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HUMAN RIGHTS AUTHORITY-SPRINGFIELD REGION

REPORT 25-050-9004
ILLINOIS MENTOR COMMUNITY SERVICES, SEVITA

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission reviewed services provided to an adult resident in the Community Integrated Living Arrangement (CILA) program at Illinois Mentor, in Springfield. The complaints received were that staff are sleeping while on duty, and the program fails to provide adequate and humane care and services pursuant to an individual services plan, by not following the plan's intention to collect behavior, sleep, dietary and exercise data appropriately for monitoring and reporting. Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

The local Illinois Mentor program provides group home, host home and intermittent support services to adults with intellectual and developmental disabilities in Springfield and surrounding counties. The HRA met with the Area Director and the staff trainer to discuss the matter. Related policies were reviewed as were sections of the resident's record with authorization.

COMPLAINT SUMMARY

It was reported that overnight staff sleep on duty although the residents require 24-hour supervision. It was further alleged that the program fails to follow a resident's personal and behavior plans that call for data collection on behaviors, sleep, meals and exercise, which does not allow for adequately tracking of responses to medications when reporting to physicians.

FINDINGS

According to the persons we interviewed, this resident lives with two other roommates, each of whom requires 24-hour supervision although one is allowed some alone time. There are six staff on the current roster, and the staff to resident ratio must be 1:3 at all shift times: 7-3; 3-11 and 11-7. Sleeping while on duty is prohibited. An internal investigation was done at the

time this complaint was received and an employee was found to be sleeping while on the job and was immediately terminated. New staff training now emphasizes no sleeping at any time, which is applied within the first three days of employment and then throughout direct support personnel training.

The Director reported that the resident was struggling at this time and had to be hospitalized. A psychiatrist discontinued all his psychotropic medications which sent him into a downfall. He is on an effective regimen again and is doing much better.

The Director described a major staffing turnover at about this same time, where there was no consistency in staff presence nor in compliance and programming follow through including with required documentation. The situation has changed at present as new staff have been hired and trained on routine documentation of shift notes, time logs, worksheets and plan-directed data collections. Their behavioral analyst also trains on behavioral programs and how to adequately document whether this resident displays targeted behaviors or not. Cross-over staff, meaning from other locations, may not work in the home unless they have been trained on the needs and devised plans for those residents. They try to respect individual choice, and this resident has his preferences. They now have a two-week menu rotation, and the individuals may pick out extras like favorite snacks. They encourage healthy choices but cannot make the resident take them. Regarding exercise, the resident's plan calls for weekly walks at the YMCA, and his guardian would like him to walk there at least six times per week which is unreasonable. He is encouraged to do that but prefers to walk at the mall or in his neighborhood which he does regularly. The Director and the trainer agreed that documentation has improved significantly since boosting training and revising tracking forms to make them simpler to complete. They are capturing data on behaviors, sleep, diet and exercise, information that is faxed to the appropriate physicians. We were provided with more recent and supportive records to review.

The HRA's initial review covered a personal plan, implementation strategies, a behavioral support plan and data from September through December 2024. Listed diagnoses included Mild Intellectual Disability, Autism Spectrum Disorder, Pervasive Developmental Disorder, Hypercholesterolemia, Morbid Obesity, Aggressive behavior, Bipolar Affective Disorder, Intermittent Explosive Disorder, Mood Disorder, Paranoid Ideation and Schizophrenia. The resident must never be unsupervised. The plans collectively direct staff to monitor the resident's eating, to cut his food into small pieces and remind him to eat slowly, to record weight monthly, encourage daily, but at least weekly trips to the YMCA, and to record daily behaviors on tracking sheets, targeting verbal aggressions, physical outbursts and self-injury primarily. Providing prompts to complete general hygiene was noted as well. Specific coping strategies and staff interventions were outlined.

-Nursing flow records showed that the resident's weight was only documented in December. Physical activity was noted on the same flow records for two partial days in September, ten in October, nineteen in November, and eighteen days in December.

-Sleep patterns were logged for only eight partial days in November and eight partial days in December.

-Zero daily behavior tracking sheets were completed in September; one sheet was completed in October when the resident displayed three instances of verbal aggression and one

physical outburst; seven in November, none of which observed behaviors, and tracking sheets were completed for six days in December which noted several instances of targeted behaviors. The sheets also reflected the resident's declines for offered exercises, opting instead for an occasional walk in the neighborhood. Monthly Q (Qualified Intellectual Disability Professional) summaries for September through December however, referenced more frequent walks in a park and at the mall.

Reviews of more recent record samples demonstrated much improved data collection. For example:

-Shift notes were entered daily from April 1 through May 15, 2025. Narratives on each described the resident's activities in and out of the home, the meals he consumed, and sleep patterns for that day. Most referenced his hygiene habits as well. Several of the notes mentioned bed checks being done on the overnight shift.

-Tracking sheets were completed consistently for each shift as opposed to partial days throughout April 2025. There was only one day in the evening shift where targeted behaviors were observed. Several noted exercise or outside activities like walking or going out to dinner, but the shift notes seemed to reference more activity.

-Incident reports for March 2025 showed two instances where the resident was verbally aggressive and had a physical outburst, both targeted behaviors. The reports included descriptions of how the situations were handled.

-Sleep tracking was more complete in April 2025. Several shifts, primarily 7-3 and 3-11 were left undone although sleep times were addressed in shift notes.

CONCLUSION

Illinois Mentor's Individual Service Planning policy states, in summary, that comprehensive, individualized person-centered planning and implementing is an inclusive approach that focuses on the individual's current strengths and needs. The plans also identify the roles and responsibilities of the service provider. Planning is completed from the individual's perspective that emphasizes choice. Positive Behavior Supports policy allows for identified supports to be integrated into an individual plan with strategies to minimize challenging behaviors. Data collection is not specifically addressed, but implementing and following personal and behavioral support plans are generally implied.

Under 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." (405 ILCS 5/2-102a). Adequate and humane care and services is defined as those reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others. (405 ILCS 5/1-101.2).

Sleeping on the job with residents who may not be left unsupervised and not collecting various data as directed by personal, implementation and behavior supports as was the case in late 2024, fail to meet the Code's standard of providing adequate and humane care and services pursuant to this resident's plans. A violation is substantiated. The problems were already

identified and remedied by bringing in new staff and a trainer and reinforcing the need to carry out their duties accordingly. No recommendations are required.

SUGGESTION

-Remind staff on all shifts to complete sleep sections on tracking sheets.
-Illinois Mentor is encouraged to be sure the resident's weight is documented monthly.
-Consider the need to add data collection to Individual Service Planning policy.

RESPONSE

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