FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
TIMBERLINE KNOLLS RESIDENTIAL TREATMENT CENTER— 16-040-9015
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 an allegation concerning Timberline Knolls Residential Treatment Center. The complaint stated that a resident was inappropriately discharged from the facility's program. If substantiated, this allegation 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. The facility reportedly started a partial hospital program for adult females about four years.

METHODOLOGY

To pursue the complaint, the Facility's Director of Compliance and a Continuing Care Clinician were interviewed. The complaint was discussed with the resident and sections of her record were reviewed with consent. Relevant facility policies were also reviewed.

COMPLAINT STATEMENT

The complaint stated that the resident was discharged from the facility because of two incidents involving a peer. In the first incident, the resident was reportedly counseled by a staff person for kissing her peer. In the second incident, she was observed being intimate with the same peer on the couch and was given 24 hours to pack her belongings and to leave the facility's campus.

FINDINGS

Information from the record, interviews and program policy

The resident's record indicated that she was admitted to the facility's residential treatment program on December 12th, 2015. She was diagnosed with Depression, Anxiety, Post-Traumatic Stress Disorder, Eating Disorder and, Drug and Alcohol Abuse. She was prescribed

medication for her psychiatric problems. Her treatment plan included goals: 1) to develop a better understanding of her eating disorder and its effects on her body, 2) to establish abstinence and to participate in a recovery based program, and, 3) to participate in therapy sessions, etc. Her mother was involved in family therapy sessions. She reportedly had problems with complying with her meal plans and had cravings for a named drug that she had previously abused. However, she made some progress toward her treatment goals and was transferred to the facility's partial hospital program on January 19th, 2016. Her record contained a "Continuing Care Agreement" indicated that this is a "gentle" a step-down program for adult females recovering from an eating disorder, substance abuse and/or mental health issues and can benefit from others in recovery to maintain abstinence.

The "Continuing Care Agreement" signed by the resident documented that the facility's partial hospital program provides for a therapeutic milieu that supports recovery through positive peer interactions and a drug and alcohol free environment. Residents develop individualized recovery plans related to their problems including supportive services such as 12-step meetings (Alcoholics Anonymous, Narcotics Anonymous, Overeaters Anonymous, etc.), individual therapy, group therapy, nutrition counseling, and medication management. Residents, who are recovering from addictions, are strongly encouraged to follow the principles of the 12-step recovery plan on a daily basis and to maintain contact with their sponsor. Also, they are encouraged to develop new living, interpersonal and coping skills necessary for a healthy and successful life. It includes rules, expectations and guidelines to provide residents with a sense of responsibility during their recovery. For example, it states that residents are prohibited from drinking alcohol beverages or using narcotics in any form or engaging in sexual contact with each other on the facility's campus. A resident who engages in a sexual relationship with another resident might be immediately terminated from the partial hospital program. By signing the document, the resident acknowledged that she understood that failure to comply with the rules and expectations of the program may result in her being dismissed from the program. Her anticipated discharge date from the partial hospital program was February 16, 2016, and her discharge plan was to follow up with outpatient services near her home town.

A note written by the resident's primary therapist indicated that a clinical assessment was completed upon the resident's admission to the facility's partial hospital program. According to the therapist's note, the resident said that she was struggling with depression, and she was having panic attacks and racing thoughts. Her treatment plan, dated January 25th, 2016, included goals: 1) to manage symptoms of mood dysregulation, and, 2) abstinence from mood altering substances and to participate in a recovery based program. The therapist's notes indicated that the resident was struggling with issues such as memory loss, taking her medication daily, and following her meal plans. Psychological testing was done because of possible brain damage due to abusing drugs. The therapist documented that the facility's administration made a decision to discharge the resident from its partial hospital program on February 8th, 2016, which is eight days before her anticipated discharge date. According to the therapist's note, the resident was informed that the discharge decision was due to her being sexually involved with a peer in violation of her "Continuing Care Agreement." Once informed, she was described as being depressed and anxious as evidenced by her tearful behavior. Her affect was flat and thought process was tangential. She said that she was embarrassed because the staff were aware of her sexual involvement with a peer. She was reminded that focusing on her recovery and abstaining

from intimate relationships during the first year of the recovery phase are emphasized at 12-step sobriety meetings. She reportedly acknowledged that placing more importance on her personal relationship was unhealthy. She said that she was going to live with her friend and would follow up with her therapist and psychiatrist in her home town. She denied having any suicidal ideations. A phone message was left for the resident's outside therapist regarding the individual being discharged from the facility's program. The HRA noticed that the resident's record lacked an incident report leading up to the discharge decision.

A physician's order indicated that the resident was in stable condition when she left the facility with all of her medication on the 8th. A "Discharge Summary" report documented that the resident had attended individual therapy sessions and had completed her assignments in a timely manner. However, she had problems with taking her medication daily upon her admission to the facility's partial hospital program. Also, she had struggled with following her meal plans and being intimately involved with a peer and focusing on her recovery. The discharge summary report repeated that the resident was "administratively discharged" from the facility for violating her partial hospital program agreement.

When the complaint was discussed with the resident, she said that she had a "close relationship" with a peer while attending the facility's program. She reported that she is about 16 years older than her peer and said that their relationship was consensual. She told the investigation team that she was observed kissing her peer one day and that a staff person had talked to them about the incident. She said that she and her peer were not intimate with each other again until they were moved to the same lodge. Then, a staff person saw them "fooling around" on the couch and told her that she was going to tell her therapist. According to the resident, she believed that she was going to be reprimanded for the second incident. However, her therapist told her that she was a threat to the other residents. She said that she was told that she had 24 hours to pack her belongings and to leave the facility.

When the complaint was discussed with Timberline's staff, the HRA was informed that residents who participate in the facility's partial hospital program have more freedom than individuals in its residential program. The average length of stay in the facility's partial hospital program is about twenty days. Some residents live on the facility's campus and some of them commute while attending the program. Residents are expected to abide by the "Continuing Care Agreement," which is same as a behavioral contract. According to the staff interviewed, the resident was making progress toward her meal plans and was building relationships with her peers. One day, a staff person saw the resident and her peer without any clothing being intimate with each other on the couch located in the common area on the lodge. The staff explained that residents are prohibited from engaging in intimate personal relationships while participating in the 12-step recovery based program. They said that some residents are very vulnerable and might have trouble saying "no" to becoming involved in such relationships. The therapist usually talks to the resident and the individual may be placed on a behavioral contract when there is a breech in the agreement. The HRA was told that the resident was discharged on February 8th, 2016, which was close to her anticipated discharge date of February 16th. The staff reported that the resident's peer, who was 18 years, was also discharged on that same day. However, her discharge from the facility had been planned. According to the staff, there was only one incident involving the resident being intimate with a peer. However, the complaint and the resident said

that there were two incidents. At the site visit, the HRA requested a copy of the incident report leading up to the resident being discharged from the facility's partial hospital program. The Director of Compliance subsequently informed the investigation team that an incident report was not done because her discharge was an administrative decision. Also, she said that the resident did not file an internal grievance with the facility about the discharge decision.

Timberline's "Treatment Contract For Continuing Treatment" policy states that a written treatment agreement will be developed with the resident's participation. It lists criteria for admission to the program or to continue treatment at the facility such as engaging in behaviors that might be harmful to self or others. It states that the facility's treatment team will work with the Director of Clinical Operations or designee to determine if discharge is warranted when a resident breeches her treatment contract. A physician's order is required when a resident is discharged for breeching her behavioral contract.

Timberline's rights policy states the facility adheres to all laws governing residents' rights. Its rights statement includes humane and adequate care in the least restrictive environment possible. Also, it includes the Illinois Guardianship and Advocacy Commission contact information.

According to the facility's "Incident Reporting-Risk Management Program" policy, it provides for a systematic, multi-disciplinary approach to managing and reporting incidents of injury, damages, and loss. An incident is defined as being an unanticipated event that is inconsistent with the standard of care and/or operation of the facility and may have occurred due to a violation of policy or procedures. It states that any staff member who witnesses, discovers, or has direct knowledge of an incident must complete an incident report before the end of their shift/work day. It includes procedures for completing and routing incident reports.

CONCLUSION

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

> A resident of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan.

The Authority does not substantiate the complaint stating that a resident was inappropriately discharged from the facility's program. According to the record, the resident was first admitted to the facility's residential program and was subsequently transferred to its partial hospital program to continue working on her treatment goals. She signed a "Continuing Care Agreement" that included rules such as residents are not allowed to engage in intimate relationships while participate in the facility's recovery based program. A therapy note indicated that the resident was administratively discharged from the facility's program for breeching her care agreement by engaging in sexual activity with a peer. A physician order, dated February 8th, 2016, supporting her discharge was found in her record. However, her record lacked an incident report leading up to her being discharge from the facility. According to the Director of Compliance, the staff person who observed the resident being intimate with her peer on the

couch did not complete an incident report. This violates the facility's incident reporting policy. The Authority finds no violations of Section 5/2-102 of the Code.

RECOMMENDATIONS

1. The facility shall follow its Incident Reporting policy stating that any staff person who witnesses, discovers, or has direct knowledge of an incident must complete an incident report.

2. The facility shall provide the HRA with documentation that its incident reporting policy was discussed with the appropriate staff members.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

TIMBERLINE KNOLLS

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June 23, 2017

Regional Human Rights Authority
P.O. Box 7009
Hines, Illinois 60141

Attention: Ms. Judith Rauls, Chairperson

Re: Response with Case # 16-040-9015

Dear Ms. Rauls:

Thank you for forwarding the Report of Findings concerning the above referenced case. In response to these Findings and the Authority's recommendations I am submitting the following:

1. Provision to the HRA, copy of PHP team signatures for review of Incident Reporting Policy and that reporting does include Administrative discharges.
2. Review of Incident Reporting Policy included in general new-hire orientation by the Director of Compliance.

If you have any further questions, please contact me anytime.

Respectfully submitted,

Barbara Damas, RN
Director of Compliance/Performance Improvement
Ph#:

Attachment