FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
TIMBERLINE KNOLLS RESIDENTIAL TREATMENT CENTER— 17-040-9017
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 as follows: 1) the facility failed to include the resident's and her parent's input in treatment planning, 2) the facility's assigned psychiatrist did not return the resident's parent's phone calls, 3) the resident's anxiety increased because the staff did not timely intervene to prevent two peers from fighting on the unit, and, 4) the resident's right to communication with persons of choice was restricted. If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.).

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

METHODOLOGY

To pursue the complaint, the Facility's Officer of Compliance, the Director of Nursing, the Assistant Director of Nursing and the Director of Nutrition were interviewed. The complaint was discussed with the guardian and sections of the resident's record were reviewed with written consent. Relevant facility policies were also reviewed.

Complaints #1 and 2

The complaint specifically stated that the resident's and her parent's input concerning her meal plan was not honored. It was reported that the resident was misdiagnosed with having an eating disorder and was placed on a restrictive meal plan. For example, it was reported that the resident had refused to eat biscuits with gravy on the second admission day and was told that she would have to drink two nutritional supplemental beverages or sit at the table for hours if she did not. It was reported that the resident had gained 15 pounds in two weeks because the facility's dietician refused to change her meal plan. Additionally, the complaint stated that the facility's

assigned psychiatrist saw the resident for about four minutes during a ten-day period. Her parent left phone messages for the psychiatrist but her calls were not returned. It was reported that the parent asked the facility's receptionist for the Illinois Guardianship and Advocacy Commission's contact information and was referred to its Patient Advocate.

FINDINGS

Information from the record, interviews and program policy

According to the record, the 16 year-old resident was admitted to the facility on March 2nd, 2017 and was diagnosed with Major Depression and Anxiety Disorder. She was accompanied by her parent who gave written consent for the administration of Effexor and Melatonin. She was provided with a copy of the Resident's Handbook, the facility's Notice of Privacy Practices, Rights Statement, and other documents. A Comprehensive Intake Assessment Report indicated that the resident had nightmares daily and problems staying asleep at night. She had attempted suicide about seven times during the past two years. Later that same day, her parent called the facility to ensure that the staff were aware of her self-injurious history. And, she was informed that the resident was on close observation status until further notice from the facility's assigned psychiatrist. Her record contained a physician's order for close monitoring. Her initial care plan indicated that she would be provided with a safe and non-threatening learning environment.

A Nursing Assessment Report documented that the resident weighed 137.6 pounds upon her admission to the facility. On that next day, a Nutritional Assessment Report indicated that she was seen by the facility's dietician and that her ideal body weight was 140 pounds. However, she believed that her ideal body weight was 125 pounds and reported that her least weight was 120 pounds in 2016 and that her most weight was 140 pounds on or around February of 2017. She told the facility's dietician that her daily meals consisted of the following: 1) fruit and coffee for breakfast, 2) sometimes graham crackers for an early snack, 3) a grilled cheese sandwich and fruit for lunch, 4) sometimes a granola bar for a midday snack, 5) lasagna or hamburger with a salad or vegetables for dinner, and, 6) sometimes a dessert item for a late night snack. She denied having any current or previous eating disorder behaviors but repeatedly asked for a weight reduction meal plan. She was placed on a weight maintenance program of 2000 calories daily and fluids were encouraged. Also, her meal plan included monitoring (checking in and checking out) her food and fluid intake and weighing her twice a week.

A History and Physical Examination Report, completed on March 4th, indicated that the resident told the physician that her depression had resulted in a little weight gain. For March 5th, a behavioral health note stated that the resident was not compliant with meals and completed her meal plan by consuming nutritional supplemental beverages. Her therapeutic treatment plan targeted problem areas such as depression, anxiety and communication with her family. It documented that her assigned psychiatrist would assess the need for medication on a weekly basis. It included a statement that the resident's and her family's signatures on the treatment plan would be an indication that they were given an opportunity to actively participate in the treatment planning process. The treatment plan was signed by the resident on the staffing date. However, there was no indication of her parent involvement in her treatment plan.

For March 6th, a psychiatric evaluation documented that the resident said that she was placed at the facility because of depression. An Adolescent Assessment Report, completed by the resident's parent, indicated that she wanted to participate in her treatment by attending family therapy sessions and visitation. It included a question concerning the differences between the resident's and her parent's expectations of what she wanted to gain from treatment. Her parent wrote that she did not want the resident to focus on food. Later, a Family Therapist's note indicated that the resident's parent had questions about her programming, the physician's availability, etc. She said that she was happy that the resident was adjusting to the facility but was concerned about her having to complete meals. According to the Family Therapist's note, the resident and her parent talked about her meals and snacks and concluded that she did not have any eating disorder issues. And, her parent was informed that the resident would be meeting with the facility's dietician to discuss meals options.

For March 8th, the Family Therapist wrote that the resident's parent continued to question her meal plan and said that she did not want her meals and snacks to be monitored. Another note documented that the facility's dietician had a meeting with the resident concerning her meal plan on that same day. She told the dietician that she did not have an eating disorder and that this issue had increased her anxiety level. She reported consuming inappropriate meals for an adolescent and was informed that her meal plan would help her to consume enough energy for her body needs. However, she appeared upset and said that "I do not need a meal plan, I need weight loss." The facility's dietician noted that the resident's parent was very angry and "denied restriction for daughter" when the purpose of the meal plan was explained. Her record indicated that her meal plan sheets used to closely monitor her meals and snacks were discontinued. A vitals and weights flow chart documented that the resident weighed 138.8 and 142.4 pounds on March 8th and the 15th, respectively. Additionally, the Family Therapist's note indicated that the resident's parent asked if the resident had been seen for an initial appointment by an outside psychiatrist. She was informed that she was being seen by the facility's psychiatrist and that she would need to reschedule her appointment with a community clinician upon her discharge from the facility. Her record contained a Clinical Formulation Report, completed on that same day by the psychiatrist, documenting serious impairment in judgement, mood, and other areas. A psychiatry note (date unclear) indicated that the resident told the clinician that Effexor medication was not helping to decrease her depression. She was abruptly discharged from the facility on March 17th.

At the site visit, Timberline's dietician said that a nutritional assessment was done and that nutrition helps the recovery process. She said that the resident denied having any eating disorder and that no behaviors to support this particular diagnosis were found. She explained that the resident weighed 137 pounds upon her admission to the facility. Her ideal body weight was 136 to 144 pounds. She was focused on her weight and requested to be placed on a weight loss meal plan. The facility's dietician said that she makes recommendations about meals but residents can make choices about food items. Residents are not punished if they do not follow their meal plan. She said that she had talked to the assigned psychiatrist about the resident's parent not being happy about her meal plan and that the recommendation to complete all meals was discontinued at that time. However, this was not found in her record. Additionally, the Director of Nursing told the HRA that treatment goals are reviewed at staffings weekly and that residents are invited to attend these meetings every other week.

The assigned psychiatrist could not be interviewed because he/she is no longer employed at the facility. However, Timberline's administration told the Authority that the psychiatrist had communication with the resident's mother and that the nursing staff would call her about medication. The investigation team was informed that the Patient Advocate did not have any interactions with the resident's parent as reported in the complaint. She said that the facility's Patient Advocate told her that she would have documented the parent's concerns and made an attempt to resolve them, if she had called her. According to the Facility's Officer of Compliance, a poster with the Illinois Guardianship and Advocacy Commission contact information is posted on each lodge. She reported that all employees received training on resident's rights annually.

Timberline Knolls' "Multidisciplinary Treatment" policy revised on July 2015 states that an initial treatment plan will be developed within 24-hours of admission. A comprehensive and multidisciplinary plan is completed within five days of admission. It states that assessments, including an initial treatment plan for disciplines 1 thru 3, shall be completed as follows: 1) Clinical Assessment by the Primary Therapist within 48-hours, 2) Family Assessment by the Family Therapist within 48-hours, 3) Nursing Assessment by a Registered Nurse as soon as possible but at least within 24 hours, 4) Psychiatric Evaluation by the psychiatrist within 24 hours, 5) Medical History and Physical Examination by a physician, and, 6) Nutritional Assessment by the Dietician within 24 hours of admission. According to the policy, a staffing to review each resident case shall be held weekly or more frequently if needed. It states that residents shall participate in their staffing bi-weekly.

CONCLUSION

According to Section 5/2-102 (a) of the Mental Health and Developmental Disabilities Code,

> 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 resident to the extent feasible and the resident's guardian, if appropriate.

The facility's rights policy state the same as Section 5/2-102 (a) of the Code.

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

The Authority cannot substantiate the complaint stating that the facility failed to include the resident's and her parent's input in treatment planning. The complaint specifically stated that the resident was placed on a restricted meal plan and that she had gained 15 pounds in two weeks because the facility's dietician refused to change her meal plan. Her record indicated that she weighed 137 pounds at intake on March 2nd, 2017 and weighed 142 pounds when she was discharged from the facility on March 17th, 2017. The facility's dietician told the HRA that the resident's ideal body weight was 136 to 144 pounds. She said that the resident denied having an

eating disorder but she asked many times for a weight loss program. She said that the resident was placed on an adolecent weight maintance program to fuel her body needs and that resdients do not have to follow their meal plan. According to the facility's dietician and documentation in the resident's record, her meal plan to complete all meals was discontinued on March 8th because her parent also was not happy about her meal plan. The investigation team noticed that the resident's parent did not sign her treatment plan indicating her invlovement in treatment decisions. Her treatment plan states that the resident's and her family's signatures on the treatment plan would be an indication that they were given an opportunity to actively participate in the treatment planning process. According to the staff interviewed, the parent was invloved in treatment decisions such as medication. The facility "Multidisciplinary Treatment" policy indicates that residents' goals are reviewed weekly by the clinical team and that residents are invited to these staffings bi-weekly.

Additionally, the complaint stated that the facility's assigned psychiatrist did not return the resident's parent's phone calls. The Authority does not discount the complaint, but we found no related evidence to substantiate the complaint. The HRA finds no clear violations of Sections 5/2-102 (a) and 5/2-201 of the Code in regard to complaints #1 and 2.

SUGGESTIONS

1. Document in the resident's record parental involvement in the treatment planning process.

2. The facility should revise its facility's "Multidisciplinary Treatment" policy and invite residents, parents, and their legal representatives to the resident's weekly staffings.

3. Ensure changes in a resident's care, such as a discontinuation of a meal plan, are documented in the resident's record.

Complaints #3 and 4

The complaint stated that the staff did not timely intervene to prevent two peers from fighting on the unit. It was reported that the staff moved one of the peers involved in the fight to another lodge but the incident caused the resident's anxiety level to increase. Additionally, the complaint stated that the resident was not allowed to talk to her parent one evening because phone communication is not allowed after 7:45 p.m. It was reported that the resident called her parent because she was upset that someone had put "silly putty" in the washing machine and had ruined her clothing. Her parent called the facility and a nurse said that she would call her back concerning the incident. However, the nurse did not call the parent back and her parent called again and was informed that the incident had occurred. It was reported that the parent asked to talk to her daughter and the nurse said "it is 7:45 p.m. and phone calls are not allowed after phone hours." It was reported that the parent told the nurse that she was coming to the facility to pick up her daughter. And, the nurse said that she could not pick her up because a physician's order was needed for this. The resident was reportedly discharged from the facility as requested by her parent on that same night.

FINDINGS
Information from the record, interviews and program policy

The Authority was not able to determine that the resident experienced increased anxiety because two peers had a fight on the unit. We found no information concerning this issue in her record. However, the staff interviewed said that the facility's behavioral management protocol directs that staff in the immediate area to intervene in altercations. The facility has a ten second rule in which the staff are expected to take the residents who are not involved in the incident to another area. The HRA was informed that the police might be called based on the seriousness of the incident and that residents involved in the incident are debriefed.

Regarding the communication complaint, a nursing note indicated that the resident's parent had called the facility on March 17, 2017 around 7:50 p.m. and said that she wanted to know what had happened to her daughter's clothing. The nurse told the parent that she would investigate her concern and would call her back as soon as possible. Her mother called again at 8:00 p.m. and was screaming that she wanted to talk to her daughter immediately. The nurse told the resident's parent that someone had put silly putty in the washing machine with her daughter's clothing. She told the parent that phone calls are not allowed after phone hours and provided her supervisor's name. Her parent continued to scream that she wanted to talk to her daughter and would not let the nurse talk as she repeated the facility's rules. Her record lacked a restriction notice or indication that the parent was not allowed to talk to the resident as requested. Another progress note stated that the resident was discharged against medical advice on that same night at 10:35 p.m. Her parent was reportedly provided with discharge instructions. Her belongings were placed in the car and she left without any incident.

An "Adolescent Residents Treatment Guidelines" form documented that designated telephone and visiting hours are necessary to maximize residents' treatment experience. The daily telephone schedule is as follows: 10:50-11:20 a.m., 3:35-4:25 p.m., and 5:35-5:55 p.m. It states that each resident will have either a phone password or open phone privileges. This will be determined by the resident's family and the facility's treatment team. The resident's program level will determine the length of her phone calls. Residents may only talk on the phone according to the time allotted based on her level once a day. At the site visit, the HRA was informed that there are eight phones on each lodge in the phone room. The staff reported that adjustments to the phone schedule are made when needed. The right to communication is included in the facility's rights statement. In regard to the complaint, the staff said that the resident's parent was screaming on the phone and that the nurse might have been concerned that her behavior would upset the resident.

Timberline Knolls' "Resident Rights" policy effective on April 2016 state that residents, parents or guardians will be provided with a copy of the resident's rights/responsibilities upon their admission to the facility. The resident's rights will be exercised by the parent, guardian, or legal authorized representative if the resident is a minor or has been adjudicated as being incompetent by the court. All employees are informed of residents' rights when their employment begins with the facility. All staff are informed of the need for clear justification and proper procedure for rights restrictions. Rights may only be restricted to protect the resident or others from harm, harassment or intimidation. A notice of the restriction must be provided.

CONCLUSION

According to Section 5/2-102 of the Code states that a recipient of services shall be provided with adequate and humane care and services in the least restrictive environment.

Section 5/2-103 of the Code states that,

> (b) Reasonable times and places for the use of telephones and visits may be established in writing by the Facility Director
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> (c) 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. When communications are restricted, the recipient shall be advised that he has the right to require the facility to notify the affected parties of the restriction and to notify them when the restrictions are no longer in effect.

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

Based on the lack of evidence, the Authority cannot substantiate the complaint stating that the resident's anxiety increased because the staff did not timely intervene to prevent two peers from fighting on the unit.

Based on the resident's record, the Authority substantiates the complaint stating that the resident's right to communication with persons of choice was restricted. The record indicated that the parent was trying to reach the resident because her daughter was upset about an incident that had occurred on the unit. The Code states in Section 2-103 that *reasonable* times for telephone use may be established. However, to deny phone access in what appeared to have been a crisis because it was about forty-five minutes after phone hours and the parent was screaming on the phone is not reasonable. The facility's violates Sections 5/2-103 (c) and 5/2-201 of the Code and the facility's rights policy in regard to communication and restriction notices.

RECOMMENDATIONS

1. Follow the Mental Health and Developmental Disabilities Code Section 5/2-103 (c) and the facility's rights policy in regard to communication. A restriction for phone communication should be the result of harm, harassment and intimidation from phone calls. Restricting a phone access for other reasons such as the parent was screaming on the phone and that her behavior could upset the resident is not consistent with the Code.

2. Complete restriction of rights notices whenever guaranteed rights within the Code are restricted under Section 5/2-201 of the Code and the facility's rights policy.

3. As previously stated, the Code states in Section 2-103 that *reasonable* times for telephone use may be established. The facility's "Adolescent Residents Treatment Guidelines" set phone times are anything but reasonable and they are limited to once per day and the length determined by program level, which means that they have to achieve a level to talk longer on the phone. Also, the facility's guidelines erroneously references phone calls as being privileges and not rights. However, to make and receive phone calls is one of the resident's guaranteed rights under the Mental Health and Developmental Disabilities Code Section 5/2-103 (c), not a privilege to be earned. The Code under Section 2-202 states that policies and procedures may amplify or expand but shall not restrict or limit the guaranteed rights within. Timberline shall revise its guidelines in regard to phone communication to comply with Sections 5/2-103 (c) and 2-202 of the Code.