FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
TIMBERLINE KNOLLS— 11-040-9010
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary—— The Authority found violations in two of the four complaints presented. 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 South Suburban Regional Human Rights Authority (HRA) has completed its investigation into allegations concerning Timberline Knolls. The specific allegations investigated were as follows: 1) the facility failed to provide a resident with adequate supervision when she eloped from the facility, 2) the resident was denied visitation because she eloped from the facility, 3) the guardian is not included in the resident's treatment planning, and, 4) the facility failed to develop an appropriate discharge plan. If substantiated, these allegations would be violations 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. The HRA was informed during the site visit that the facility's census population was 35 adolescents and 85 adult residents.

This community-based facility treatment program has three recovery phases (the Coming In, Looking In and Looking Out). In the first phase, residents focus on achieving abstinence from addictive and self-destructive behaviors. In the second phase, they work on developing character and healthy coping skills. In the third phase, they prepare for life after treatment by developing community and healthy social networks. Residents who achieve the second and third level might be given unsupervised privileges on-campus if approved by their assigned Primary Therapist or psychiatrist.

METHODOLOGY

To pursue the investigation, Timberline Knolls' Vice President, the Chief Executive Officer, the Medical Director, the Coordinator of Nursing, the Assistant Coordinator of Nursing, the Director of Discharge Planning, a Discharger Planner, and a Primary Therapist were

interviewed. A letter from the facility's Vice President was reviewed. The complaint was discussed with the guardian. Sections of the adult resident's record and a copy of her Guardianship Order, dated July 8th, 2010, were reviewed with written consent. This order appoints guardianship over the resident's personal care and finances. Relevant facility policies were also reviewed.

COMPLAINT STATEMENT

The complaint stated that the resident walked away from the facility on January 11th, 2011 because she was not properly supervised. A security camera reportedly showed that the resident was at the local train station on the incident day at 9:00 a.m., but the staff told the guardian that the resident was last seen when she went out for a walk on the facility's campus around 12:40 p.m. The staff notified the police that the resident was missing, and the guardian filed an official Missing Person's report on that same day at 4:30 pm. and 9:00 p.m. respectively. The resident was allegedly sexually assaulted while in the community. The staff reportedly told the guardian that the resident was free to come and go as she pleased. She was informed that she had been discharged upon her return to the facility three days later. An employee from the facility's security department put her belongings in the guardian's car, and she was readmitted to the facility on that following evening. The resident reportedly was initially denied visitation because of her elopement. She had to sleep on a couch in the milieu; she was not allowed to go to the bathroom alone and was closely monitored for the duration of her stay at the facility. The guardian reportedly was not included in treatment decisions regarding the resident's care, and she was not properly notified that the resident had attempted to runaway twice before she eloped on the 11th. Additionally, the complaint stated that the facility failed to develop an appropriate discharge plan.

FINDINGS
Information from the record, interviews and program policies

According to the record, the resident was diagnosed with Bipolar Disorder, Generalized Anxiety Disorder, Post Traumatic Stress Disorder, Eating Disorder and Poly-Substance Dependence upon her arrival to the facility on May 29th, 2010. Her mood was described as manic, her thoughts were disorganized, and she exhibited signs of paranoia four days later. She reportedly took off her clothing in front of her peers and tried to elope. She was discharged to a local psychiatric hospital, and her parent was notified on that same day. A Restriction of Rights notice indicated that an unclothed body search was done when she was readmitted to the facility on July 2nd. A treatment plan was developed and signed by the resident.

A psychiatric evaluation, completed on July 4th, recorded that the resident was at high risk for suicide. Her diagnoses included Bipolar Disorder with Psychotic Features, Oppositional Defiant Disorder, Borderline Personality Disorder, and some of those previously listed. A court order documented that the resident's parent became her legal guardian on July 10th. The record does not clearly indicate when the facility was informed about the guardianship order, but this issue was discussed during a family therapy session on September 9th. Documentation indicated that the resident accepted psychotropic medication, but her guardian's informed consent for

medication was not found during the record review. Her treatment plan was updated throughout her stay at the facility but was never signed by the guardian.

According to the record, the resident had problems adjusting to the facility. An Incident Report stated that the resident walked out of a sobriety meeting in the community on October 15th. The facility's staff person tried to follow her, but she disappeared and came back to the meeting about ten minutes later. The resident's guardian was informed about the incident during a family therapy session on October 20th. According to the therapy note, the guardian said that she should have been notified about the incident because of safety issues. On November 1st, the resident was discharged to an inpatient psychiatric unit because of suicidal ideations and self harm. On November 16th, she was returned to the facility, and the therapist wrote that the resident was given her "White Hat" back on December 27th.

The facility administration told the Authority that residents who are given "White Hats" have been approved for unsupervised privileges on campus. The facility provided the HRA with a form entitled, "Guidelines and Expectations for Unsupervised Walks" stating that residents who achieve this status do not require staff's supervision to and from groups, school, meals, and therapy sessions and during free time. The form includes a list of rules such as staying on the facility property. We note that the therapist's note on the 27th was the first reference of the resident having unsupervised privileges found during the record review. Also, there was no clear documentation of the guardian's input or a written order regarding this issue.

Documentation stated that the Discharge Planner or her supervisor met with the resident concerning discharge planning and the levels of care on January 11th at 10:00 a.m. An Incident Report and Addendum indicated that she eloped from the facility on that same day. She reportedly was last seen in the lodge at 1:30 p.m. She did not attend her assigned therapy group at 2:05 p.m. and could not be found when rounds were made at 3:30 p.m. A Code Green (the facility's elopement code) was called about twenty minutes later, and the staff were dispatched in cars and on foot to search for the resident. The local police, the resident's guardian, her father, and the facility's treatment team and administration were notified. The search was continued until 6:00 p.m., and local shelters and hospitals were also notified. At 8:15 p.m., the staff reportedly met with the guardian and the police. The Discharge Planner wrote that the guardian requested a group home placement when the levels of care were explained on the following day, although the resident had not returned to the facility.

A nursing note recorded that the resident was informed that she had been discharged upon returning to the facility with her guardian on January 13th at 11:30 p.m. They were told to call the facility's admission office in the morning and given a three-day supply of medication. A physician's order indicated that the resident's medication regimen was continued when she was readmitted to the facility on that next day. The order also stated that she was placed on Close Observation II for the duration of her stay. Her bed was placed in a group room for close monitoring purposes. On January 16th, the resident signed a request for discharge form but rescinded on that next day. A statement on the form recorded that the facility recommended that the resident should remain in treatment for at least 72 hours. It states that she would be allowed to leave absent any risk of harm to self or others after the recommended time period if she still desired. The resident met with the Discharge Planner on that following day. She told the staff

person that she wanted a group home living arrangement, and that she did not want to be placed in a psychiatric nursing home.

According to a letter written by the resident's Primary Therapist dated on January 21st, the resident was clearly very unstable upon her admission to the facility and that any treatment decision such as giving her "White Hat" privileges needed to be carefully assessed. The letter explained that the resident was on "the Coming In Phase" in recovery for more than two months. She had been working on improving her emotional stability prior to her achieving "the Looking In Phase" without having "White Hat" privileges. She reportedly was given unsupervised privileges about four months after she was placed in the program second recovery phase. According to the letter, the guardian had inquired about the resident having a "White Hat" before she earned this status. A determination was made to reinstate her unsupervised privileges about two weeks after she was readmitted from an inpatient psychiatric hospital because the facility's treatment team was looking for clear signs of stabilization. The therapist wrote that the resident had unsupervised privileges on-campus when she eloped from the facility on January 11th. She initially did very well when she was placed on this programmatic level. There were no clinical indications of her wanting to run away, and the guardian reported her previous elopements after the incident.

A physician order written on January 28th suggested that there was a problem with visitation after the resident's elopement from the facility. The order stated that the resident could have visits with her guardian in the lodge while she was on Close Observation status. The resident was described as extremely agitated on that same day; she started packing her belongings and said that she was leaving. An employee from the facility's Safety Department was called to ensure that the resident could not leave the lodge. It was recorded that she accepted Thorazine as needed medication and was tearful as she sat in the group room. The guardian was informed that the resident would be discharged to a more appropriate facility within a week. She was told that finding a group home placement would be difficult because of the resident's diagnoses and that receiving facilities might have waiting lists. The guardian reportedly told the staff that she had hired a consultant who had "connections" with facilities, and that she still wanted a group home placement for the resident.

On January 29th, a clinical restraint note stated that the resident announced that she was leaving Against Medical Advice. She was placed in a therapeutic hold when she attempted to leave the lodge. A Code Green was called. She reportedly managed to free herself from the staffs' physical hold and ran out of the lodge. The staff gave chase, she was physically restrained again, and Thorazine 50 mg and scheduled medications were administered. It was recorded that she verbally agreed to return to the milieu as directed by the staff, and Close Observation was continued. A corresponding Restriction of Rights notice indicated that she was restrained for about 10 or 15 minutes to prevent self harm, and that a copy of the notice was given to the guardian.

Documentation indicated that the facility's treatment team made a determination that the resident need a more appropriate higher level of care long term placement. On January 31st, the Discharge Planner wrote that the resident was agreeable when she was told that the facility was planning on transferring her. On that same day, the guardian was informed that the resident

would be discharged from the facility on February 2nd at 9:30 a.m. She reportedly was provided with information concerning two facilities approved by her insurance company for immediate transfer, but she requested that the Discharge Planner should talk to the consultant that she had hired. On February 5th, a family therapy note recorded that the resident wanted to live with her guardian, but this was not an option. She reportedly agreed to a group home living arrangement if the transfer did not take too long. According to the note, the guardian said that a psychiatric nursing home or "bridging facility" might be needed if the resident could not handle the time involved in securing a group home placement. Three days later, the resident met with the facility administration concerning her new placement. She reportedly visited with her guardian, and they called a hospital located in another state regarding placement as directed by the Director of Discharge Planning. It was also recorded that the guardian brought the resident's belongings to the facility on that same evening.

The record contained a form authorizing Timberline Knolls to release copies of the resident's medical, mental health and substance abuse information to the out-of-state receiving psychiatric hospital that offers residential services signed by the guardian on February 8th. The resident and guardian reportedly both agreed to the discharge plan, and she was transferred to the receiving facility on February 11th. A nurse wrote that the resident's mood was stable on the discharge day, and that she verbalized an understanding of the discharge and transfer decision. It was recorded that she left with all of her belongings, and that the facility was not planning on accepting her back.

A letter dated on March 3rd from Timberline Knolls' Vice President and the staff interviewed explained that the resident was given unsupervised privileges on-grounds because she had made sufficient progress in treatment. According to the Medical Director, the resident was compliant with medication, her participation in group therapy sessions was minimal, and she was working on "the Looking In Phase" in her recovery. She reportedly was given "White Hat" privileges about one week before she eloped on January 11th. This privilege previously had been taken away from her because of the same behavior. As before, the Primary Therapist reportedly remembered completing the form regarding unsupervised walks with the resident, although the form was not found in her record. The staff acknowledged that an order for on-grounds privileges was not written. The therapist reportedly was reprimanded for not following the facility's procedures.

Documentation indicated that the facility did a thorough investigation but was unable to determine the exact time of the resident's elopement. The Discharge Planner told the HRA that she had met with resident on the incident day between 8:00 a.m. and 10:00 a.m. This is supported by the record. According to the staff, the resident could not be located when the second shift staff came on duty. She had eloped from another treatment facility one year ago on that same day, but the guardian did not mention this until after the incident. They later discovered that the resident's father had given her about $350.00 during a visit on that previous week. The police reportedly showed the staff a photograph of a woman at the train on the incident day at 9:00 a.m., but all they saw was the back of her "blurry" head. This was the woman whom the complaint alleged was the resident, per the staff. The HRA was informed that the facility usually does not file a Missing Person's report with the police because the document becomes a public record.

The staff reported that a bed hold is done if a resident does not return from elopement within 24 hours. This conflicts with the facility's policy. The resident's bed in this complaint was reportedly held, and she was found by the Indiana police. According to the Coordinator of Nursing, the staff did not have medical clearance to allow the resident back in the facility when she returned from elopement with her guardian. The facility's security employee who put the resident's belongings in the guardian's car reportedly was reprimanded.

The Authority was informed that the staff are expected to facilitate programming that begins early in the morning. Residents are escorted to group therapy sessions, meals and medication administration. The staff are required to make three different rounds during the day to ensure that residents are accounted for. Residents are checked on hourly during the night. The staff reported that attendance is not taken during group sessions, but group notes are written. We noticed that the resident's record lacked groups written on the incident day and was told that residents are sometimes pulled from the group by the therapist, physician or another staff person. The investigation team was told that three staff members were given final warnings for failure to notice that the resident had eloped from the facility. One staff person was terminated from employment because of a discrepancy in accounting for another resident. The Coordinator of Nursing said that staff are now required to do a head count when residents are escorted to group sessions on campus. The staff reported that two adolescent residents had eloped from Timberline Knolls, but they voluntarily returned to the facility.

The facility administration said that the resident was sometimes upset because her guardian would visit the lodge without authorization. The treatment team told the guardian that visits would be allowed only on the weekends, which are scheduled visiting days. Residents are allowed visits and phone calls while on Close Observation I or II unless they refuse. They are not allowed to leave their assigned lodge, and meals are delivered to them. Residents who require Close Observation II should be in the staff's view for their protection. Their beds are placed in the group room, and the staff person stands outside of the bathroom with the door partially opened for monitoring purposes. The facility's Administrator said that the resident was inadvertently not allowed visits with her guardian for maybe one week because she was restricted to the lodge under Close Observation II and visitation takes place in the dining hall. The guardian reportedly was offered unlimited visitation after she brought this issue to the staff's attention and visited on a regular basis. A staff person reportedly was disciplined because a Restriction of Rights Notice was not completed in accordance with the facility's close monitoring policy.

Additionally, the staff told the HRA that the guardian was involved in treatment decisions, family therapy sessions and discharge planning. They said that residents are invited to weekly treatment staffings. The Family Therapist shares the treatment plan with those appropriate and provides feedback to the treatment team. The resident and her guardian needed to agree on a facility approved by the guardian's insurance company based on the individual's clinical needs. The guardian reportedly chose not to attend the discharge meeting. She was discharged to a psychiatric hospital because she required a higher level of care to meet her "complex psychiatric needs." According to the Coordinator of Nursing, this was first time that the facility had provided services to an adult resident under guardianship.

Timberline Knolls' "Administrative Policy on Resident Rights" effective on January 2006 states that the facility adheres to all laws governing residents' rights including the right to receive treatment in the least restrictive environment. It states that all residents, parents, guardians and authorized representative shall be informed of rights verbally and in writing during the admission process. A notice shall be given to the resident or significant other whenever rights are restricted by a physician.

The facility's "Legal Court Ordered Guardianship and White Hat Privileges" policy effective on February 2011 states that any resident under guardianship at intake, or who acquires this legal status while at the facility, shall not be given on-grounds privileges (White Hat). It states that the facility's treatment team and the resident will discuss why this privilege status cannot be achieved when it is determined to be "clinically inappropriate."

Timberline Knolls "Responding To A Code Green" policy revised on August 2009 states that the staff person should follow the resident when the individual is observed trying to elope from the facility's campus if possible. The incident will be documented in the resident's record. The lodge staff are directed to immediately notify certain staff members and the facility's security personnel when a resident is missing but was not observed leaving the facility. According to the policy, a search of the lodge, grounds and buildings will be done. The nursing staff are directed to immediately notify the local police or designate this task to the facility's security personnel. In both instances, the parent, guardian or significant other will be notified. They will be informed whether a Missing Person's Report has been filed with the police if the resident elopes. It states that the resident will be discharged within 24 hours if she does not return. This conflicts with the staff's report that a bed hold is done. The policy includes procedures such as obtaining physician's orders and notifying those appropriate if the resident returns from elopement.

The facility's "Close Observation" policy revised on July 2008 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. The resident's Primary Therapist, psychiatrist or nurse can write an order for Close Observation I or II. A resident on Close Observation I should be directly observed by the staff every 15 minutes. A resident on Close Observation II should always be in staff's view including when the person is in the bathroom. They are restricted to the lodge on either Close Observation status unless an order is specifically written by the psychiatrist allowing them to attend activities in the community. A restriction of rights notice will be completed. The staff is required to document the resident's behaviors during Close Observation every 15 minutes. 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.

According to Timberline Knolls' "Visiting" policy, all visits will take place in the dining hall, and visitors should check at the reception area. Visiting hours are on Saturday and Sunday

from 2:00 p.m. to 5:00 p.m. The receptionist must get approval from the treatment team for any visitor whose name is not on the resident's visitation list.

The facility's "Multidisciplinary Treatment Plan" policy revised on January 2007 states that the Primary Therapist is responsible for ensuring that treatment plans are signed by the resident and guardian if appropriate.

According to Timberline Knolls' "Discharge" policy revised on October 2008, the facility's treatment team will determine an appropriate discharge date. If the resident is discharged to another facility, the treatment team will determine the mode of transportation and who will accompany the individual to the receiving facility. All aftercare plans shall be in place at the time of discharge. The Discharge Planner responsibilities include: 1) ensuring that the plan is coordinated with the resident, parent or guardian and other appropriate agencies and interested parties with appropriate consents, and, 2) ensuring that all discharge and follow up information is communicated to the resident, parent or guardian.

The facility's rights statement mirrors the Code's Sections 5/2-102 (a) and 5/2-103 (c) below.

CONCLUSION

According to Section 5/2-102 of the Code,

> (a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The plan shall be formulated and periodically reviewed with the participation of the recipient, if feasible, and with the recipient's guardian or other substitute decision makers. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided.
>
> (a-5) If the services include the administration of psychotropic medication and electroconvulsive therapy, 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 the 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 …. 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 5/2-103 (c) of the Code states that,

> Unimpeded, private and uncensored communication by mail, telephone and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission.

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

The Illinois Probate Act, Section 5/11a-23 states,

> Every health care provider and other person (reliant) has the right to rely on any decision or direction made by the guardian … as though the decision or direction had been made or given by the ward.

Based on the resident's record, the staff interviewed, and written correspondence from the facility, the resident had tried to elope while in the community with a staff escort on October 15th, 2010, but the guardian was not informed about the incident until October 20th. She had been authorized unsupervised walks on-grounds by the facility's treatment team when she eloped from the facility on January 11th, 2011. The Primary Therapist reportedly remembered completing the form regarding unsupervised grounds privileges with the resident as required by the facility, but the document was not found in the record. The facility also acknowledged that an order for unsupervised privileges was not written. Documentation indicated that a thorough search for the resident was done, and that those appropriate were notified in accordance to program policy. The record lacked clear indication of the guardian's involvement in the staffs' decision to give the resident unsupervised privileges. Timberline Knolls developed a policy concerning this issue after the elopement incident on the 11th, but the policy lacked provisions to include the guardian in this decision.

Although the progress notes documented that the guardian was involved in family therapy sessions, there was no indication regarding her participation in treatment planning development and review. The treatment plan provides spaces for the resident's, guardian and members of the treatment team signatures, but the space documenting the guardian's involvement was blank. The record indicated that the resident accepted psychotropic medications during her stay at the facility, but her guardian's informed consent was not found during the record review.

Complaint #1 that the facility failed to provide a resident with adequate supervision when she eloped from the facility is unsubstantiated. Complaint #3 that the guardian was not included in the resident's treatment planning is substantiated. Timberline Knolls violates Section 5/2-102 of the Code and the Illinois Probate Act Section 5/11a-23 because the guardian has the right to make informed decision regarding the resident's care. This includes the right to participate in the development and review of the individual's treatment plan, and to request or refuse treatment.

The facility violates its "Multidisciplinary Treatment Plan" policy because the resident's care plan was not signed by her guardian as required by the policy. Additionally, the facility violates its elopement policy concerning notification in regard to the resident's attempted elopement on October 15th.

Complaint #2 that the resident was denied visitation because she eloped from the facility is unsubstantiated. The staff reported that the resident's right to visitation was inadvertently restricted for a short time after she had returned from elopement on January 14th because she was restricted to the lodge under Close Observation and visits are usually held in the dining room. Although the Authority understands that rights to communication with persons of choice were reportedly inadvertently restricted, this violates Section 5/2-103 (c) of the Code. The facility also violates Section 5/2-201 of the Code, and the facility's "Close Observation" and "Administrative Policy on Resident Rights" because the resident was not free to leave the lodge with a staff escort for programming, meals and visitation, but there was no rights restriction notice found in the record.

Complaint #4 that the facility failed to develop an appropriate discharge plan is unsubstantiated. Documentation clearly indicated that the resident and guardian both agreed to the discharge plan. A form signed by the guardian authorized the facility to release the resident's personal health information to the receiving residential psychiatric hospital. On February 11th, she was discharged to the receiving hospital and transported by a staff person in the facility's van. No violations of Section 5/2-102 (a) of the Code or the facility's policy were found.

RECOMMENDATIONS

1. Review program policies and consent laws regarding substitute decision making with all appropriate staff. Under the Probate Act of 1975, if a court adjudges a person to be disabled, as in this resident's case, a guardian of his person is appointed because it was found by clear and convincing evidence that the resident lacked sufficient understanding or capacity to make or communicate responsible decisions concerning personal care (755 ILCS 5/11a-3).

2. The facility shall revise its "Legal Court Ordered Guardianship and White Hat Privileges" policy to reflect that guardian consent will be required.

3. The HRA requests a copy of the revised policy.

4. Ensure that guardians are notified when residents attempt to elope as required by the facility's elopement policy. To facilitate informed decision making and treatment planning participation, guardians should be kept apprised of behavioral incidents, safety concerns or any other issues that impact treatment or services.

5. Follow Section 5/2-103 (c) of the Code, Timberline Knolls' policy and rights statement concerning the right to communication by mail, telephone and visitation.

6. Ensure that Section 5/2-201 of the Code, the facility's policy and rights statement regarding completion of rights restriction notices are followed.

7. Follow Section 5/2-102 (a) of the Code that guarantees recipients, parents, or guardians the right to participate in the development and review of the individual's treatment plan.

8. Ensure that the treatment plans are signed by guardians in accordance with the facility's "Multidisciplinary Treatment Plan" policy.

9. The facility shall obtain guardians' consent prior to administering scheduled and non-emergent psychotropic medications pursuant to Section 5/2-102 (a-5) of the Code and the Illinois Probate Act, Section 5/11a-23.

SUGGESTIONS

1. Develop policy and procedures that addresses guardians' involvement in treatment planning.

2. Include in resident's records documentation that residents, guardians or significant others are invited to treatment staffings.

3. Follow procedures and complete necessary forms for supervision levels and changes.

4. The HRA seriously questions the facility's reported practice of not filing missing persons reports when individuals are missing from the facility due to concerns of the report being public. The Confidentiality Act allows for exemptions to confidentiality protections. The HRA strongly suggests that the facility revisit this practice and confidentiality exemptions.

5. The HRA suggests that the facility revisit the White Hat Privileges policy that states that on-grounds privileges are automatically denied for residents under guardianship. Such decisions should be determined on an individual basis through the treatment planning process with the involvement of the guardian.