FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
TIMBERLINE KNOLLS— 09-040-9008
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary— The Authority made corrective recommendations regarding one of four allegations that were accepted by the service provider. The public record on this case is recorded below; the provider did not request that its response be included as part of the public record.]

INTRODUCTION

The Human Rights Authority (HRA) has completed its investigation opened in February 2009 regarding allegations of possible rights violations at Timberline Knolls. The specific allegations investigated are as follows: 1) a resident's parents were not adequately included in her treatment because the facility's emergency contact procedures are flawed, 2) the resident was not adequately supervised in the community and on the unit, 3) the resident was inappropriately terminated from the facility's program, and, 4) the resident's property was not returned at discharge.

If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.).

Timberline Knolls is a private residential treatment facility located in Lemont Illinois 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.

METHODOLOGY

To pursue the investigation, a site visit was conducted on May 28th, 2009. The Vice President of Compliance, the Administrator, the Coordinator of Nursing, the Coordinator of Clinical Services, a Discharge Planner, a Family Therapist and a Primary Therapist were interviewed. The complaint was discussed with the facility's Professional Marketing Representative (Out Reach Worker). The HRA reviewed the resident's record with her written consent. The facility's related policies were also reviewed.

COMPLAINT STATEMENT

The resident was reportedly hospitalized after ingesting a drug called Gamma Hydroxyo Butyrate that she allegedly got from a peer who was not properly searched at intake. A facility's staff person notified the resident's parents during the night that the resident was unresponsive and had been placed on a ventilator. Her parents who reside in another state made calls through the

night trying to reach a facility representative concerning the incident, but the facility reportedly does not have a 24-hour, seven-days-a-week system for addressing parental concerns. They even called the facility's Out Reach Worker in their area, and she was reportedly confused about the facility's emergency contact procedures. Other examples of inadequate supervision alleged that the resident walked away from her group during a community outing; she was subsequently hospitalized after cutting herself with a light bulb on the unit. The facility did not accept the resident back from the hospital nor provide continuity of care. A staff person delivered the resident's belongings to the hospital, but her electric hair straightening comb and two journals (diaries) were allegedly missing. Additionally, it was reported that peers read the resident's diaries after she left the facility.

FINDINGS

The record indicated that the 20-year old resident was admitted to the facility on August 8th, 2008. Her admitting problems included bulimia (eating disorder), drug and alcohol addiction and a Mood Disorder. She had lived with her parents prior to intake, and they were financially involved in her care. The resident gave written consent during the admission process for her private health information to be released to her parents "only in case of emergency." A form documented that the resident was given on the admission day the following: 1) the Resident Handbook, 2) Rights Statement, 3), the facility's Notice of Privacy Practices, 4) the 72 Hour Policy for Release from Treatment Agreement, and, 5) the Internet Use Policy. Individual, Group and Family Therapy, Narcotics Anonymous and/or Alcoholic Anonymous 12-step sobriety meetings were recommended. Medication records reflected that the resident gave written consent for the administration of many psychotropic medications during her stay.

There were many entries in the record detailing that the resident was non-compliant with treatment. On August 20th, the resident signed a behavioral contract stating that she would follow her plan or that she might be discharged. But she continued to miss therapy sessions due to somatic complaints and had problems following the rules. An order written on August 29th stated that the resident was restricted from using the computer due to inappropriate browsing. On September 2nd, the resident threatened to runaway when informed that she would be transferred to a more structured facility. She was allowed to stay at the facility after some discussions between the staff and her parents, but she struggled to follow the rules. Orders indicated that unclothed body and room searches were done during her stay because of safety concerns. There were Restriction of Rights notices for all occurrences in the record.

Documentation on Saturday, September 13th confirmed that the resident was transported by ambulance around 7:00 p.m. to a local hospital's emergency department after ingesting Gamma Hydroxyo Butyrate (GHB). This clear liquid drug is commonly called the date rape drug. She was placed on a ventilator and admitted to the hospital's Intensive Care Unit for precautionary observations. According to a therapist's note, there was speculation that the drug might have been concealed in a contact lens solution bottle that belonged to the resident's peer, but this was not confirmed. Therapists' notes verified that the resident's parents called the facility's Professional Marketing Representative (Out Reach Worker) in their area after notification was given. The complaint acknowledged that her parents were notified by phone on that same night, but there was no documentation in the record concerning the notice. On the 14th

around 12:30 a.m. the Family Therapist and the Primary Therapist recorded a call from the Out Reach Worker regarding the resident's parent's call. The Primary Therapist also noted that she did not listen to the message until later that morning. There were no written indications that a facility staff person followed up with her parents during the night after they contacted the Out Reach Worker, but there were many entries documenting interactions between the staff concerning the incident later that same day.

On the morning of September 14th, the Family Therapist wrote that she discussed the incident with the facility's Coordinator of Nursing, the Administrator and the Primary Therapist. According to her note, she called the hospital but could not get information about the resident because of the privacy rules that govern health information. At 9:30 a.m., she spoke to the resident's parents upon their arrival at the airport and directed them to the hospital. The Primary Therapist wrote that the clinical appropriateness of the resident returning to the facility due to her refusal to attend group therapy, somatic complaints, and the alleged drug incident was discussed with the Family Therapist. They also discussed parental requests for: 1) a staff person to meet them at the hospital on that same day, 2) a copy of the resident's medical records and assistance with releases, and, 3) a meeting with the facility's staff be scheduled on the following Monday. Entries in the record indicated that the facility complied with all of the above requests except for number one.

At 11:54 a.m. the Primary Therapist recorded that she was encouraged by the Out Reach Worker to call the resident's parents upon returning her call. She gave the Out Reach Worker the Administrator's cell number for information concerning the resident. By documentation, there was no indication that the Out Reach Worker discussed parental concerns with the Administrator. But the therapist called the Administrator who reported that he had been in contact with the Facility's Medical Director and the Coordinator of Nursing since midnight. The HRA notes that the Administrator did not mention any contact with resident's parents during the night. At 12:32 p.m. the therapist recorded that resident's father was very distraught about the incident, and support was provided. She suggested transferring the resident to another facility, but her father reportedly asked for reassurance that she would be safe if returned to the facility. On September 15th, a meeting was held with the resident's parents as requested, and a physician's order indicated that she was placed on Close Observation II upon her return to the facility on that same day. An unclothed body and room search for contraband items were also done. The next day, her therapists met with the resident and her mother regarding parental concerns. And, the special precaution order was discontinued.

Documentation on September 20th confirmed that the resident became separated from the group while attending a 12-step sobriety meeting in the community. According to the record, she left the group with a peer to go to the bathroom upon arrival at 7:00 p.m. but did not tell the staff. She returned to the facility's bus three hours later when the meeting ended. The resident reportedly met a young man during her absence from the group but denied that she had intentionally become separated from the group as alleged by peers. A urine test, breathalyzer and body check later revealed no findings of contraband items. On September 23rd, the resident and her father were informed that she would be discharged to a more structured long-term treatment because of the alleged elopement incident. Her father reportedly blamed the facility's staff for the resident's lack of investment in treatment and refused the transfer plan. Also, her

father “pleaded” for the resident to be allowed to "complete the program and [said] fix my daughter as you promised in your brochure." The therapist noted that she would follow up with the parent after the case was discussed with the clinical team.

On September 24th, the resident signed a second behavioral contract, and she was informed that any infraction would result in her immediate discharge from the facility. The contract stated that the resident would follow her program, she was restricted from using the computer, her phone calls would be monitored, etc. The contract was amended on the 25th stating that the resident would not miss therapy sessions nor have phone contact with her “boyfriend" that she met at the 12-step meeting. Within the hour, the Coordinator of Nursing observed the resident using the computer after she had signed the contract. She reportedly asked the staff person not to tell the Family Therapist and alleged that the facility's Discharge Planner had given her permission to use the computer for aftercare options. The same day, the resident and her father were informed that she would be discharged on September 27th. She was placed on Close Observations II, and a message was left for the resident’s private psychologist concerning the decision. A signed consent form for sharing information was found in the record. Although the resident's discharge was scheduled for the 27th, a written notice dated September 26th indicated that her parents were told to hire an Interventionist because she needed to be off the facility's campus within 24 hours. It was documented that the resident was only willing to go to a facility in the Chicago area. Her parents refused to escort the resident to one of the recommended facilities in their area or to hire an Interventionist. Her father insisted that the resident be allowed to stay until October 15th which was the intake agreement. The clinical team decided to facilitate "a harm reduction referral to a sober living home." The resident was interviewed by the receiving home, but the agency did not have openings.

According to a September 29th therapy note, the resident was informed that she could stay at the facility until October 15th. She was encouraged not to call her boyfriend, but she should be honest if she did. At 7:30 p.m. the resident's father was called regarding scheduling a family therapy session and parental concerns. At 12:00 a.m. her mother reportedly demanded that the therapist call her on that same night. The next day, the resident's father told the therapist that it was the staff’s responsibility to convince the resident to return home upon her discharge date. The therapist repeated that the facility's policy is reduction in harm, and that the resident is an adult. Documentation on October 5th stated that the resident's parents insisted during a family therapy session that the resident should be informed about financial issues. Her mother reportedly demanded that the facility "fix [the resident] before discharging her on October 15th". An agreement was made with her parents to extend the resident's stay until November 15th after the resident developed goals for herself including interventions to achieve them. On October 22nd, the resident gave written consent for sharing information with her parents for coordination of treatment. Entries detailed that the family continued to disagree about aftercare services; the resident’s inconsistencies in following her treatment plan; she was disruptive on the milieu; and that her behaviors became harmful.

On October 23rd, a nurse noticed a superficial cut on the resident’s hand, and first-aid was administered. She reported using a pin to cut herself and gave the object to the nurse. Her therapist and the Coordinator of Clinical Services were notified. Four days later, a room and body search was done because the resident was suspected of having contraband materials.

According to the documentation, bloody safety pins and cigarettes were found. On November 4th, the resident ran in her room and grabbed a small bag that contained dental floss after more superficial cuts were observed on her arm. Broken pieces of light bulb glass were found inside of the dental floss container, and she alleged that she had found the glass outside of the facility. Also, the staff found more pieces of glass in a box on top of her roommate's window ledge. Later, the resident requested that her physician be called for anxiety medication. A nurse suggested that she should take her scheduled and as needed medications before calling her physician. The resident reportedly slept about seven hours without incident and would not get out of bed on the next morning.

On November 6th, the resident alleged that she had found a piece of glass under her dresser, and first-aid was administered after the nurse noticed 20-24 cuts on her arm. She was placed on Close Observations II and stated "I cannot trust myself." Her physician and Family Therapist were notified, and she was transported to a local hospital's emergency room for an evaluation at 10:30 p.m. She returned to the facility on that same night, and the special precaution order was continued. There were close observations flow sheets showing that she was monitored every 15 minutes. Three days later, the resident and her peer cut themselves with a light bulb from a ceiling fixture during another incident involving many residents on the lodge. She was sent to a hospital's emergency department for an evaluation and transferred to another hospital with a behavioral health unit. On the 10th at 1:00 a.m. the resident's parents were notified that she had been admitted to a hospital for self-injurious and drug seeking behaviors. The same day, her parents were informed that the resident would not be allowed to return to the facility. A phone conference was also held with the resident's private psychologist and her parents concerning the discharge decision. The conference note documented that the facility's Discharge planner mentioned that appropriate placement referrals had been given during her stay.

According to a discharge report, the resident's parents hired an Interventionist as previously recommended by the facility's staff. And, he reportedly visited the resident in the hospital to facilitate an appropriate discharge plan to a higher level of care because Timberline Knolls was no longer an option. Additionally, the investigation team reviewed the resident's property log at intake that listed clothing, shoes, a hair dryer and a straightening comb, one notebook, and miscellaneous items. Documentation on November 12th indicated that the resident's belongings that included clothing, a hair dryer, notebooks and miscellaneous items were inventoried and packed in two suitcases and shipping boxes. There was nothing mentioned of her electric hair straightening comb or journals on the discharge inventory list.

The facility first responded to the complaint in a letter dated February 23rd, 2009 stating that the resident had not given authorization for contact with her parents in emergency situations until October 22nd, 2008 at which time she expanded her consent for sharing information with them. This statement is confirmed by the record. The letter referenced therapy notes documenting discussions with the resident and her parents regarding treatment, emergency discharge, family therapy sessions and the emergency incident. It explained the facility's Close Observation policies and included dates that the resident was under this status. She was hospitalized twice because of dangerous behaviors towards herself. Her belongings were inventoried on November 12th, her items were placed in two boxes, and the hospital's nurse

signed for them. According to Timberline Knolls, other unspecified items were found later and returned. The letter stated that the facility was not aware of the alleged missing items prior to receiving the complaint letter from the HRA.

When the complaint was discussed with the facility's staff, the Vice President of Compliance reported that parents are given informational packets and the assigned therapists' work cell numbers at intake. He said that there is staff on both lodges 24 hours everyday to answer questions. The facility's "General Information Adult Program" form also states that staff are always available to answer questions, address concerns, and offer support. And, the lodge's telephone number is listed on the sheet. According to the facility's Out Reach Worker, the resident's parent called her on September 14th around 1:30 a.m. She described the parent as extremely upset, and she was trying to get information regarding the resident's hospitalization. According to the Out Reach Worker, she tried to get information regarding the resident from the facility on that same night but could not because of the privacy rules. She reported leaving messages for the resident's two therapists during the night; she did not have the Facility's Administrator contact information at that time; and she could not remember if she called the parent back. Subsequently, the Out Reach Worker's supervisor reportedly told her that the Facility's Administrator is the emergency contact person. This was verified by the Administrator. The investigation team was informed that family is very important to the facility. They mentioned that the resident's therapists had several discussions with her parents concerning the September 13th incident.

In regard to supervision, the Vice President of Compliance said that the GHB incident was the first time that a resident has managed to bring drugs in the facility. He stated that the contact lens solution bottle appeared to have been sealed. The staff said that residents attend many supervised outings in the community but only a few have gotten lost. There were supposedly many people at the 12-step community meeting where the resident became separated from her group. Residents are given instructions regarding what to do if they become separated from their group. According to the Family Therapist, the resident involved in the complaint had planned to elope from the group. The Coordinator of Nursing explained that the staff was very concerned when the resident's self-harming behaviors became more serious on November 9th. Although the staff removed many things from the resident's environment because of safety concerns, the Primary Therapist said that a person can find something to harm oneself when determined. The HRA was informed that it is very unusual for the facility to write a behavioral contract for an adult resident because treatment is voluntary. The Discharge Planner said that the resident's parents wanted her to receive aftercare services on the East Coast. He stated that options such as a sober living program were discussed, but the resident was more concerned about seeing her boyfriend. According to the Discharge Planner, he worked with the family and the Interventionist, who was suggested as an impartial person, regarding aftercare services.

The investigation team was informed that property is packed after a determination is made that the resident will not be returning to the facility or the bed space is needed. This resident's belongings were reportedly all over her room. The Vice President of Compliance and the Discharge Planner personally inventoried the resident's items that included journals but did not record them on the log. Her electric straightening comb was reportedly shipped to her on November 26th. A delivery receipt confirmed that two boxes were shipped to the resident on the

above date. According to the complaint, the resident received three boxes that included some of her peers' belongings, but her alleged missing items were not returned. The staff denied that the resident's peers read her journals but reported that she was observed reading a peer's journal. This was confirmed in the record.

The facility's "Close Observation" policy provides for an increased level of observation and intervention for residents exhibiting self-injurious or threatening behaviors toward others, but their behaviors are potentially non-suicidal, homicidal or life threatening. A resident's primary therapist, psychiatrist or nurse can write an order for Close Observation I or II. The clinicians are directed to determine the need for a clothed or unclothed body inspection and/or room inspection. A resident on Close Observation II should be in constant view of the staff at all times including when the resident is in the bathroom. They are restricted to the lodge unless an order is specifically written by the psychiatrist allowing them to attend activities in the community. A resident on Close Observation I should be directly observed by the staff every 15 minutes and their behaviors will be recorded on the designated sheet. The need for continuation will be reviewed in 48 hours by the treatment team including the psychiatrist, the primary therapist and lodge staff. Only a psychiatrist may order a step down from level II to level I or discontinue either precaution. Those residents exhibiting behaviors that warrant additional levels of care due to risk of suicide or aggression toward others may be transferred to a psychiatric hospital under the Mental Health Code.

The only provisions for unplanned discharge were found in the Resident Handbook. It stated that residents who have impulses to leave treatment are asked to stay at least 72 hours following such impulses.

According to Timberline Knolls' policy, the facility is not responsible for residents' personal property. Residents are encouraged to send money and other valuables home with family members if possible. It states that personal hygiene products should be non-aerosol and in plastic containers. Residents are allowed to keep electric curlers or straighteners in their cubical or other locked storage area. The policy outlines a list of items such as drugs, alcohol, glass containers and mirrors that are not allowed during their stay. It states that staff can examine residents' belongings upon their arrival for safety reasons.

Timberline Knolls' policy states that all residents and guardians shall be notified at admission of the mechanism for filing complaints against the facility. The Resident Handbook outlines the procedures for grievance resolution. It includes the facility's Complaint Officer and the Illinois Guardianship and Advocacy Commission contact information.

CONCLUSION

Section 5/2-102 (a) of the Mental Health Code guarantees all recipients of services that adequate and humane care and services shall be provided, pursuant to an individual services plan.

Section 5/2-104 (c) of the Mental Health Code and Timberline Knolls' residents' rights statement #14 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

The complaint alleged that the facility's emergency contact procedures are flawed, and there was evidence in the record that the resident's parents called the facility's Professional Marketing Representative (Outreach Reach Worker) during the night because of a health-related emergency. The HRA found no statutory requirements stating that the facility must have a 24-hour, seven-days-a-week system for addressing parental concerns about adult residents who are legally competent. But information in the Timberline Knolls' welcome packet states that the staff are always available to answer questions. Documentation indicated that the resident's parents were adequately included in her treatment planning with consent from the resident.

The HRA finds that the facility made reasonable efforts to supervise the resident, even though an illegal drug made its way into the facility through another resident. At intake, residents are searched including their belongings. The GHB that was ingested by the resident is clear liquid form, and the drug was allegedly disguised in a contact lens solution bottle. The investigation team cannot dispute the facility's assertion that the bottle might have appeared sealed at intake. The facility has a process for monitoring residents who require more supervision such as the resident involved in the complaint. Orders in the record indicated that she was placed on Close Observations several times. There was staff supervision at the community meeting when the resident allegedly became separated from the group. Whether she planned to elope from the group cannot be determined. What is clear, the resident would not have been allowed to attend the meeting if she was under special precaution, according to the policy.

The record contained many entries documenting the resident's behaviors that precipitated her discharge from the facility. She refused to attend groups as outlined in her treatment plan; there were indications of drug usage, alleged elopement, and self-injurious behaviors. She signed three behavioral contracts during her stay, but she did not follow them. On November 10th, the resident was hospitalized for self-injurious behaviors, and Timberline Knolls' staff determined that she needed a higher level of care. She was offered appropriate aftercare services prior to hospitalization but the family could not agree. Documentation on November 12th indicated that the resident's belongings that included clothing, notebooks and miscellaneous items were inventoried and packed in two suitcases and shipping boxes. The staff reported that her journals were inventoried, but they did not list them on the log. Her inventory list also does not include an electric hair straightening comb recorded on her intake sheet. A tracking receipt from a shipping company indicated that a box was delivered to the resident's home on November 26th, but there was no written indication of its contents to support the facility's assertion that her straightening comb was in the box.

Based on the lack of documentation concerning the resident's property, the Authority finds a violation Section 5/2-104 (c) of the Mental Health Code and the facility's residents' rights statement #14. Based on the record and statements from the facility's staff, the Authority cannot substantiate that the resident was not adequately supervised in the community on the unit; she was inappropriately terminated from the facility's program; and that aftercare services were not offered. No violations of Section 5/2-102 (a) of the Mental Health Code were found. The

Authority finds that Timberline Knolls does not have clear written procedures for emergency discharges nor for securing resident's property in its custody during hospitalizations or unplanned discharges. Although the HRA does not discredit that the resident's peers read her journals that contained her personal thoughts, this allegation is difficult to prove because the resident reportedly left them on top of her dresser.

RECOMMENDATIONS

1. Follow Section 5/2-104 (c) of the Mental Health and Developmental Disabilities Code, Timberline Knolls' residents' rights statement #14 concerning resident's property.

SUGGESTIONS

1. Consider policy development linking parents with the facility's administration during emergency health-related incidents 24 hours, seven-days-a-week.

2. Take reasonable precautions to ensure that containers that can be used to disguise contraband items are securely sealed at intake.

3. For assurance, develop a policy regarding the safekeeping of residents' property during an unplanned discharge that is in the facility's custody.

4. According to the record, the resident gave written consent during the admission process for her private health information to be released to her parents "only in case of emergency." Consider including in policy the advisement that adult residents have the right to self-determination and that this should be clearly explained during the intake process or shortly thereafter.