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Egyptian Regional Human Rights Authority
Report of Findings
18-110-9005
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:

> **A recipient is not receiving adequate care due to PICA behavior not being addressed in his treatment plan or behavioral intervention plan.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5 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, reviewed the recipient's record with consent, and examined pertinent policies and mandates.

I. Interviews:

A. Complainant: The complainant was concerned that the recipient in this case has had multiple incidents of PICA behavior, most recently ingesting screws approximately 7 months after a previous PICA incident. To the complainant's knowledge, there was not a behavior intervention plan (BIP) in place to address this PICA behavior.

B. Therapist: This therapist had been the recipient's therapist for approximately 3 months at the time of the HRA's interview. She stated that she meets with him at least weekly but sometimes more frequently if needed. He also makes telephone calls from her office when he has no telephone card. His last incident of self-injurious behavior (SIB) of PICA was in early July 2017 when he swallowed screws from the wall. He was given a restriction of rights for property for safety reasons which had been recently lifted. His previous BIP (dated July 2015) required the use of restraints immediately when he made threats to harm self or others. She explained that she was not the therapist at that time so she could not speak to the rationale of that BIP, but her understanding was that he would escalate to the point where restraints were necessary for safety. The recipient had a 1:1 staff assigned and the therapist said that may not have been enough at times, but they tried to use the least restrictive option to keep him safe. She also explained that she is in the process of developing a new BIP but it was not finished and had

not been formally implemented. This was due to her large caseload of "high maintenance" individuals that require a lot of her attention. At the time of our interview, the therapist was implementing other techniques "informally" to address his maladaptive behaviors. The techniques included muscle relaxation where she would ask the recipient to "stretch high like a cat and scrunch low like a turtle." He understood when she explained it that way and enjoyed the exercises. She was also teaching him breathing techniques and would remind him that he can always speak with staff, watch television and participate in activities off the unit to help keep his mind off things that were bothering him. Positive reinforcement also works well for him. She stated that participating in activities off the unit helped him the most because most of his maladaptive behaviors are attention seeking in nature and typically occur on the weekend when he is on the module all day. In order to be transferred to a less secure environment, he will need to have 6 months with no SIB behaviors, restraints or restrictions. He has a mother who is involved in his care that lives out of state and would like him to move home with her.

II. Clinical Chart Review:

A. Treatment Plan Reviews (TPRs): The 2/1/17 TPR shows a restriction of rights for property "due to history of self-injury in this Treatment facility." The TPR indicates that the recipient's pencil use is supervised, he is not allowed clothing with zippers, buttons or snaps, no belt and rosary beads are to be kept in closet (recipient may request use during prayer, with supervision). The recipient and his room are subject to search once per shift and it noted that he was housed in a secure room which is monitored for loose hardware screws. Housing the recipient in the secure room was initiated on 8/6/15 and modified 11/17/16. The recipient also had 1:1 observation 12/26/16-1/11/17 and 1/18/17-1/19/17 as well as frequent observation 1/12/17-1/17 and 1/19-1/20/17. Self-Injurious behavior in the form of ingesting foreign objects was listed as a problem to address. The therapist was to meet with the recipient once a week to provide him the opportunity to learn effective coping skills/methods to utilize during periods of agitation. It was noted that he was on 1:1 observation after ingesting a metallic screw from his bedframe on 12/26/16 which was removed via colonoscopy. The "extent to which benefitting from treatment" section noted that the recipient has *"ongoing problems with SIB, aggression and attention-seeking behaviors. He remains on property restriction, supervised pencil use and supervised toilet paper use due to property destruction and SIB. He is on supervised telephone use due to engaging in counter-therapeutic conversations with others and stealing phone cards from peers."* The restriction of rights section on the 5/24/17 TPR was verbatim to the February TPR. The restrictive procedures utilized were listed as FLR (Full Leather Restraints) on 4/28 for fighting with a peer and the 1:1 observation for SIB was implemented 4/28-5/1 due to him injuring his own nose and blaming a peer. The SIB goal section noted the same procedures in place of weekly therapy sessions and the therapist had documented that he is closely monitored for signs and symptoms of self-injury. The "extent to which benefitting from treatment" section was also verbatim to the February TPR. The 6/24/17 TPR documented that some restrictions had been lifted; the recipient no longer had supervised telephone use and the pencil supervision, clothing restrictions and searches were not documented. The supervised use of the rosary beads was still noted. The restrictive procedures section noted that he was placed on 1:1 observation 6/9-6/13 due to SIB of injuring his face and blaming a peer. He was also placed in FLR on 6/9 after striking the wall and fighting with a peer. The SIB goal section noted the same interventions and progress as the May TPR documented. The "extent to which benefitting from

treatment" section was verbatim to the previous TPRs including telephone and pencil supervision. This TPR also included a new page entitled "Identified triggers, behaviors and preferred interventions" which listed triggers that upset the recipient, the behaviors indicating the recipient is upset, and the preferred interventions that the patient and staff will complete. Behaviors indicating that the recipient is upset were listed as: SIB of striking objects, striking his head with his fist, and inserting objects as well as ingesting objects. Prior to that, irritability and rudeness with staff and peers, breathing hard, pacing, intrusive behaviors and verbal threats were the behaviors listed. The interventions included redirection to alternative activities, staff providing empathetic listening and praise for appropriate behavior, patient going to a room to calm, talking to staff, requesting contingency medication, and writing down his feelings to share with his therapist. A psychiatrist note in this TPR documented that restraint use was required on 6/9/17 due to aggressive behavior and then the recipient was placed on 1:1 observation for banging his head. He later reported he did this to blame a peer whom he wanted to avoid. The issue was discussed with the recipient during his TPR and he was reminded of more appropriate behaviors he should utilize when he is upset or distressed. An interim treatment plan dated 7/13/17 was held to discuss a restraint episode on 7/11 due to the recipient threatening staff and displaying agitated behavior. It was documented that a contingency medication was given but the recipient "refused to calm down." The recipient continued to curse and threaten staff and was threatening SIB so he was placed in a physical hold and FLRs. The plan modification was to continue the current course of 1:1 supervision for SIB after he had swallowed a screw on 7/5/17. The 7/18/17 TPR noted previous restriction of rights being re-implemented and the restrictive procedures utilized included restraints on 7/11 for attacking his 1:1 staff, frequent observation 6/13-6/19 and that 1:1 observation had begun 7/5 and continued due to ingestion of a metallic screw. The SIB problem/goals section was verbatim to previous TPRs. Nothing else was added or modified on this TPR. An interim treatment plan dated 7/21/17 was also reviewed by the HRA. This interim plan was due to restraint use after attacking staff. He was placed on 2:1 special observation due to "multiple episodes of aggression towards staff." The recipient was "unable to describe any coping strategies and voiced he just ready to get up out of here." The treatment plan modifications were listed as "*consider simplification of current goals."* The 11/7/17 TPR listed a new therapist but the problem/goal section for SIB remained the same as did the other sections of the TPR previously noted. Finally, the 1/3/18 TPR was reviewed. No restriction of rights or restrictive procedures was listed. It was documented in the "extent to which benefitting from treatment" section that the recipient had not exhibited any SIB since July, 2017.

B. Progress Notes: The 12/24/16 case notes at 10:25 a.m. indicate that the recipient was hit by a peer on the left side of his face and no injury or complaints of discomfort were noted. There is an illegible nursing note at 12:05 p.m. and then a note at 3:33 p.m. documenting the patient reported to staff that he swallowed a screw from his bed. The physician was contacted and he ordered 1:1 observation, restriction of personal property, 2 safety blankets, 1 safety smock, that the recipient be housed in a security room and for the recipient's stool to be strained. The recipient was placed in restraints at 4:00 p.m. for attempting to attack staff after numerous redirection attempts failed. The recipient was released from restraints at 10:00 p.m. and placed on 1:1 observation for SIB per physician order. The recipient's stool was strained and he was to be assessed for abdominal pain through 12/27/16 when an order was received for an x-ray which revealed a screw in ascending colon. An order was received for clear liquid diet, magnesium

citrate and to continue straining his stools. The physician continued to monitor him and repeat x-rays were completed. A colonoscopy was scheduled for 1/3/17 and the screw was removed during that procedure. During a treatment meeting on 12/28/16 the team discussed his SIB of ingesting a screw. The recipient was unable to name alternate strategies for getting positive attention from staff and he stated that he wanted to get away from peers that were frustrating him. Upon return from the hospital the recipient was returned to 1:1 observation for SIB and placed in the security room with property restrictions in place. On 1/12/17 he was taken off 1:1 supervision and placed on frequent observation with was his own clothing and regular bedding but still no personal property.

A nursing note dated 7/5/17 stated that the recipient claims he swallowed a screw. The physician placed the recipient on 1:1 observation for SIB with 2 safety blankets and a safety smock. He was later transferred to a community hospital and upon return to the facility he continued on 1:1 observation for SIB. A 7/18/17 psychiatrist note documented the SIB on 7/5/17 of ingesting a screw which had to be removed by colonoscopy. The recipient was continued on 1:1 observation for SIB. It was noted that he attended his TPR and *"his behavior was again earnestly discussed and was able to acknowledge; more appropriate behaviors that he should utilize when he gets upset or distressed."* A 7/17/17 therapist note documented a treatment meeting where the recipient stated that he learned his lesson and he was not going to do that anymore. He denied thoughts of SIB but focused on how long he would be on 1:1 observation. The patient remained on 1:1 observation when on 7/21/17 a nursing note documented that he claimed to have swallowed the cardboard from the toilet paper roll. It was documented that he had no difficulty swallowing or speaking. The physician was notified and the order was updated to include a safety smock, 2 safety blankets, restriction of personal property and no paper products. The therapist note that same day documented that he continued to exhibit challenges with SIB and noted that he had reported ingesting cardboard. It was also noted that he would be "closely monitored while on 1:1 special observation. Access to personal property and ingestible materials will be restricted for his safety." Later that day, the recipient was also placed in restraints for attacking staff and following the restraint episode, he was placed in a safety smock with 2:1 observation for both SIB and attacking staff. It was noted by the physician on 7/23/17 that the recipient "appears to be escalating his behavior recently including SIB which led to hospitalization and recent restraints and staff attacks. Will observe. Tx [treatment] team needs to address." On 7/27/17 at 3:05, two STA notes documented that the recipient showed a piece of wood and when staff tried to stop him, became combative and was placed in a physical hold followed by 4 point restraints for his protection. At 3:45 a NP [sic] note documented that his room was "shook down" by security and it was noted that no screws were missing however, the recipient was "adamant he swallowed a screw." X-ray staff was gone for the day and would not return the following day. The local hospital was called and instructed the facility to monitor the recipient's stools, place him on a full liquid diet and to follow up with a KUB [kidney, ureter and bladder] X-ray the next morning. The note also documented that the psychiatrist and treatment team was to evaluate his behavior and the psychiatrist, unit director and therapist met with the recipient to discuss. He was released from restraints at 10:30 p.m. and was placed on 1:1 observation at that time for SIB. He was also given a safety smock and safety blankets, restricted personal property or paper products and was housed in the secure room. A nursing note on 7/28/17 documented that the KUB X-ray showed no foreign body and the physician ordered to discontinue straining all stools and to resume his previous diet. On 7/29/17 at 7:20

p.m. a nursing note documented that the recipient reported swallowing a piece of the wall and noted that upon review, a 2 inch piece of mortar was missing from his wall. The recipient was "placed in 4 point restraints to prevent any further injuries" and the physicians were notified. An order was given to strain all bowel movements to look for the foreign body. The recipient was released from restraints at 11:15 p.m. and placed on 1:1 observation in the safety room. The Security Therapy Aides (STA) were instructed to keep the recipient within an arm's reach and also for the recipient to lay on the bed with his head towards the door. A staff member assigned to him and it was stated that at no time should the recipient's head or hands be covered so that the staff member unable to see them. On 7/31/17 a nursing note documented that the recipient had a bowel movement with visible signs of masonry present. A psychiatrist note on 8/1/17 documented that he discussed coping skills other than utilizing contingency medications and restraints and discussed examples such as counting, push-ups and muscle relaxation.

C. Behavior Intervention Plan (BIP): The Behavior Modification Plan for SIB/Aggression created 6/3/15 and modified 7/10/15 states that when the recipient "exhibits any imminent threat to harm SELF or OTHERS, verbally or physically, the use of restraints (FLR) will be utilized immediately. This plan will be put in place to protect [recipient] and everyone on his living unit…" The behaviors noted that would warrant FLR included physical aggression or verbalization/threats to cause harm to himself, staff or peers; threatening gestures toward staff or peers, demanding to be put in restraints, "shadow boxing" or hitting the wall and spitting at staff or peers. The BIP provided for a "step down" process following each FLR episode of 2:1 observation for aggression toward others if needed, 1:1 observation for self-injurious behavior/safety and finally frequent observation.

D. Office of Inspector General (OIG) Report: An OIG report was reviewed involving an incident of SIB of PICA which occurred on July 29, 2017. It was alleged that a STA neglected the recipient by watching him eat broken pieces of concrete without redirecting or stopping the behavior because he was preoccupied with speaking with other staff. The recipient had visible signs of masonry present in his bowel movement on July 31, 2017 and there was a 2 inch gap of mortar missing from the wall which the recipient was washing on July 29, 2017. The allegation of neglect was substantiated.

III...Facility Policies:

A. RI.01.01.02.01 Patient Rights policy states *"A patient shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual treatment plan."*

B. IM.03.01.01.03 Treatment Plan policy requires that the facility *"shall ensure that each individual is receiving active treatment to address problem areas which precipitated hospitalization. Treatment planning is an ongoing process in which problems, goals, objectives and interventions are identified and monitored. The multi-disciplinary treatment planning process is to be documented upon admission and throughout a patient's stay via assessments, treatment plan, treatment plan reviews, progress notes and other documentation…*

Treatment Plan Participation and Treatment Oversight…It is the responsibility of all disciplines to participate in the development of a multidisciplinary treatment plan. It is the responsibility of the primary therapist to serve as the coordinator of the treatment plan, ensuring the following:

A. Treatment plan meetings happen within all the required time frames.

B. All discipline input is gathered and utilized for treatment plan reviews.

C. The plan is comprehensive and individualized based upon the assessment of the individual's clinical needs, strengths and limitations and is written in behaviorally defined and measurable terms.

D. The treatment plan reflects current treatment.

E. The patient is given a daily schedule of assigned groups and activities based on the interventions assigned in the treatment plan…

G. All Comprehensive treatment plan documents are typed and filed in the chart within the required time frame…

C. TX .07.00.00.01 Guidelines for the Treatment of Patients with Severe Maladaptive Behaviors Policy states that *"Chester Mental Health Center provides treatment for patients exhibiting severe maladaptive behaviors. Treatment will focus on the replacement of maladaptive behaviors with more socially acceptable behaviors. The treatment program will teach adaptive replacement behaviors as well as provide the environment to practice these skills. The level system helps establish guidelines for both patients and staff regarding the type of behavior that is required in order to engage in specific activities within the treatment program. This will establish an environment that fosters improved social functioning and positive outcomes for the performance of adaptive behaviors…Gathering Information: The following assessment tools are available:*

1. *Violence Risk Assessment Tool (VRAT)*
2. *Functional Behavior Assessment*
3. *Triggers for Maladaptive Behaviors*
4. *Psychological Evaluation*

C. The treatment team, patient, and family members when appropriate, will be involved in the development of the treatment plan. This plan is initially developed within three days of admission, with a review at 21 days and 30 days thereafter. Any unwanted or maladaptive behavior will be considered a critical treatment issue.

D. Treatment prescribed in a patient's treatment plan addressing the goal of managing or extinguishing maladaptive behaviors and promoting adaptive replacement behaviors will be identified in the treatment plan as a 'Behavior Intervention Plan.' It will include the following:

1. *Definition of the target behavior*
2. *A hypothesis on the function of the behavior*
3. *Identifying a goal and objectives for the patient to achieve, including the replacement of the behavior with a more adaptive one*
4. *Interventions should include the method of implementation, strategy, support, teaching methods, motivation and reward if used, frequency, and circumstances under which the plan will be implemented*
5. *A condition for discontinuation*
6. *All interventions attempted*
7. *Data collection in order to monitor response to treatment*

Progress towards objectives is reviewed at each review meeting with the patient, and information collected during the reporting period is shared to determine whether the plan will remain in effect, or requires revisions…

H. ***Severe behavior management issues may be characterized by the following:***

1. ***Unwanted or maladaptive behaviors which result in serious injury of self or another person.***
2. ***The patient's behaviors warrant placement in restraints with consideration being given to ambulatory restraints.***
3. ***The patient's behaviors are impeding his ability to achieve goals established for treatment as indicated by repeated episodes of seclusion or restraint.***

When a patient's behavior meets one or more of the above criteria, a referral may be sent from the treatment team to the Clinical Director, or designee, who will review the case. [Emphasis added] *The Clinical Director or designee may then recommend a psychologist to evaluate the patient. The purpose of the evaluation is to determine those factors which underlie the onset and maintenance of the maladaptive behaviors and may include a number of assessment instruments/methods including functional behavior assessment.*

The functional behavior assessment will include an operational definition of each targeted behavior, factors that may influence the target behavior, factors related to the function of the target behavior, defining events and situations that predict occurrences of the target behavior, and a summary listing precipitating events/settings or triggers and the possible function of the target behavior. In the event that behavior problems persist following the implementation of a behavior plan based on functional assessment, a psychological evaluation will be completed. The unit director of the patient's assigned unit will ensure a referral is sent to the Clinical Director or designee, who will ensure the need for an evaluation is assigned for completion…

TREATMENT A. The patient will be offered alternative ways to cope with situations that result in the unwanted or maladaptive behavior. These skills may be taught in individual or group therapies, rehabilitation classes or activity therapies. Interventions found to be successful will be documented in the treatment plan in order to ensure continuity of care within the treatment milieu and after transfer or discharge from this hospital. Each part of the treatment program offers an environment where appropriate social behaviors (such as replacement behaviors) can be learned and monitored to determine utilization of skills learned by the patient…"

The HRA was informed that the individual treatment teams are responsible for developing "behavior management plans." If there are behavior management issues that continue to be chronic then those are addressed in three ways:

1. Clinical Care Monitoring (CCM) is recommended to the Medical Director by any of the Treatment Team members with a consultant who may be a Social Worker, psychologist, nurse, educator, activity therapist, or a physician who is not a member of the treatment team.

2. Utilization Review is a routine process with the treatment teams and hospital leadership to ensure that the patients are receiving proper care and that any barriers to discharge/transfer are being addressed, which also includes review of behavior management plans.

3. Referral to Clinical Director or designee for review and recommendations. However, since the facility currently does not have the position of Clinical Director filled, the HRA was informed that this step of the process will be resumed when this position is filled.

PE 02.05.00.01 Clinical Care Monitoring: This policy states that "*CMHC provides a mechanism for dealing with individual patients who do not respond to treatments and interventions as predicted and may require consultations with individuals outside their treatment teams…*

A. When a treatment team member becomes aware of any of the following issues involving a patient's treatment process he/she will report this to the coordinating therapist who will request a clinical care monitoring (CCM) meeting.

1. Unresolved diagnosis problem
2. Unimproved recipients
3. Diagnostic Errors
4. Complications in treatment
5. Disagreement between treatment team members regarding transfer of a patient to less restrictive environment.
6. Other treatment issues, for example, conflicts or disagreement within treatment team, discordance amongst treatment team members as to an individual's restoration to fitness to stand trial or counter-transference of any treatment team member impeding the treatment process.

B. If the treatment team concludes that they have exhausted possible alternatives in dealing with the stated problem, this will be documented in a progress note, including a brief description of how the problem has been addressed to date.

C. The CCM will be scheduled by the coordinating therapist.

D. The person seeking the CCM will ensure that all problems in any of the above areas are addressed at that meeting.

E. Participants will be members of the treatment team assisted by an off-unit consultant. The consultant may be Social Worker, psychologist, nurse, educator, activity therapist, or a M.D. who is not a member of the treatment team. In selecting a consultant, attention is to be given to the relevance of the consultant's specialty and experience with the problem(s) being addressed. Problems relating to medication, diagnosis or other areas will be addressed by consultants who are qualified to do so… The Unit Director will maintain a log of all requested CCMs to ensure completion in an appropriate timeframe and ensure the CCM recommendation and patient progress is reviewed in their next UR review."

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…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 5/3-209) requires that *"Within three days of admission under this Chapter, a treatment plan shall be prepared for each recipient of service and entered into his or her record. The plan shall include an assessment of the recipient's treatment needs, a description of the services recommended for treatment, the goals of each type of element of service, an anticipated timetable for the accomplishment of the goals, and a designation of the qualified professional responsible for the implementation of the plan. The plan shall include a written assessment of whether or not the recipient is in need of psychotropic medications. The plan shall be reviewed and updated as the clinical condition warrants, but not less than every 30 days."*

The Code requires in (405 ILCS 5/4-309) that "*(a) Within 14 days of admission, the facility shall prepare a written habilitation plan consistent with the client's diagnosis and needs. The Department shall fully implement habilitation plans. Every reasonable effort shall be made to involve the client and his family in the preparation and implementation of the plans. (b) The habilitation plan shall describe the habilitation goals; a projected timetable for their attainment; the services to be provided; the role of the family in the implementation of the plan; and the name of the person responsible for supervising the habilitation plan. (c) The habilitation plan shall be reviewed regularly, but at least once every calendar month, by the person responsible for its supervision. They shall be modified when necessary. The client and the persons specified in Section 4-206 shall be informed regularly of the client's progress."*

Conclusion

The allegation is that a recipient is receiving inadequate treatment due to his PICA behavior not being addressed in treatment planning or a behavioral intervention plan (BIP). The recipient had an instance of PICA by swallowing a screw in December 2016 which had to be removed via colonoscopy and then repeated the same PICA behavior in July 2017 by ingesting another screw. Later that month the recipient ingested cardboard from a toilet paper roll and mortar from the wall. The HRA reviewed the BIP which was dated 6/3/15 and modified 7/10/15. Essentially, this plan was to utilize restraints when the recipient exhibited "any imminent threat to harm self or others." Restraint use was followed by a step down process of 2:1 observation (if needed), 1:1 observation and finally frequent observation. The treatment plans dated from February through July 2017 documented that PICA behavior was addressed by utilizing a restriction of rights for 1:1 supervision and restricting property and clothing with zippers, buttons, snaps or belts. The restriction also provided for room and patient searches once per shift

and for the recipient to be housed in the secure room. The problem/goals section required a therapist to meet with the recipient once per week to teach effective coping skills and methods to utilize during periods of agitation. It was noted that the recipient was also *"closely monitored for signs and symptoms of self-injury."* The HRA found no documentation in the treatment plans regarding the recipient's response to the therapy sessions. The treatment plans remained unchanged until June 2017 when a new page was added to the plan which listed triggers that upset the recipient, behaviors that indicate he is upset, interventions for the patient and interventions for staff. There was no documentation as to why this new page was added. Case notes from June to July when the second instance of PICA occurred did not document whether any of these new interventions were utilized. Two more PICA instances occurred in July as well and an OIG report that was reviewed substantiated neglect by staff that adequate supervision was not being provided by 1:1 staff. Therefore, this allegation is **substantiated**. The HRA makes the following **recommendations:**

1. **Facility Policy *IM.03.01.01.03 Treatment Plan* requires that the plan be *comprehensive and individualized based upon the assessment of the individual's clinical needs, strengths and limitations and is written in behaviorally defined and measurable terms.* The monthly TPRs for this recipient were verbatim from month to month as to how the recipient was responding to interventions. Therapists and other treatment members responsible for documenting progress in TPRs should be retrained on this policy and ensure that plans adequately document progress or lack thereof from month to month so that treatment can be personalized to individual needs to ensure maximum recovery.**

2. **This recipient met the criteria for additional review as outlined in facility policy *TX .07.00.00.01 Guidelines for the Treatment of Patients with Severe Maladaptive Behaviors* such as maladaptive behaviors resulting in serious injury of self; behaviors that warrant placement in restraints and behaviors impeding his ability to achieve goals indicated by repeated episodes of restraint. Although he met these criteria, the HRA found no documentation that any such referral occurred. The treatment plan should include estimated timetables for accomplishing goals as required by the Mental Health and Developmental Disabilities Code (405 ILCS 5/3-209 and 405 ILCS 5/4-309); if goals are not being met and no progress towards achieving these goals has occurred, then the treatment team should make appropriate referrals for a Clinical Director review or Psychologist to complete a Functional Behavioral Assessment and, when appropriate, further referral for Clinical Care Monitoring or Utilization Review. This policy also requires data collection in order to monitor response to treatment. Staff should be retrained on the requirements of this policy and therapists and treatment team members should ensure that these practices occur.**

The HRA offers the following suggestion:

The facility policy *TX .07.00.00.01 Guidelines for the Treatment of Patients with Severe Maladaptive Behaviors* states that step 3 for chronic behavioral issues is to refer to the Clinical Director for review and recommendations. However, since the position of Clinical Director is

currently vacant, the facility has eliminated this step until it is filled. The HRA suggests that rather than eliminating this step of the process, administration should appoint another person to complete this step. Possibly someone at another state operated facility who currently holds that job title could be utilized until such time as the Clinical Director position is filled at Chester MHC. The policy should also be revised to reflect this procedure.