FOR IMMEDIATE RELEASE

REPORT OF FINDINGS- 19-040-9009
TIMBERLINE KNOLLS RESIDENTIAL TREATMENT CENTER
HUMAN RIGHTS AUTHORITY- South Suburban Region

INTRODUCTION

The complaints stated as follows: 1)) the facility failed to include a resident's input in her meal plan, 2) the facility failed to provide appropriate therapeutic activities, 3) the resident was not seen by her therapist in a timely manner, 4) medication was not administered as prescribed, 5) the resident was physically abused by her peer, and, 6) the bathrooms on the unit are kept locked during the night and the bathrooms are not unlocked as requested by the residents. If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.).

Located in Lemont, Timberline Knolls is a private residential treatment facility that provides services to female adolescents and adults. These services include, but are not limited to, eating disorders, drug and alcohol abuse and psychiatric disorders. Additionally, the facility has a partial hospital program for adult females.

METHODOLOGY

To pursue the complaint, the Facility's Chief Executive Officer, the Chief Officer of Operations, the Director of Nursing and the Associate Director of Clinical Services were interviewed. The complaint was discussed with the resident's parents and her records were reviewed with written consent. Relevant facility policies and general admission documents were reviewed. The HRA reviewed a note about an incident involving the resident and her peers written by a staff person that was not part of the record. Additionally, the investigation team gathered information for this report from the facility's website.

The parents of the adolescent resident maintain all rights.

COMPLAINT#1, 2, 3 and 4: Meal Plan, Therapy and Medication

The complaint stated that the resident did not have any input in her meal plan. It was reported that the resident's father was informed that the resident would be able to choose food items from a menu. However, she was not allowed to choose what she wanted to eat. The complaint stated that the facility failed to provide appropriate group therapy activities such as

expressive art and dancing. It was reported that the resident was coloring pictures instead of creating her own designs in a group art therapy session. The complaint stated that the resident was not seen by her therapist in a timely manner. It was reported that she did not see her therapist until the third admission day. Additionally, the complaint stated that a diuretic medication (for headaches) and other medication were not administered as ordered.

Information from the record, interviews and program policy

According to the record, the 16-year old resident was admitted to the facility's adolescent residential treatment program on Tuesday, February 19th, 2019 around 1:00 p.m. She was provided with a copy of the Resident's Handbook, the facility's Notice of Privacy Practices, the Rights Statement, the 72-hour Notice for Release Treatment Agreement and other documents on the admission day. A "Comprehensive Admission Assessment" and Nursing Assessment Report documented that the resident's medical history included trauma, self-harming behaviors and migraine headaches. She denied having an eating disorder. She was diagnosed with a Mood Disorder, Post Traumatic Stress Disorder, Anxiety, Migraine Headaches and Acid Reflux. The admitting orders included Fluoxetine, Zantac and Lo Loestrin FE daily in the morning, and Topiramate daily at night, and Oxcarbazepine, Buspirone and Propranolol twice daily. Vistaril and other medication as needed were ordered. Her record contained parental consent for the administration of the psychotropic medications above and documented that medication information was provided and that her parents wanted to be notified prior to any medication changes.

The resident's initial treatment plan indicated that she would be monitored for self-harming and suicidal behaviors. A safe and non-threatening learning environment would be provided. Her treatment plan stated that migraine headaches were problematic and included interventions such as compliancy with medication and having her vital signs taken. Her program included group Therapeutic Movement (Dancing) on Monday, Wednesday and Saturday, Art Therapy on Thursday and Saturday, Dialectical Behavior Therapy on Monday, Wednesday and Thursday, school on weekdays, church on Sunday, etc. An expressive therapy consultation was ordered. However, this was not found in her record reviewed. The medication record documented that all scheduled dosages of Topiramate, Oxcarbazepine, Buspirone and Propranolol were administered on the admission night.

For February 20th, a History and Physical Examination Report documented that psychiatric medications were "helping" the resident, but migraines headaches and stress were making her feel worse. A Nutrition Assessment Report indicated that the resident was seen by the facility's dietitian and weighed 212 pounds upon her admission to the facility. Her ideal body weight was 115 pounds and her desired ideal body weight was 180 pounds. Her lightest weight was 160 pounds about two years ago and her heaviest weight was 230 pounds about two months ago. She reported having restricted her food intake leading up to her least weight of 160 pounds. She denied having any existing eating disorders or food preferences. Her eating habits included skipping breakfast and eating a sandwich and chips for lunch. The resident's Interdisciplinary Treatment Plan documented that she might benefit from meal plan exchanges as evident of her 37.5 body mass index and having a previous eating disorder. Her dietary goals were as follows: 1) to choose balanced meals and snacks with provided recommendations for

meal plan exchanges, and, 2) to appropriately engage in physical activity as recommended by her treatment team. Three meals including snacks and water through meal plan exchanges to meet her needs were recommended. Both the resident's treatment plan and the nutrition assessment report documented "own use," which means she could make choices about her meal plan according to the staff interviewed.

For February 20th, a First Session Orientation Report form and clinical note completed by the Covering Primary Therapist documented that the resident reported having increased panic attacks, nightmares, and problems with sleeping. She told the therapist that her Christian faith was important to her and the facility's Christian program was discussed with her. She told the therapist that she was not sure if the facility was right for her. She said that having restrictions on music and art would be difficult for her. However, the investigation team found no documentation of any restrictions on therapy groups, and her participation in a group therapy session on clarifying goals was recorded in her record on that same day. According to the medication record, all scheduled dosages of medication were administered except for Zantac and Oxcarbazepine. There was no clear documented explanation for the missed medication dosages. Her parent was reportedly informed that Diamox (a diuretic medication) 500 mg twice daily was added to her medication regimen.

For February 21st, the resident's record contained a physician's order documenting "own/use," which means she could make choices about her meal plan as previously noted in the report. A psychiatric evaluation documented that the resident said that she needed help because she was "struggling." A Clinical Formulation Report, completed by the psychiatrist, indicated that Dialectical Behavior Therapy (DBT) and medication management were recommended. The clinical notes recorded the resident's participation in a therapy group on body imaging and the group members were given a choice of coloring or making a list of things that they would like to happen in their life. Another note recorded her participation in a DBT group discussion on managing urges, emotions, and behaviors. The investigation team found no documentation that she had attended dancing or art therapy groups/classes in her record. According to the medication record, the resident was allowed to refuse scheduled morning dosages of Fluoxetine, Oxcarbazepine, Buspirone, Propranolol, and all scheduled evening dosages of medication were administered except for Diamox. There was no clear documented explanation for the missed medication dosage.

For February 22nd, a Clinical Interview Report and a clinical note documented that the resident wanted to learn about the underlying causes of her anxiety. She told the Assigned Primary Therapist that she wanted to work on her relationship with God. And, she had expected to have more time for school and experiential therapies and was not sure if the facility was right for her. According to a Family Therapist's note, the resident told the clinician that she did not have an eating disorder and that her mother was concerned about her being treated for this medical problem. A goal and interventions concerning her insomnia were added to her treatment plan on that same day. For February 22nd thru the 24th, the medication record documented that all scheduled dosages of medication were administered except for nightly dosages of Diamox, and all scheduled dosages of morning medication were administered except for Oxcarbazepine and Diamox on the 25th. As before, there was no clear documented explanation for the missed medication dosages. Her record indicated that she was compliant with programming and

attending therapy groups on the 22nd and the 24th. The resident's record indicated that she was discharged against medical advice and was happy when she left the facility with her parents on the 25th.

Regarding the complaint about meals, the resident's father told the HRA that he was informed during the admission process that the resident would be able to choose food items from a menu each day. However, her meal consisted of chicken polenta with cheese that she did not want to eat on the first admission day. According to the Timberline's response letter to the complaint, the HRA was informed that all residents will meet with the facility's dietician about their meal plan to ensure that their dietary needs are met. The staff interviewed reported that all residents will discuss their meal plan with a nutritional technician with 24 hours upon their admission to the facility. Residents are provided with a menu and can choose what they want to eat. The investigation team was informed that the resident had input in her meal plan and was able to choose her food items.

Regarding the complaint about therapy services, the resident's parent reported that the facility's intake worker had suggested a church pass for the resident. However, the resident was later told that a physician's order for a church pass was needed. He said that he was informed that the resident would be offered therapeutic art and dance classes. However, she was coloring pictures in a group session, which was not therapeutic, and did not participate in any dance classes. In the Timberline's response letter, the HRA was informed that the facility has a full program available to all residents. The Director of Nursing explained that the physician might want the resident to be assessed prior to giving her a pass to attend church. She said that evaluating a resident for safety takes more than a few days. Residents are escorted to church on Sunday if appropriate. According to the facility's website, all residents will participate in creative dance movement and art therapy group classes weekly or twice weekly. The staff told the investigation team that creative dancing and art therapy group classes are held on Wednesday and Thursday, respectively. However, there was no documentation of the resident's participation in the therapies above found in her record. The Facility's Chief Executive Officer reported that training on better documentation in residents' records was started in May of 2019 and is ongoing.

Regarding the complaint about therapy services, the resident's parent told the HRA that the resident was supposed to meet with her therapist within 25 hours upon her admission to the facility. However, she did not see her therapist until the third admission day. According to the Timberline's response letter, it is the facility's expectation that residents should be seen by their therapist within 48 hours after they are admitted to its program. The staff explained that the resident involved in the complaint was seen by the Covering Primary Therapist on the second admission day because her Assigned Primary Therapist had taken a few personal days off from work. The staff said that residents can ask questions if their assigned therapist is not available to meet with them. They said that residents newly admitted to the facility should be seen by the Family Therapist within 72 hours.

Regarding the complaint about medication, the resident's parent reported that a diuretic medication for the resident's headaches was not administered until the fourth admission day. Her parent said that other medication also was not administered as ordered. Additionally, the parent said that he had picked up the resident from the facility prior to her planned discharge

date. He reportedly was reimbursed $5500.00 for out-of-pocket money for her care but did not receive the $2000.00 for the airplane tickets. The facility's response letter documented that medication is administered according to the physician's order and regulations and program policy that govern medication. At the site visit, the investigation team mentioned the scheduled dosages of medication such as Diamox were not administered without a documented explanation. The Director of Nursing explained that the resident's pulse rate was higher on some days and that Diamox (diuretic medication) would have been "held" if she was dizzy or pulse rate was high. Additionally, the staff reported that the resident did not want to be at the facility and was discharged early from the facility because her parents were not happy with the program.

According to the facility's "Multidisciplinary Treatment Plan" policy, an initial treatment plan will be developed within 24 hours of admission. A comprehensive and multidisciplinary plan is completed within 72 hours of admission. The policy states that assessments, including an initial treatment plan for disciplines 1 thru 3, shall be completed as follows: 1) Clinical Assessment by the Primary Therapist within 48 hours, 2) Family Assessment by the Family Therapist within 48 hours, 3) Nursing Assessment by a Registered Nurse as soon as possible but at least within 24 hours, 4) Psychiatric Evaluation by the psychiatrist within 72 hours, 5) Medical History and Physical Examination by a physician within 72 hours of admission, 6) Nutritional Assessment by a Registered Dietician within 24 hours of admission, 7) Expressive Therapy Skills Assessment within 48 hours of admission and prior to the development of the treatment plan etc. According to the policy, the Primary Therapist is responsible for involving the resident and her family members in the treatment planning process and ensuring that the plan is signed by the resident. The facility's multidisciplinary treatment team is responsible for reviewing and updating with the resident's input each case weekly or more frequently if needed.

The facility's "Monitoring and Identification of Residents for Nutritional Care" policy ensures that residents make choices according to their dietary needs when they are offered nutritionally balanced meal selections. All residents on a meal plan will be identified and monitored for compliancy to her appropriate diet. It states that the facility's food and nutritional department will provide meals for residents requiring a prescribed meal plan according to her meal ticket. Meals will be monitored for accuracy and compliancy by the Behavioral Health Specialist. The facility's dietician will be notified of food items substituted on the resident's meal ticket and about problems or noncompliancy.

According to the Timberline's "Adolescent Resident Handbook," care is provided by a multidisciplinary treatment team including psychiatrists, individual and family therapists, creative art therapists, dieticians, etc. A treatment team will be assigned to each resident based on their needs within 24 hours upon their admission to the facility. The assigned individual therapist will meet with the resident twice weekly. An initial Family Assessment will be done, and family therapy sessions will be provided weekly. According to the facility's handbook, residents who view their Christian faith as an integral part of their identity and recovery process will be provided with the option of Christian-based treatment and programming.

According to the Timberline's "Adolescent Residents Treatment Guidelines," the facility offers a comprehensive expressive therapy program, which includes art, dance movement, yoga, and recreational therapies. Through the Creative Arts Therapy Department, residents will

explore a variety of activities such as creative movement, painting, sculping, and physical activities. This program increases self-esteem and promotes positive self-expression and reduces stress and shame.

The facility's rights statement includes the rights as follows: 1) services based on an individualized services plan developed with the resident's and the nearest family member's participation if feasible, 2) humane and adequate care in the least restrictive environment, and, 3) to choose spiritual health services if the resident is a member of a well-recognized religious denomination.

The facility's "Medication Administration" policy ensures that medication is accurately and safely administered to residents. The policy states that the nursing staff shall: 1) ensure that consent is obtained for psychotropic medication prior to the administration of the medication, 2) document whether the medication was refused or withheld by drawing a circle around the time on the medication record. The patient's refusal or reasons why the medication was withheld shall be documented on the backside of the medication administration record and in a clinical note, 3) inform the attending physician or treatment team about any medication not administered, and, 4) document the reason why the medication was not administered or any side effects in the resident's record.

CONCLUSION

Section 5/2-102 (a) of the Code states that 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 Authority cannot substantiate the complaint stating that the facility failed to include a resident's input in her meal plan. According to the resident's father, the resident was not allowed to choose her food items from a menu as reported during the facility's admission process. A Nutritional Assessment Report, completed on the second admission day, indicated that the resident's history included symptoms of having an eating disorder leading up to her least weight of 160 pounds. However, she denied having an existing eating disorder as recorded by the facility's dietician. The nutritional assessment report, the resident's treatment plan and a physician order documented that her meal plan included "own use." This means that she could make choices about her meal plan according to the staff interviewed. The facility's "Monitoring and Identification of Residents for Nutritional Care" policy states that meals will be provided for residents according to their meal plan. The policy states that residents can substitute food items based on their meal plan. The HRA found no clear violations of Section 5/2-102 (a) of the Code and the facility's nutritional care policy. However, the facility violates its "Multidisciplinary Treatment Plan" policy because the resident's treatment plan was not signed by her parent(s) or the individual nor documents if she had refused to sign.

The Authority cannot substantiate the complaint stating that the facility failed to provide appropriate therapeutic activities. It was reported that the resident was coloring in art therapy versus creating her own designs. According to the resident's record, she was admitted to the facility on Tuesday, February 19th, and the admitting orders included an expressive therapy

consultation. Her program included group Therapeutic Movement (Dancing) on Monday, Wednesday and Saturday, Art Therapy on Thursday and Saturday, Dialectical Behavior Therapy on Monday, Wednesday and Thursday, school on weekdays, church on Sunday, etc. A Clinical Formulation Report, completed by the psychiatrist, indicated that Dialectical Behavior Therapy (DBT) and medication management were recommended. Her record lacked documentation that an expressive therapy consultation was completed as ordered and her participation in dance movement and art therapy group classes or church attendance prior to her unplanned discharged from the facility on February 25th, 2019. In response to the complaint, the staff reported that the physician might want the resident to be assessed prior to giving her a pass for church and that the evaluation takes more than a few days. The Facility's Chief Executive Officer reported that training on better documentation in residents' records is ongoing. The facility violates Section 5/2-102 (a) of the Code regarding the completion of an expressive therapy consultation. Additionally, the facility violates its "Multidisciplinary Treatment Plan" stating that a therapy skills assessment will be completed within 48 hours of admission and prior to the development of the treatment plan.

The Authority cannot substantiate the complaint stating that the resident was not seen by her therapist in a timely manner. The resident's parent reported that he was informed that the resident would be seen by her therapist within 25 hours upon her admission to the facility. According to the staff, the resident was initially seen by the Covering Primary Therapist because her assigned Primary Therapist had taken a few personal days off from work. Her record documented that the First Session Orientation Report was completed by the Covering Primary Therapist on the second admission day. This meets the facility's "Multidisciplinary Treatment Plan" policy stating that a Clinical Assessment must be completed by the Primary Therapist within 48 hours. A Clinical Assessment Report was completed on the fourth admission day. This violates the facility's multidisciplinary policy stating that a Clinical Assessment Report shall be completed by the Primary Therapist within 48 hours. The HRA finds no clear violations of Section 5/2-102 (a) of the Code.

The Authority substantiates the complaint stating that medication was not administered as prescribed. The medication record documented that scheduled dosages of Zantac and Oxcarbazepine were not administered as ordered on the 20th, Diamox on the 21st thru the 25th and Oxcarbazepine on the 25th. There was no clear documented explanation for the missed medication dosages or indication that the attending physician or treatment team were informed. This violates Section 5/2-102 (a) of the Code and the facility's rights statement that services shall be provided with adequate and humane care and services, pursuant to an individual services plan. Additionally, the facility violates its "Medication Administration" policy stating that the nursing staff shall document the reason why the medication was not administered and that the attending physician or treatment team were informed about the missed medication dosages in the resident's record.

RECOMMEDNATIONS

1. The facility shall follow its "Multidisciplinary Treatment Plan" policy and ensure that the resident or parent(s) sign the person's treatment plan.

2. Timberline shall follow its "Multidisciplinary Treatment Plan" policy and ensure that a Clinical Assessment Report is completed by the Primary Therapist within 48 hours.

3. The resident's record documented that an expressive therapy consultation was ordered. However, this was not found in the resident's record. The facility must ensure that physician's orders are followed and its "Multidisciplinary Treatment Plan" policy that directs the Expressive Therapy staff to complete a skills assessment within 48 hours of admission and prior to the development of the treatment. The facility must discuss this issue with the appropriate staff members and provide the HRA with documentation.

4. Timberline shall follow Section 5/2-102 (a) of the Code and the facility's rights statement and ensure that medication is administered as ordered if the resident is willing to accept the medication.

5. The facility shall follow its "Medication Administration" policy and document the reason why the medication was not administered and that the attending physician or treatment team were informed in the resident's records.

COMPLAINT# 5 and 6: Abuse/Bathrooms

The complaint stated that the resident was physically abused by her peer. It was reported that a Code Green (the facility's emergency code) was called because the resident's peer had placed her in a choke hold and threw her on the floor. The complaint stated that the resident had to hold her urine every night because the bathrooms on the unit are kept locked and residents are not allowed access to them at night.

Information from the record, interviews and program policy

There was no documentation of any behavioral incidents found in the resident's record reviewed. However, the resident's father told the HRA that the resident was choked by a peer and pushed on the floor. He said that the resident was not examined for bruises and that her peer was discharged from the facility because of the incident. He said that a staff person told the resident's mother that she had made up the abuse allegation because she wanted to be discharged from the facility. He said that the facility administration did not return his phone calls about possible abuse. Additionally, the resident's father said that during the facility's admission process he was not informed that the bathrooms on the unit are kept locked. He reported that a staff person would stand in the bathroom with the resident when access was provided.

Regarding the complaint about possible abuse, the Timberline's response letter stated that the facility did not have any have indications of the resident being physically abused during her stay at the facility. At the site visit, the investigation team was provided with a note, dated February 22nd, 2019, stating that an "identified resident" told a nurse and a behavioral health specialist that she and two other residents were "playing around" that included placing the identified resident in a "head lock" in the phone room. The note recorded that there were no injuries reported nor observed by the nurse upon examination. It stated that another resident also provided a written statement about the incident. The facility's Lodge Manager, the physician and the treatment team were notified. The note documented that the residents' parents reportedly

were not informed because there "no injury or violence" associated with the incident. The facility's Chief Officer of Operations told the HRA that the "horse playing" incident was not really an incident due to the lack of severity and both residents were able to follow redirections. The investigation team was informed that an incident report would have been completed if the incident had occurred as stated in the complaint.

Regarding the complaint about the bathrooms, the resident's treatment plan indicated that she would be routinely monitored in the bathroom due to her history of having symptoms of an eating disorder. In the facility's response letter to the complaint, the HRA was informed that the bathrooms are unlocked throughout the day and night at different times and as requested. According to the staff interviewed, the bathrooms on the lodges have been locked since the facility was opened years ago. They reported that guardians are informed during the pre-screening process about the bathrooms being locked on the lodges. The facility's "Welcome To Timberline Knolls" informational letter reportedly provided to guardians documented that the facility has five lodges and a private bathroom in each bedroom that is kept locked during the day except for assigned hygiene times. The HRA noticed that the facility's welcome letter does not mention that the community bathroom on the lodges are also kept locked. The resident's father told the HRA that he was not informed about the locked bathrooms.

The staff reported that the resident was placed on the Oak Lodge that consists of 35 beds, one community bathroom, and residents share a bedroom that includes a bathroom. There are two nurses, one certified nursing assistant, and three behavioral health staff members assigned to the adolescent lodge each night at the minimal. The staff said that all of the bathrooms are locked to monitor residents with eating disorders and those who have thoughts of suicide or harming self. The bathrooms are unlocked for hygiene purposes in the morning and night and as requested by residents. A staff person would stand in the community bathroom, and the toilet stall door would be closed, if the resident has an eating disorder. The facility's Chief Executive Officer said that the facility is planning on placing adult residents with an Eating Disorder or high safety acuity level on the same lodge. The investigation team was informed that the Illinois Department of Children and Family Services (IDCFS) monitors the facility's two adolescent lodges and inspect them at the minimal yearly. The staff reported that the facility has been asked who has the keys to the bathrooms at night, but the child protection agency is not concerned about the bathrooms being locked.

The facility's rights statement includes the right to be free from abuse and neglect.

According to the facility's "Incident Reporting-Risk Management Program" policy, it provides for a systematic, multi-disciplinary approach to managing and reporting incidents of injury, damages, and loss. An incident is defined as being an unanticipated event that is inconsistent with the standard of care and/or operation of the facility and may have occurred due to a violation of policy or procedures. It states that any staff member who witnesses, discovers, or has direct knowledge of an incident must complete an incident report before the end of their work day. It includes examples of incidents ranging from level 1 to level 4 such as death and incidents without injury, respectively. It includes procedures for completing and routing incident reports.

Timberline's "Resident Rights and Informed Consent" policy state that the facility adheres to all laws governing residents' rights and informed consent that supports treatment in the least restrictive environment. All residents, parents or guardians will be informed of rights verbally and in writing upon the resident's admission to the facility. Rights may only be restricted to protect the resident or others from harm, harassment or intimidation. A notice of the restriction must be provided. Its rights statement includes the Illinois Guardianship and Advocacy Commission contact information.

The Timberline's "Adolescent Resident Handbook" states that residents are responsible for informing the staff if their bathroom door is not locked. A form signed by the resident indicated that she was provided with a copy of the facility's handbook.

CONCLUSION

According to Section 5/1-101.1 of the Code, "abuse" means any physical injury, sexual abuse, or mental injury inflicted on a recipient of services other than by accidental means.

Section 5/3-211 of the Code states that when an investigation of a report of suspected abuse of a recipient of services indicates, based upon credible evidence, that another recipient of services in a mental health or developmental disability facility is the perpetrator of the abuse, the condition of the recipient suspected of being the perpetrator shall be immediately evaluated to determine the most suitable therapy and placement, considering the safety of that recipient as well as the safety of other recipients of services and employees of the facility.

Section 5/2-102 (a) of the Code states that 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.

Section 5/2-201 of the Code states that whenever any rights of a recipient of services are restricted, the recipient shall be promptly given notice of the restriction.

The Authority cannot substantiate the complaint stating that the resident was physically abused by her peer. There was no documentation of any incidents found in the resident's record reviewed. However, the facility provided the HRA with a note stating the resident was placed in a "head lock" while "horse playing" with her peers in the phone room one day. It documented that there were no injuries reported or observed by the nurse. According to the facility's Chief Officer of Operations, an incident report was not completed because the residents were able to follow redirections and their "horse playing" was not considered as being a real incident. Although the HRA disagrees with the administrative staff person, the Authority finds clear no violations of the Code's Section 5/3-211 as defined by Section /1-101.1 of the Code. However, the facility violates its "Incident Reporting-Risk Management Program" policy stating that any staff member who witnesses, discovers, or has direct knowledge of an incident must complete an incident report before the end of their workday.

The Authority cannot substantiate the complaint stating that the bathrooms on the unit are kept locked during the night and the bathrooms are not unlocked as requested by the residents. The facility's response letter to the complaint and the staff interviewed acknowledged that the

bathrooms are kept locked except for during morning and evening hygiene hours. The facility's "Welcome To Timberline Knolls" informational letter provides notice that the bathroom in residents' rooms are kept locked. However, there is no mention that the community bathroom on each lodge is also kept locked. According to the staff, guardians also are informed during the prescreening process about the bathrooms being locked. However, the resident's father disagrees with this. The investigation team was informed that a staff person would unlock the door whenever a resident request to use the bathroom. The HRA notes that the resident involved in the complaint had a history of eating disorder behaviors and denied having an existing eating order. The HRA believes that such safeguards for residents with eating disorders may be appropriate and not a violation of rights, if prior notice is provided. And, residents are not prevented from using the bathrooms and the doors are unlocked for them when needed. The Authority finds no clear violations of Sections 5/2-102 (a) and 5/2-201 of the Code, the facility's rights statement or the informed consent policy regarding the locked bathrooms.

RECOMMENDATIONS

1. The facility shall follow its "Incident Reporting- Risk Management Program" and complete an incident report whenever any staff member witnesses, discovers, or has direct knowledge of an incident.

2. The facility shall notify guardians or parents about all incidents although injuries might not be visible.

SUGGESTION

1. Consider revising the facility's "Welcome To Timberline Knolls" informational letter and include that the community bathroom on the lodges also are locked.