FOR IMMEDIATE RELEASE

Northwest Regional Human Rights Authority
Report of Findings
Report #20-080-9013
Stepping Stones of Rockford

Introduction

The Human Rights Authority (HRA) opened an investigation into potential rights violations at Stepping Stones of Rockford, Supervised Home. The complaints that were brought forward were that the facility did not consider a resident's religious preference, and that the resident was not allowed to refuse medication, was not provided with adequate and humane care, was unable to appropriately receive personal property and was not free-from abuse and neglect. Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Community Integrated Living Arrangement (CILA) Rules (59 Ill. Admin. Code 115.250/5).

Stepping Stones of Rockford has five group homes throughout the city of Rockford and they are designed to provide 24-hour mental health services to 6-8 adults per home. The home in question is specifically for residents who need more intensive services, which are court mandated and must be included in a resident's service plan. The facility participates in an initiative called the Community Conditional Release Program offered throughout the state. The intent of this program is to offer the participants training on skills that will develop and enhance activities of daily living, diminish the possibility of readmission and a positive return to be a productive member of society. The HRA conducted a teleconference call and discussed the case with representatives from the administration and mental health team. Relevant policies were reviewed as was the resident's record with authorization.

Complaint Summary

According to the complaint, the CILA resident was being consistently harassed by staff, was allegedly forced to cook food that was not aligned with religious beliefs and practices of the resident, was not allowed to refuse medication or alter the medication schedule and after discharge was refused the return of personal property.

Resident Records

Per the records received, the resident was admitted to the group home on May 2nd at 9:15am; during this time the resident met with the mental health personnel and completed the intake process. The intake process included completion of a treatment plan, the clients' rights statement, a resident agreement, the client handbook orientation, and a consent for treatment and services. In reviewing the resident agreement, when a resident arrives at the home, the first 30 days is considered an orientation phase in which the residents will

familiarizes themselves with the policy and procedures of the facility, as well the staff and other residents in the home. Also, the resident agreement points out that any and all belongings are the responsibility of the resident, kept in their room and the facility is not responsible for items that might be lost, stolen or damaged, which should be packed in plastic bins or cardboard boxes. On May 3rd, a psychiatric assessment was completed, and the psychiatrist claimed that the resident was being "cooperative with providing history but also reported being nervous regarding this new phase of life and living situation". The psychiatrist also confirmed and prescribed the resident's medication regime.

While at the home, a quarterly progress review was completed on August 7th, which provided insight on how the resident was adjusting to the group home setting. The feedback provided mixed reviews of the resident's adjustment: it was noted that the resident was not open and honest with staff during check-ins and the interaction with female staff members who were in positions of authority was very poor. The report provided some positive feedback in which the resident was mainly compliant with medication and the completion of tasks without being told. It was also stated that the resident did put forth efforts to participate in mandatory treatment requirements from the court order. Per the treatment plan developed by the resident and the mental health team, there were seventeen goals established that ranged from mental health services (quarterly psychiatric appointments, community group services), to legal and daily living skills (case management services), which included the mandatory treatment requirement. The mandatory treatment court requirements of the resident included in the treatment plan were attendance at community-based Alcoholics Anonymous (AA) meetings, Moral Reconation Therapy (MRT) and mental illness and substance abuse (MISA) groups. Per the resident's signed quarterly progress report, it was stated that the resident had been compliant with medication, attendance at AA meetings, and completion of daily tasks. There are areas in which he had difficulty in being successful including: engaging in positive and meaningful peer interactions, responding to authority figure, specifically female staff and acknowledging when he does not understand but acts as if he does.

On August 23rd, the resident was admitted to a local psychiatric hospital unit, after calling 911 and expressing suicidal ideations. While hospitalized the resident discussed in detail a plan to bring deadly harm to staff at the group home. It was determined that the resident was not appropriate for the services offered in the group home and was returned to a state operated hospital on September 24th. Per the discharge summary dated September 24th, there were several items listed as strengths which the resident displayed while residing in the home. A few of the strengths mentioned were that the resident had formed "limited supportive relationships with peers and staff", displayed a "strong sense of confidence" and "prayed regularly". The discharge summary pointed out some areas that needed improvement, such as "work on following rules", "impulsivity around money" and when dealing with staff engaging in "issues of power and domination".

Interviews

Executive Director/CEO

There was discussion on what happens when a resident leaves the facility or is discharged inadvertently before completion of the program and still has personal items in the home. In this particular case, the facility worked with family members to come and retrieve personal items; unfortunately, one package arrived after the agreed upon retrieval date. After the site visit, the HRA relayed contact information where the package could be forwarded to the former resident. Due to the nature of the complaints, it was asked if the group home has a resident council in which complaints that are brought by residents can be discussed. It was stated that there is not a resident council, but there is an individual recovery support specialist assigned to each home, in which issues and concerns from residents can be brought, discussed and, if need be, escalated up the protocol chain. Per the Executive Director, there are different tracks to follow in regard to a resident not agreeing with treatment and services that are offered. When a resident's plan includes court mandates or the resident is part of the Community Conditional Release Program (CCRP), there is no room for interpretation or changes; all action and inaction must be reported to the court. A resident enrolled without court mandates can request discharge, and refuse treatment, medication and services without pushback from the staff. Residents in the CCRP must meet and discuss with the assigned public defender any form of a request for discharge, which must be approved through the courts, before the change can occur.

Director of Services

When reviewing this resident's record, the Director of Services shared that a sibling of the resident came to the facility within the first week of discharge to pick up belongings that were left behind. Per the Director of Services, when issues, disagreements or complaints arise in the homes, one of the goals of the program is to equip the resident with the necessary tools to address their concerns, issues or complaints with other individuals (staff or peer) and to follow the appropriate protocol to develop a workable solution. A complaint of the resident was that the facility was not adhering or respecting his cultural and religious beliefs. During the discussion, the Director of Services provided the following steps to working with the residents to develop a happy medium regarding their respective cultural and religious beliefs. There is discussion during the intake session surrounding a resident's cultural and religious beliefs to develop a plan on what items/services can and cannot be provided. The home tries to keep the door of communication open to discuss instances of changing needs, case expectations and court adjustments. This particular resident's beliefs were discussed in the initial intake session, but there was not ongoing discussion or requests for changes, because that resident did not bring any issues or concerns back to the staff. Per Director, the resident made choices to not attend services regularly at any local mosque and ate pork items in and out of the home, although other food items were available.

Licensed Professional Counselor (LPC)/Qualified Mental Health Professional (QMHP)

The process of admission to the program was discussed in detail to provide an understanding on how residents are accepted into the group home by the agency's Licensed Professional Counselor (LPC). The resident was referred to the (CCRP) by the state operated hospital in which he was residing. Per the LPC, a pre-assessment is completed in-person, while the resident is still hospitalized, in which the requirements and expectations of the program are explained in detail. The resident is then asked if the requirements, programs expectations and court guidelines are something they can agree and adhere to in order to be successful. The LPC goes before the court to provide the pre-assessment results and the participant's level of agreement and understanding as well as the determination if this would be an appropriate placement. After it is agreed by all parties involved, the resident is admitted to the group home and participates in an admission intake meeting at the facility. The intake meeting involves the resident meeting with the mental health team, and the program intake packet is reviewed including the resident handbook, medication policy, client's rights and responsibilities, resident agreement, consent for treatment and privacy policy, which are signed by client and members of the mental health team. The resident signed all the required forms and agreed to understanding what all the documents meant; copies were provided to the resident immediately following the intake meeting.

A comment posed to the LPC was the complaint of the resident, that there was constant and consistent harassment from staff members and no action took place. The LPC pointed out that the resident , did not bring this complaint or issue forward, was not very open with the staff and did not indicate that there was a particular issue with staff, until the resident self-reported wanting to harm staff members while hospitalized. In reviewing the resident's complaint regarding the facility not adhering or accepting his known cultural and religious beliefs, the agency's LPC stated the specific home chosen for the resident had another resident who practiced the same belief system. The LPC stated through trial and error, the facility received an education on the Islamic faith and practices from conversations and interactions with an older resident and felt they had developed an understanding. Also, a member of the clinical team is a practicing Muslim and has been utilized as a resource for residents in the past. The LPC shared an occurrence in which the resident was practicing his faith during the Ramadan season. The resident was on a medication schedule that was still in effect during this time. The scheduling of medication conflicted with prayer time and the resident complained. The LPC stated that the home has adjusted residents' daily schedules in the past based on their request and discussions. The resident in question did not try to adjust or discuss scheduling, but just opted to take medication after sundown.

Policy Review

The **"Community Conditional Release Program -Medication Policy",** ensures that "any and all medications are taken appropriately as prescribed". This policy provides step-by-step instructions on how all medications (regular and psychotropic) are given to residents by the staff in this program and the responsible actions of the resident surrounding medication while in the program. This policy is found in the manual that governs the

CCRP and is discussed with any client who might be referred to the program and the expectations. By agreeing to take part in this program before leaving their initial placement, the resident is informed and well aware of the expectations of self and staff responsibilities surrounding medication monitoring.

The **"Personnel Policy" discusses** staff members' responsibility to clients and their care while in any program offered by Stepping Stones of Rockford. This policy details staff conduct and interactions with clients while in the care of the agency. The policy points out that staff members shall not discriminate against any resident regardless of their race, age, marital status, religion, political belief or personal characteristic. According to the staff during the site visit and documents received the resident identified as a member of a particular community at the referral assessment. The staff prided themselves on learning and developing an awareness of the various Islamic practices in the community. The agency has a Muslim psychiatrist and other residents in the group home who also were Muslim and engaged in the community as a source of reference and understanding of particular religious practices and beliefs. The agency stated participation in a resident's religious beliefs and customs would ultimately fall back on the resident to have the conversation with staff on what works and what doesn't work for them as resident.

The **"OIG Policy: Reporting and Responding to Allegations of Client Abuse, Neglect, Financial Exploitation or Death" provides** procedural details how to assist staff in making reports to the Office of Inspector General Office(OIGO), regarding allegations towards clients on any level varying from abuse, neglect or financial exploration. The CEO confirmed that any and all reports are made within four hours of being reported by staff members. This policy is provided to staff members on their first day of employment. During the investigation, the resident stated that, after being discharged from the facility, he did not receive all his personal items and they were not provided to a relative. Through a follow-up call to the OIGO office, an attempt was made to pick up any and all items left, but a specified date and time was not agreed upon. The issue of the residents' personal items was brought up during the site visit and it was stated that all the items were given to a relative on the agreed upon dated, unfortunately an item was received after the handoff occurred. After the site visit, the resident was contacted and a mailing address was confirmed; the remaining item was mailed, and the resident confirmed receipt of the package.

Conclusion

Complaint: The resident's religious preferences and beliefs were not considered.

Per the Mental Health and Developmental Disabilities Code, a person with a known developmental disability or mental illness will not be denied services based on age, sex, race or religious belief (405ILCS 5/2-100). The complaint stated the facility did not respect a resident's religious beliefs, by having him cook items that contained pork and not allowing him to fully participate in fasting and Ramadan. In reviewing the records, the discharge summary stated, "he had limited opportunity to cook, but more experience with household management" and "he was largely medication complaint, with some issues related to fasting and Ramadan". A follow-up letter to the discharge summary, pointed out that the

complainant during a special outing "independently purchased pork hot dogs" more than once and ate pork items while in the home. Based on the interview and records provided, the resident was afforded accommodations to participate in fasting, but unfortunately did not have the conversation with facility staff to align religious beliefs with the accommodations that could be provided. A rights violation is **not substantiated**. In reviewing the records and the interviews with program staff there is familiarity with the Muslim faith in the home due to having contact with a long-term resident and staff member who are both practicing Muslims. Also, based on notes and interviews, the resident did not attend the mosque and chose his own food choices, although other food items were available in the home and during outings.

Complaint: The resident's right to receive adequate and humane care in the least restrictive environment was denied.

Per the Mental Health and Developmental Disabilities Code, a recipient receiving services is to be provided the most appropriate services in the least restrictive environment (405ILCS 5/2-102). The resident was in a group home setting, which catered to individuals with his background and was deemed least restrictive setting in the CCRP program. The home provided outings in the community, assistance with and training on daily living skills, quarterly psychiatric appointments, weekly case management meetings, medication monitoring, and access to weekly AA meetings. A rights violation is **not substantiated**. In reviewing the records and program requirements for participants in CCRP, this program offered stability, reentry into civilian life and tried to provide the resident with some semblance of normalcy.

Complaint: The resident's right to be free from abuse and neglect was violated.

Per the Mental Health and Developmental Disabilities Code, a receipt receiving services should be free from any type of abuse and neglect (405ILCS 5/2-112 and CILA 59 Ill. Admin. Code 115.250/5). The resident reported being harassed consistently by staff with negative words and statements. Although the home does not have a resident council, there are opportunities for the residents to voice complaints and grievances through therapy sessions, a program supervisor and the assigned individual recovery support specialist. Per the records received and during the interview there was no mention of any staff complaints or grievances being made. Also, the resident did report, while hospitalized, wanting to bring physical harm to the program supervisor and the rehab supervisor, which ultimately led to discharge. There was no documentation to show issues between resident and staff (harassment or disagreements). Per the discharge summary it was reported that the resident "demonstrated anger and irritability when not achieving personal goals or when refusing to meet expectations." There were no complaints or grievances regarding either staff person made to the assigned individual recovery support specialist in the home. A rights violation is **not substantiated**.

Complaint: The resident's right to refuse services and medications was not honored.

Per the Mental Health and Developmental Disabilities Code, a recipient shall have the opportunity to refuse services, which includes medication (405 ILCS 5/2-107). Based on

the interview, the resident was part of specialized program called the Community Conditional Release Program (CCRP) which included additional requirements and tasks that are mandatory through the court and must be followed for the resident to remain active in the program. Some of the resident's mandatory additional requirements included; attending weekly community-based AA meetings, MRT and MISA groups. If a resident chose to refuse any treatment services, this would be a violation of the agreed upon Order of Conditional Release and could possibly lead to the resident being discharged back to the State Operated Hospital. The resident records that were provided included the clients' rights and agreement, which listed all the rights that a client has while participating and residing in the home and falls in accordance with the following: Mental Health and Developmental Disabilities Code (405 ILCS 5/2), Confidentiality Act, Rehabilitation Act, Human Rights Act, Americans with Disabilities Act (ADA) and the Health Insurance Portability and Accountability Act of 1996. A rights violation is **not substantiated,** although under the Mental Health and Developmental Disabilities Code, a mental health patient has the right to refuse services, treatment and medication; this resident entered into the CCRP program which included stricter requirements. By entering this program there was a signed agreement between the resident and staff to comply with the treatment and program goals as a condition for release. The staff ultimately encouraged him to comply and did not force him when he chose not to comply.

Complaint: The resident's right to receive, possess and use of personal property was not honored.

Per the Mental Health and Developmental Disabilities Code, a recipient shall be allowed to receive, own and use their personal items and should be provided with reasonable amount of storage space (405 ILCS 5/2-104). According to the resident agreement, each resident is responsible for their own property (storing and keeping track of their items). The property is kept in their rooms in the allotted space for each resident and the house has no responsibility for items that are lost, stolen or damaged. A rights violation is **not substantiated**; after the resident was discharged, the facility worked with the resident to ensure belongings were picked up and returned through a family member. After the family member picked up the items that remained at the house, an additional item was received in the mail for the resident. This was discussed in the interview and the facility agreed to forward the item to the resident's current placement, which was completed.

Suggestion

1) Update the client right rights form to address the court order for residents enrolled in in the Community Conditional Release Program and the impact of treatment refusals.

RESPONSE

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

December 21, 2020

Stepping Stones of Rockford Inc.

706 N. Main St.

Rockford, IL. 61103

Colleen Parks Human Rights Authority

Illinois Guardianship & Advocacy Commission

4302 N. Main St. Suite 108

Rockford IL. 61103

Ms Parks:

Stepping Stones plans to implement the recommendation from the Guardianship and Advocacy Commission to update our Client Rights Statement to include specifics surrounding obligations that individuals who have court involvement may experience while involved in our program. We feel that this is an easy way to communicate up front the special commitments that court involved individuals may have. We would also like to elect to have the findings of the investigation published.

Please let me know if you have any further questions or comments.

Thankyou,

Chris Overton LCSW, LPHA

Christina Overton LCSW, LPHA

Director of Services

Stepping Stones of Rockford Inc.