooperate with his attorney. He presented with "grandiose delusions and believes he is above others in regard to his thoughts and writing abilities. He becomes sarcastic and demeaning to others. He has no insight to his condition and was refusing to take medication at that time." At that time, the treatment team considered him unfit to stand trial. The problem section noted that the recipient was presenting with grandiose delusions and lack of insight. He had not been aggressive or had self-injurious behavior but had been verbally aggressive with others at times.

B. Restriction of Rights (ROR): The HRA reviewed a ROR form dated 8/5/16 at 3:10 p.m. which documented that the patient was yelling in the hallway to peers that they better get in their room or staff will beat them. Staff attempted de-escalation but he continued to become more agitated and threatening he was offered and accepted seclusion. It was noted that he walked himself to the seclusion room making threats along the way. The form was signed by the nurse and the physician. The physician continued the seclusion order at 3:35 p.m. stating that he stated with a superficial smile that "they violated my 1st amendment…I have a lawsuit I need papers" The physician noted that he was preoccupied with being mistreated by staff and denied responsibility for his actions. He was "medically stable, behaviorally inappropriate, quite talkative." Another nurse completed a second ROR form dated 8/5/16 at 3:10 p.m. stating the recipient was extremely agitated, yelling, cursing, threatening, sexually inappropriate with female nurses, yelling "I'm going to kill you [expletive.]" "Per pt [patient] preference escorted to seclusion. Entered seclusion, without seclusion pt poses imminent risk of harm to self and others." He was in seclusion from 3:15 p.m. until 5:47 p.m. After utilizing his second preference, medication, which was unsuccessful in calming him down, he was moved to restraints per physician order due to self-injurious behavior of hitting the seclusion room door multiple times. He was in restraints until 1:40 a.m. after he was calm and cooperative. The post-episode nursing debriefing noted that an injury report was completed due to an abrasion on his

left hand 3rd knuckle. The timetable for this episode was 3:10 p.m. seclusion, 5:25 p.m. medication and 5:47 p.m. restraints until 1:40 a.m. when he was released. The recipient's preferences were seclusion, medication and then restraints. No restriction of rights form was found regarding his toothbrush restriction.

C. Progress Notes: A July 5th therapist note documented that the recipient had not had any behavioral problems since his admission in mid-June, however a July 15th nursing note at 1:15 p.m. stated that the recipient came back from the dining room yelling and not following directions and was "placed in comfort room" to calm anxiety. Another nurse's note at 2:20 p.m. documented that the recipient returned to the unit calm and cooperative. On August 5th at 3:10 p.m. a nursing note documented that the recipient was standing in the doorway of his room yelling and screaming to peers to get in their room or staff would beat them. Staff attempted to deescalate him and he began making threats to kill module staff. He was offered and accepted seclusion and walked himself into the seclusion room making threats to staff along the way. A restriction of rights was given and the physician was notified. A note from another nurse at the same time documented that the patient was *"extremely loud and disruptive to module. Sexually inappropriate."* The note also documented word for word obscenities and threats this recipient made to nursing staff on the unit regarding forced sexual acts he said he would perform on the female staff. It continued to document that the patient walked with staff to the seclusion room for the safety of all after multiple attempts of staff redirection. No physical hold was initiated. A restriction of rights form was given. Another note at 5:20 p.m. that same day documented that he continued to yell out threats and racial slurs against Caucasians and yelling out to peers *"they hate us all they hate us black people hold on."* The recipient hit the door in seclusion at least twice. The physician was contacted and emergency enforced medication was given for extreme agitation. A restriction of rights form was given. At 5:47 p.m. a nursing note documented that the recipient continued to hit the door in seclusion. A STA IV was contacted and the recipient was walked from seclusion to the restraint room "per self no physical hold initiated." The patient was educated and given risks of self-injurious behaviors and placed in 4 point restraints for the safety of all. The physician was notified, injury report completed, no injuries noted and restriction of rights form was given. A physician renewed the restraint order at 9:45 p.m. due to the recipient continuing to be "an imminent risk for harm to all." It was documented that the recipient remained argumentative and refused to accept responsibility for his behavior and stated *"if you guys leave me alone it will all be fine but if not then…you know."* A nursing note dated August 6th at 1:40 a.m. documented that the patient was released from restraints. He was given medication information per his request at 10:30 a.m. and stated that he was going to *"shut this place down."* An August 27th nursing note documented a conversation the recipient had with the nurse complaining about the STAs and said that he *"kept my toothbrush in my sock and [STA2] took it."* The nurse explained that he cannot keep his toothbrush in his sock but if he wanted a paper towel to place it on at his desk she would give him one. The recipient responded *"I don't need your advice."* In a sarcastic tone and walked away.

D. Discharge Summary: The HRA reviewed this recipient's discharge summary dated 10/18/16. The Interventions and Response to Treatment section stated under the Medications section *"none. The patient is unwilling to take treatment."* Under the Treatment section it stated *"In addition to medication, [recipient's]treatment at Chester Mental Health Center includes Fitness to Stand Trial restoration counseling; Individual Counseling with his therapist; Recreational*

Therapy and other Therapeutic Interventions. [Recipient's] participation in programming has been good. Overall, [recipient's]progress has been good." Under the Progress section it stated *"Since his admission to Chester Mental Health Center on 6/15/16 [recipient] has done well. He has had no episodes of violent behavior and no use of restraints or seclusions. He has passed the fitness test. He attends groups and activities."* The current mental status is listed as the recipient *"denies any auditory or visual hallucinations. He also denies suicidal or homicidal ideation or plans. He has not had any physical altercations with peers."* The form was signed by a physician at the facility.

III...Facility Policies:

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… All patients have the right to their personal property. If the patient's clinical condition warrants removal of personal property* ***or limiting access*** *to specific personal property then it will be considered a restriction. When a patient's desk, bed, chair, ability to utilize water in their room, and ability to flush toilet is removed a restriction of rights is necessary. If a patient is restricted from accessing his personal property, a restriction of right has to be issued. The notification of the restriction must indicate where his property will be stored during the restriction and whether or not he will be allowed access to it. If a patient's access is limited in any way to communication tools, for example; supervised pencil use and supervised calls, a restriction of rights must be given to the patient…*

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

C. Documentation of the Restriction of Rights.

If any patient's rights are restricted the restriction will be documented as follows:

1. The Unit Director or designee is to ensure that the form IL462-2004M NOTICE REGARDING RESTRICTED RIGHTS OF AN INDIVIDUAL is completed by clinical staff overseeing the patient's treatment plan.

2. The Unit Director will ensure that the original of the IL462-2004M will be given to the patient and copies will be distributed to the following people:

a. The Facility Director or designee.

b. The parent or guardian if the patient is a minor or under guardianship…

c. Any person of the patient's choice. If that person requests that the facility not send him or her such notice, that person's request shall be honored and the patient shall be notified of the person's request not to be sent such notice.

d. The Guardianship and Advocacy Commission, if the patient has so indicated.

3. A copy of the IL462-2004M NOTICE REGARDING RESTRICTED RIGHTS OF AN INDIVIDUAL will also be filed in Section 3 of the clinical record.

4. A progress note will be made in the patients chart upon initiation of the Restriction of Rights and shall include the following.

a. Date and time initiated.

b. Circumstances and/or assessment that resulted in the Restriction of Rights.

c. Rationale for the Restriction of Rights.

5. An Information Report CMHC-207 is to be completed for each incident involving the initiation of a restriction of rights. All CMHC-207 Information Report forms shall be routed according to established facility procedures to ensure proper documentation of events. A restriction imposed during a treatment team meeting should be documented in the treatment plan review.

6. Restrictions or modifications to restrictions will also be documented in the unit log book."

TX .06.00.00.03 Use of Restraint and Seclusion states *"The goal of Chester Mental Health Center is to limit the use of Restraint or Seclusion to emergencies in which there is a clear and present danger of an individual harming himself, other patients, or staff. Neither Restraint nor Seclusion may ever be used as a means of coercion, discipline, punishment, convenience or staff retaliation. The least restrictive intervention that is safe and effective for a given individual will be used. Additionally, CMHC will follow the program directive, 02.02.06.030 Use of Restraint*

and Seclusion (Containment) in Mental Health Facilities, as a guide and discontinue use of Restraint or Seclusion will be at the earliest possible time, regardless of the scheduled expiration of the order. CMHC's goal
is to provide treatment in a non-coercive, violence free, recovery oriented, consumer focused and trauma informed treatment environment…
Procedure
I. Use of restraint and seclusion will be implemented according to the Department of Human Services Program Directive Restraint/Seclusion Procedures…
F. Continuous video and simultaneous audio observation may be used after the first hour of seclusion as described below unless such monitoring is determined to be contraindicated by the staff member ordering the seclusion…"

TX .07.00.00.02 Comfort Room for Medium Secure Unit policy states *"The goal of the Comfort Room is to provide a supportive, relaxed and calm environment in which patients can practice self-soothing emotional regulation skills. The Comfort Room is not intended for those who have become so agitated that they pose a threat, physical harm to themselves, others or to the room and its contents. It is also not to be used as a reward for good behavior, taken away as a punishment or as a seclusion room…patients may use the Comfort Room up to an hour if other patients are not waiting. If other patients are waiting for the room, the limit will be thirty minutes…"*

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."*

The 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 5/2-104) ensures 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."

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, 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 therefor 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"

The Code (405 ILCS 5/2-109) states that *"Seclusion may be used only as a therapeutic measure physical to prevent a recipient from causing harm to himself or physical abuse to others. In no event shall seclusion be utilized to punish or discipline a recipient, nor is seclusion to be used as a convenience for the staff.*
(a) Seclusion shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, clinical professional counselor, or registered nurse with supervisory responsibilities. No seclusion shall be ordered unless the physician, clinical psychologist, clinical social worker, clinical professional counselor, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of seclusion is justified to prevent the recipient from causing physical harm to himself or others. In no event may seclusion 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 seclusion 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 seclusion and the purposes for which seclusion is

employed. The order shall also state the length of time seclusion is to be employed and the clinical justification for the length of time. No order for seclusion shall be valid for more than 16 hours. If further seclusion is required, a new order must be issued pursuant to the requirements provided in this Section.
(b) The person who orders seclusion shall inform the facility director or his designee in writing of the use of seclusion within 24 hours.
(c) The facility director shall review all seclusion orders daily and shall inquire into the reasons for the orders for seclusion by any person who routinely orders them…
(g) Whenever seclusion is used, the recipient shall be advised of his right, pursuant to Sections 2-200 and 2-201 of this Code, to have any person of his choosing, including the Guardianship and Advocacy Commission notified of the seclusion. A person who is under guardianship may request that any person of his choosing be notified of the seclusion whether or not the guardian approves of the notice. Whenever the Guardianship and Advocacy Commission is notified that a recipient has been secluded, it shall contact that recipient to determine the circumstances of the seclusion and whether further action is warranted.

Conclusion

The first allegation was inappropriate seclusion of a recipient. Documentation was found regarding a seclusion episode August 5th in which the recipient was yelling at peers regarding staff and making threats towards female staff on the unit. In that instance the recipient's preferences which are 1) Seclusion 2) Emergency Medication and 3) Restraints, were honored and he was in seclusion first then had medication and finally was placed in restraints when the other two preferences were unsuccessful. A restriction of rights form was given for each instance.

However, the recipient said that on July 15th one STA pulled him out of the lunch line for talking and took him to the seclusion room for 1½ hours. STA 1 told the HRA that on the day he was placed in seclusion it was due to him being loud and threatening in the lines, not just for talking. He was threatening staff by saying that he was going to get them fired and was telling peers that his posse would come down and he would have someone else "take care of it." STA 2 corroborated that the recipient had made threats in the lunch line to get staff fired and have his posse come down and "take care of" his peers. No restriction of rights form was found regarding a July 15th seclusion episode. Upon review of case notes surrounding the July 15th seclusion episode, the HRA found a nursing note which documented that the recipient came back from the dining room yelling and not following directions and was *"placed in comfort room"* at 1:15 p.m. to calm anxiety. Another nurse's note at 2:20 p.m. documented that the recipient returned to the unit calm and cooperative. According to facility policies, the comfort room is utilized to provide a supportive, relaxed and calm environment in which patients can practice self-soothing emotional regulation skills. The policy does not require a restriction of rights form to be completed as the comfort room is patients' choice and the door is left open. There was no documentation stating whether or not the door was left open on the July 15th seclusion episode. The STAs both corroborated that the recipient was loud and threatening when returning from the lunch line. Their testimonies to the HRA implied that it was the STAs who placed him in the seclusion room and although the nursing note used the wording of comfort room, the language stating he was "placed" in the room rather than he chose the comfort room or requested the comfort room. Therefore, this allegation is **substantiated**. The following **recommendations** are offered:

1. **Ensure that documentation accurately and clearly reflects when the seclusion room is used for seclusion or for comfort.**

2. **Ensure the MH Code standard for using the seclusion room is met as per Section 5/2-109.**

3. **Ensure that restriction of rights notices are used for all incidents of seclusion as per Section 5/2-201.**

Suggestions:

1. The case notes surrounding the July 15th episode stated that the patient was *"placed in comfort room"* which does not clarify if it was at the patient's request or staff's. In the future staff should document that the seclusion room use was at the patient's request and it should be noted if the door was open or closed, which will provide clarity as to whether or not the instance was a seclusion episode or the patient utilizing the seclusion room for calming himself.

2. Consider using a room other than the seclusion room as a comfort room so there is no confusion as to when a recipient is seeking comfort or being placed in seclusion.

3. Review comfort room practices and ensure that recipients can easily exit the comfort room if using for comfort.

4. Revise the comfort room policy to addresses keeping the door open and the recipient's ability to freely enter and exit.

5. The HRA noted that the Discharge Summary documented that the recipient had no use of restraints or seclusions despite documentation in the chart stating otherwise. The HRA suggests that physicians ensure that accurate and up to date information is included in reports and other documentation.

The second allegation was that no restriction of rights form was given when property was restricted, specifically the recipient's toothbrush during a room shake down. According to the recipient, when his room was shaken down, staff took his toothbrush and did not give him a restriction of rights form stating why it was removed. He said he keeps his toothbrush in a clean sock to keep the germs off of it and he assumed they thought he was going to use it as a weapon. STA 2 told the HRA that this recipient's room was shaken down during a unit wide search of all three modules. His toothbrush edges were filed down and that is why it was taken and given to the charge aide and he stated that a restriction of rights form was completed. When the HRA reviewed the recipient's chart, no restriction of rights form was found regarding the toothbrush, only the seclusion, medication, restraint episode he had on August 5th. There was one case note documenting a conversation the recipient had with the nurse regarding his toothbrush being taken by STA 2 above because he kept it in a sock but there was no case note documenting when it was taken or that a restriction of rights was given. Recipient's Rights Policy RI 01.01.02.01

states "*All patients have the right to their personal property. If the patient's clinical condition warrants removal of personal property or limiting access to specific personal property then it will be considered a restriction…If a patient is restricted from accessing his personal property, a restriction of right has to be issued…"* The Code (405 ILCS 5/2-201 requires that "*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…The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefor in the recipient's record."* Therefore this allegation is **substantiated.** The following **recommendations** are made:

1. The Unit Director should ensure that when a recipient's rights have been restricted that proper documentation and notification occurs as required by facility policy RI .01.01.02.01 Patient Rights.

2. Staff should be retrained on proper documentation and notification of all restriction of rights as required by the facility policy and the Mental Health Code (405 ILCS 5/2-201).