FOR IMMEDIATE RELEASE

REPORT OF FINDINGS- 20-040-9012
TIMBERLINE KNOLLS RESIDENTIAL TREATMENT CENTER
HUMAN RIGHTS AUTHORITY- South Suburban Region

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA), the investigative division of the Illinois Guardianship & Advocacy Commission has completed its investigation into allegations concerning Timberline Knolls Residential Treatment Center. The complaint stated that the facility had failed to provide adequate and humane care and services to a resident. If substantiated, this allegation would be a violation of 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. This 192-bed residential facility had about 140 adult residents when the complaint was discussed with the facility administration. Additionally, the facility has a partial hospital program for adult females located in Orland Park, Illinois.

METHODOLOGY

To pursue the complaint, the Facility's Chief Executive Officer, the Chief Operating Officer, the Director of Risk Management and Compliance, and the Director of Nursing were interviewed. A letter dated October 6th, 2020 addressed to the HRA from the facility concerning the complaint was reviewed. The resident's records were reviewed with written consent. Relevant facility policies also were reviewed.

COMPLAINT STATEMENT

The complaint specifically stated that a resident had to wear the same underwear for three days because her belongings were not properly inventoried on the admission day. It was reported that a staff person said that "we went through everything … you didn't bring your underwear [and] we are not [going to] bring up your suitcase." It was reported that her boyfriend had to bring some underwear to the facility so she could change underwear and that her underwear was later found in the inner pocket of her suitcase while she was packing her belongings. The complaint stated that the resident did not have any input in her meal plan and was placed on a lodge for individuals with eating disorders even though she denied having an eating disorder many times. The complaint stated that a behavioral health staff person told the resident to talk to her therapist about her eating disorder diagnosis even though she did not have an assigned therapist. The complaint stated that the behavioral health staff person also said that the resident was lying about being constipated and refused to unlock the bathroom door upon her request.

The complaint stated that medication was administered without informed consent. The complaint stated that a staff person told the resident to be "quiet" and that she was lying about having flashbacks related to her being raped. It was reported that the assigned psychiatrist said that the resident was lying about being constipated and the severity of her pain because she wanted to be skinny. It was reported that a nurse said that the resident was intentionally vomiting and called her a "spoiled bitch" and refused to help her to insert an enema. It was reported that a nurse said that the resident was "faking" her pain and refused to call the paramedic unless she would agree to continue in the facility's program for one more week. It was reported that the resident was admitted to the hospital on that same night because her white blood cell count was very high. The complaint stated that the facility did not provide the hospital with a legible copy of her medications as requested. Additionally, the complaint stated that the resident's medications were not returned upon her discharge from the facility, and she was without her Orilissa medication for two days. It was reported that the resident was informed that a physician's order was needed to release her medications, and later her boyfriend was allowed to pick up all of her intake medications.

Information from the record, interviews and program policy

According to the record, the resident was admitted to the facility's adult residential treatment program on Friday, January 31st, 2020. She was provided with a copy of the Resident's Handbook, the facility's Notice of Privacy Practices, Rights Statement, the 72-hour Notice for Release Treatment Agreement, the Patient Advocacy and Grievance Procedure, and other documents on the admission day. A "Comprehensive Admission Assessment" and a "Nursing Assessment Report" documented that the resident's medical history included sexual trauma, self-harming behaviors, eating disorder symptoms such as weight loss and avoidance of body image, and irregular bowel movements. She denied having an eating disorder. The nursing admission note documented that the resident presented with symptoms of anger and depression upon her arrival to the facility's lodge. She reported having problems with eating food when feeling sad.

An "Inventory Consent" form signed by the resident and a staff person on the admission day indicated that the individual did not wish to be present when her belongings were inventoried. Her belongings reportedly were searched with consent and those items considered to be contraband were restricted to her luggage or purse or the facility's storage container. Her inventory log indicated that she had many items such as pants, shirts, socks, books, hygiene products, one brassiere, a cell phone, etc. However, her inventory sheets do not indicate that she had panties or any more underwear in her luggage as stated in the complaint. She was allowed to keep some clothing items and hygiene products in her room. Some of her items such as her cell phone and coconut oil were placed in the facility's storage container for restricted items or restricted to her luggage.

The Timberline record indicated that the resident was diagnosed with a Mood Disorder, Eating Disorder OSFED (Other Specified Feeding or Eating Disorder), and Post Traumatic Stress Disorder and some physical problems. The admitting medication order included Quetiapine 100 mg nightly (for sleep) and 25 mg orally three times daily as needed, Sertraline 75 mg (for mood), Guanfacine Extended Release 2 mg (for flashbacks) daily, Orilissa 200 mg orally daily (for hormone replacement therapy), Gaba 500 mg and Niacin 500 mg orally twice daily, Mega-B Vitamins three times daily, and Vitamin-D twice weekly. Her record contained signed psychotropic medication consent forms for the administration of Quetiapine, Sertraline and documented that medication information was provided to her. Additionally, the admitting orders indicated that the resident should

be weighed daily, and this was done. Her record indicated that psychotropic medication and those for her physical medical problems were routinely administered as ordered.

For February 1st, 2020, a History and Physical Examination Report documented that the resident told the physician that she was [unclear] started on Quetiapine and Sertraline about 12 years ago and that the medications had helped her. She said that she was "too thin" and weighed about 98 pounds and that Seroquel had helped to increase her weight to 140 pounds about 12 years ago. She reported having irregular bowel movements and nightmares and being a victim of trauma. She denied having a history of an eating disorder. A Nutrition Assessment Report indicated that the resident was seen by the facility's dietitian and weighed 129 pounds upon her admission to the facility. Her usual body weight was 120 pounds and her desired ideal body weight was between 130 to 140 pounds. Her lightest weight was 89 pounds in the early 2000s and her heaviest weight was 180 pounds about two years ago. She reported having feelings of depression leading up to her lightest weight of 89 pounds. She denied having any existing eating disorders or food preferences. Her eating habits included eating oatmeal and bacon for breakfast and a sandwich for lunch and fish or sausage and vegetables for dinner. She reported that her most recent bowel movement was on the admission day. She was placed on a weight maintenance program of 1700 to 1900 calories daily and her meal plan included support.

For February 1st, 2020, the "Interdisciplinary Treatment Plan- Dietary Team" form signed by the facility's registered dietitian documented that the resident had presented with "disordered, eating patterns related to history of trauma" as evidenced by her report of skipping meals unless she has support. Her meal plan included short-term goals as follows: 1) to comply with meal plan to meet energy intake needs, 2) to obtain laboratory values related to nutritional risk, and, 3) to meet with the dietitian for nutritional, educational and support as needed. It documented that three meals including snacks, a meal plan with support, routine bathroom monitoring, weight monitoring daily, eight ounces of water with meals and snacks were recommended. Also, vitamins and minerals as recommended by the physician. Her "Interdisciplinary Treatment Plan" documented insomnia as a problem area. A "First Session Orientation Report" form and clinical note completed by a clinical therapist documented that the resident had been recommended to the facility's program due to her mood, trauma, and suicidal behaviors. It was recorded that the resident was cooperative and oriented during the meeting with the therapist. She reportedly did not have any questions after the program, and expectations, etc. were explained. A group schedule was discussed with the resident and a copy was provided.

For February 2nd, 2020, a "Psychiatric Evaluation" report documented that the resident was positive for suicidal ideations and auditory and visual hallucinations. The medication record indicated that Tums orally once daily was ordered and that the medication was administered as ordered. For February 3rd, 2020, a physician's note indicated that the resident reported problems such as constipation, nausea, pain, and night sweats. The medication administration record indicated that Magnesium Citrate one dosage, Dulcolax one-time dosage, Florastor (supplement), Bactrim (for Urinary Tract Infection) stat twice daily, Dicyclomine 20 mg (for irritable bowel syndrome), and Zofran (for nausea) four times daily were ordered. The medication record does not indicate that the medications administered for constipation were effective.

For February 4th, 2020, a behavioral health note indicated that the resident reported that she was having nightmares and flashbacks and hearing voices. She reported having urges to restrict eating because of trauma versus an eating disorder. She told the staff person that antibiotics were

being administered for a possible Urinary Tract Infection. A nursing note documented that the resident was shaking in the kitchen … and then hit herself twice in her head with her hand. She reportedly was provided with breathing techniques as her concerns were addressed. She told the nurse that she wanted her ex-roommate to apologize about an incident that had occurred earlier on that same day. She then told the nurse that she wanted to sign a 72-hour request for discharge form and was provided with a list of "pros and cons" to complete concerning her request. It was recorded that the resident's head was assessed for trauma but there was no visible injury. For February 5th, 2020, a behavioral health note indicated that the resident could not make up her mind if she wanted to stay or leave the facility. Her record contained a physician's order documenting that bathroom monitoring was discontinued.

For February 6th, 2020, a nursing note documented that the resident had been vomiting and was complaining of rectal pain and constipation even though Moviprep, Ducolax and Miralax were administered. The medication record indicated that Mineral Oil Enema one-time dosage and gatorade 16 ounces every four hours were also ordered. She told the nurse that she wanted to go to the hospital because of severe pain and refused to have her vital signs taken. She reportedly became more agitated and the physician was notified, and she was transported to a hospital emergency department as ordered. There was no mention that the nurse had refused to call the paramedics unless the resident would agree to continue in the facility's program for one more week as stated in the complaint. A physician follow up note stated that the resident was upset because she did not have a bowel movement for seven days and was feeling nauseated and bloated. It was recorded that Magnesium Citrate had been administered on that previous night and the medication did not help and that she was usually not constipated. Her record indicated that she did not return to the facility post-hospital discharge. Her record lacked documentation of any requests from the hospital concerning her medication list as stated in the complaint.

The facility administration told the HRA that that residents' belongings are inventoried at intake and that they should meet with their assigned primary therapist three times weekly. The facility's Director of Nursing told the HRA that residents can choose food items from the menu. A behavior health staff person will sit with resident during meals and encourages them to eat all of their food. She said that a dietician technician can approve other food items for residents and that this will be discussed with the Registered Dietician. She reported that some residents do not follow their meal plan and that the clinical team will discontinue them. The investigation team was informed that each resident's diagnoses are based on all of the assessments done. In the facility's response letter to the complaint, the HRA was informed that the facility does not have a policy on bathroom access, however, some residents might have an order for bathroom monitoring or lockout for a specific time after eating to decrease the chances of them engaging in maladaptive eating behaviors. The facility's letter stated that staff are to unlock the bathroom door if requested and monitor the resident in the bathroom as appropriate. The facility's administration told the HRA that residents can refuse medication and that this would be documented on the medication administration record if they do refuse.

In the facility's response letter to the complaint, the HRA was informed that residents are free to call the facility's patient advocacy phone line. A "Patient /Family Complaint/Grievance Resolution" report dated February 6th, 2020 indicated that the resident was still frustrated and said that she wanted to leave the facility when she met with the facility's Patient Advocate on that same day. She said that she was billed for services that she had not received. She said that she did not have an eating disorder but was placed on a lodge for individuals with such a disorder. She said that

her most recent bowel movement was Friday, January 31st, and that she wanted to talk to the facility's 'upper management team." An email reportedly was sent to the facility's clinical team requesting that the facility's Chief Executive Officer or an employee from the finance department would meet with the resident on that same day. It was recorded that the facility's Chief Executive Officer and a therapist had a meeting with the resident on that same day. The meeting with the therapist was terminated sooner than planned because the resident reportedly was not feeling very well.

According to the facility's Director of Risk Management Compliance, the facility does not have any incident reports of possible abuse involving the resident. He said that the facility would have completed a full investigation to ensure the resident's safety and dignity upon becoming aware of possible abuse. The facility's Director of Nursing told the investigation team that paramedics are provided with information such as the resident's medications before the individual is transported to a hospital. A resident's medication administration record would be reviewed by phone with the hospital. She said that the facility's practice does not include providing medication to residents if they are discharged to a hospital.

The Timberline's "Initial Multidisciplinary Assessments" policy states an initial treatment plan will be developed within 12 hours of admission. A comprehensive and multidisciplinary plan is completed within 48 hours of admission. The policy states that assessments, including an initial treatment plan, shall be completed as follows: 1) Clinical Assessment by a mental health professional within 48 hours, 2) Family Assessment by a mental health professional within 72 hours, 3) Nursing Assessment by a Registered Nurse as soon as possible but at least within 12 hours of admission 4) Psychiatric Evaluation by the psychiatrist within 72 hours, 5) Medical History and Physical Examination by a physician or physician's assistant or practitioner of nursing within 72 hours of admission, 6) Nutritional Assessment by a Registered Dietician within 72 hours of admission, and, 7) other appropriate assessments if needed. According to the policy, the therapist is responsible for reviewing and updating the resident's treatment plan with input from the individual and the facility's multidisciplinary treatment team.

According to the Timberline's "Resident Rights and Informed Consent" policy, all residents, parents, legal guardians, and authorized representatives shall be informed of the resident's rights verbally and in writing at the time of admission. The facility's rights statement includes as follows: 1) the right to be free from abuse and neglect, 2) the right to refuse services, and, 3) the right to receive all belongings upon discharge from the facility. It states that the Illinois Guardianship and Advocacy Commission and other external agencies contact information is posted on each lodge.

According to the Timberline's "Abuse, Neglect, and Agency Reporting" policy, it is the policy of the facility to report alleged and suspected abuse and neglect to the appropriate authorities in accordance with state and federal statutes. The policy states that patients have the right to access protective agencies/services as needed and signs are posted on each unit including a list of names and contact information of advocacy groups and information about the patient's right to file a complaint. All staff are provided with education on the identification of abuse and neglect, including sexual abuse of a minor, the reporting process, and hospital's policies. It states that employees will receive training during the orientation phase and annually thereafter.

According to the Timberline's "Emergency Room Evaluation For Medical/Psychiatric Care" policy, a physician shall authorize transfer to an emergency room for medical/psychiatric care, except

in situations in which a nurse or physician is not available such as community outings. A nurse will consult with medical professionals, the psychiatrist and/or medical director about the need for possible emergency evaluation. The nurse will call 911 for paramedics if needed and maintain 1:1 supervision of the resident needing emergency care. The staff accompanying the resident or paramedics will be provided with copies of the individual's face sheet, insurance card, history and physical information, medication administration record and, petition and certificate if appropriate. The facility's nurse will call the hospital's emergency department and provide a nurse to nurse report and document all contacts and follow up procedures.

The Timberline's "Medication At Discharge" policy states that all of the resident's medications shall be listed on the Medical Aftercare Plan, and a copy of the plan will be provided to the resident, and medications will be returned as ordered.

The Timberline's "Grievance – Procedure Resident & Family" policy states that the facility will provide an effective mechanism for handling resident/family grievance as an important part of providing quality care and services to its patients. All residents and their family are informed of the resident's rights and responsibilities upon admission and the process by which they can voice any concerns about their rights and/or treatment. This information includes the facility's Patient Advocacy hotline phone number, the time frame for review of the grievance and the provision of a written response to the resident within that time frame. There are signs posted throughout the facility that include information concerning advocacy services. A resident may submit her concerns in writing to the facility's Patient Rights/Ethics Committee, if the individual is not satisfied with the resolution provided by the Patient Advocate. According to the policy the facility's Board of Governors have the final authority and responsibility in resolving grievances.

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 5/2-102 (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.

> (a-5) If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with recipient's ability to understand the information communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. The physician or designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only [i] pursuant to Section 5/2-107 ….

Section 5/2-104 (c) of the Code states that 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.

Section 5/2-112 of the Code states that every recipient of services in a mental health facility shall be free from abuse and neglect.

Complaint # 1 thru 5

The Authority cannot substantiate the complaint stating that the resident had to wear the same underwear for three days because her belongings were not properly inventoried on the admission day. It was reported that the resident's boyfriend had to bring more underwear to the facility so that she could change underwear. Although the HRA does not discount the complaint, the investigation team was not able to determine if she had underwear in her luggage. The Authority finds no violation of Section 5/2-102 (a) of the Code regarding the complaint.

The Authority cannot substantiate the complaint stating that the resident was not assigned a therapist. The resident's record documented that the First Session Orientation Report was completed by a clinical therapist on the second admission day. This meets the facility's "Multidisciplinary Treatment Plan" policy stating that a Clinical Assessment must be completed by a therapist within 48 hours. The facility administration reported that residents should meet with their assigned primary therapist three times weekly. However, her record indicated that she was seen again by a therapist until the seventh admission day after she had contacted the facility's Patient Advocate about services. Her record also lacked an indication that the Family Assessment was completed by a mental health professional during her stay at the facility, per the policy. This violates Section 5/2-102 (a) of the Code and the facility's "Initial Multidisciplinary Assessments" policy regarding assessments.

The Authority cannot substantiate the complaint stating that the resident did not have any input in her meal plan and that the bathroom door was not unlocked upon the resident's requests. According to the record, the resident's medical history included symptoms of having an eating disorder and she was diagnosed with having an eating disorder. Her treatment plan indicated that her medical history included symptoms of having an eating disorder. She was placed on a weight maintenance program and her meal plan included support. Her record contained a physician order documenting that she would be routinely monitored in the bathroom. The order was discontinued on the sixth admission day. The HRA does not discount the complaint about the facility's locked bathroom doors and noticed that this has been a systemic complaint issue concerning the facility. In the facility's response letter to the complaint, the HRA was informed that the bathrooms are unlocked upon residents' requests and they are monitored as appropriate. The Authority finds no violations of Section 5/2-102 (a) of the Code or the facility's "Initial Multidisciplinary Assessments" policy regarding assessments with regard to meal plans or bathroom doors.

The Authority substantiates the complaint stating that medication was administered without informed consent. The resident's record contained consent forms signed by individual for the administration of psychotropic medications. The medications were administered as ordered and there was no documentation of her refusal to accept them when offered. However, her record lacked a clear physician's statement of her capacity to make a reasoned decision about the treatment. This violates Section 5/2-102 (a-5) of the Code.

Complaint # 6 thru 9

The Authority cannot substantiate the complaint stating as follows: a staff person said that the resident was lying about having flashbacks about being raped, the clinical staff said that the resident was lying about being constipated because she wanted to be skinny, a nurse said that the resident was intentionally vomiting and called her a "spoiled bitch," and a nurse said that the resident was "faking" her pain and refused to call the paramedic unless she would agree to continue in the facility's program for one more week. The HRA found no supportive evidence of abuse concerning the complaint above. The investigation team was not able to interview the assigned psychiatrist named in complaint #7 because the facility reported that the clinician is no longer employed by the provider and the staff members were not clearly identified in the other complaints. The Authority finds no violations of Section 5/2-112 of the Code or the facility's policy on reporting abuse and neglect.

Complaint # 10 thru 11

The Authority cannot substantiate the complaint stating that the facility did not provide the hospital with a legible copy of her medications as requested and that the resident's medications were not returned upon her discharge from the facility. According to the facility's Director of Nursing, a resident's medications are reviewed by phone with the hospital and continuity of care or follow up is provided. She said that medications are not provided to residents if they are discharged to a hospital. The investigation team was informed that all of the resident's medications will be returned as ordered by the physician. It was reported that the resident's medications were released to her boyfriend two days after she was admitted to the hospital. The Authority finds no violations of Sections 5/2-102 (a) and 5/2-104 (c) of the Code or the facility's "Emergency Room Evaluation For Medical/Psychiatric Care" or "Medication At Discharge" policies.

RECOMMENDATIONS

1. The facility shall follow Section 5/2-102 (a) of the Code and the facility's "Initial Multidisciplinary Assessments" policy and ensure that all services such as therapy sessions are provided, and all assessments are completed.

2. The facility shall follow Section 5/2-102 (a-5) of the Code that requires a physician's capacity statement to be document in the resident's record when services include the administration of psychotropic medications.

SUGGESTION

1. Consider developing a policy on bathroom access.