FOR IMMEDIATE RELEASE

REPORT OF FINDINGS 09-040-9009
CORNERSTONE SERVICES, INC.
HUMAN RIGHTS AUTHORITY-South Suburban Region

[Case Summary— The Authority did not substantiate the complaint as presented but found that documentation in the resident's record did not clearly support the reason given concerning termination from housing. The public record on this case is recorded below; the provider's response immediately follows the report.]

INTRODUCTION

The Human Rights Authority (HRA) has completed its investigation into allegations concerning Cornerstone Services, Incorporated located in Joliet. The complaint alleged that: 1) a resident was terminated from the agency's housing and program without adequate cause, 2) the resident's right to confidentiality was breeched by the agency's staff, and, 3) the agency did not provide referrals for aftercare services. Substantiated allegations would be violations of the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/2-102 [a]), the Illinois Administrative Code for Medicaid Community Mental Health Services Programs (59 Ill. Admin. Code Part 132 et seq.), the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/5 [a]), the U.S. Department of Housing and Urban Development (HUD) Community Facilities Supportive Housing Program (24 C.F.R. 583.300) and the Department of Health and Human Services Standards for Privacy of Individually Identifiable Health Information (the Privacy Rules) (45 C.F.R. 164).

Cornerstone offers a wide range of services to individuals with disabilities. This agency's Behavioral Health Program also provides supportive community housing to approximately 140 residents that include a specialized homeless program for veterans who served in the military.

METHODOLOGY

To pursue the investigation, the allegations were discussed with Cornerstone's Vice President, the Director of Behavioral Health, the agency's Coordinator of Community Housing and a Case Manager. The court-appointed guardian of the adult resident's estate and supplemental needs trust was interviewed by telephone. Relevant policies were reviewed as well as the resident's record with written consent.

COMPLAINT STATEMENT

According to the complaint, the resident was initially informed that he was discharged from the agency's housing program because he had successfully completed services. Subsequently, the Director of Behavioral Health allegedly said that he was no longer eligible for housing services because of a large monetary settlement awarded after his intake. It was reported that the money was placed in a supplemental needs trust (special needs trust) arranged by Cornerstone and cannot be used for the resident's basic needs such as housing. It was reported that a certain staff person knew that the resident's monthly veteran pension check would be reduced due to an overpayment. And, the resident would not be able to maintain his apartment without the agency's rental assistance. It was reported that financial information such as the resident's trust fund and Social Security disability income was disclosed to the Veterans Administration without his written consent. Additionally, the complaint alleged that the resident was discharged from the agency's counseling program without continuity of care.

FINDINGS

According to the record, the resident was diagnosed with Bipolar Disorder, Post Traumatic Stress Disorder, and a Degenerative Disk Disease. He was admitted to Cornerstone's Community Housing Veterans Program in November 2005. A contract indicated that both parties agreed to the following: The agency shall furnish room and board, guidance, support and program services…. The resident's portion of his rent was determined by the HUD…. Each resident will receive training to live as independently as possible…. Each resident will take part in cooking, cleaning, shopping, planning sessions on home management and nutrition…. Each resident will attend all assigned classes and try to learn the skills which are being taught…. Each resident will develop and comply with goals and objectives in his Individual Program Plan…. Action taken in direct conflict with state and city laws and HUD's regulations may result in legal action and program termination…." In most situations, a 30-day notice was required of either party to terminate the contract. A general letter stated that all housing participants were expected to pay 30% of their monthly gross income for rent and that Cornerstone would pay the remaining 70%.

A summary of the resident's treatment plans dated January 13th, July 3rd and September 18th, 2007 and January 25th, 2008 included objectives to improve, increase or maintain: 1) and 2) symptoms management and social skills, 3) independent living skills and psychiatric stability, 4) access and utilization of community resources, 5) knowledge of medication, and, 6) achievement of goals for a successful discharge from the program. The resident's plans documented improvement in money management and using community resources such as food pantries. His housekeeping skills had significantly improved, but he needed help with anger management. The resident signed the plans indicating that he was offered a copy of them. Contrary to the treatment plans, progress notes dated June 24th, July 3rd, 10th, 11th and 15th 2008 indicated that the resident's impulsive spending and poor housekeeping and eating habits continued to affect his daily living skills.

A pre-discharge staffing was held on July 15th, 2008. The record lacked documentation that notice of the pending discharge was given. According to the report, the resident had made a lot of progress in the housing program. His financial situation had also significantly improved; he was receiving a pension check monthly from the Veterans Administration (VA) and has a

trust fund. It was explained that residents are expected to graduate from the housing program whenever possible. The resident replied that the program was stressful, and that his Case Manager and therapist had not been helpful. He said that he still needed help with getting services from the VA. The Coordinator of Community Housing told the resident that the housing staff had advocated on his behalf but could not make the agency that provides care to veterans change their rules. It was explained that the resident would not be discharged from the agency but transferred to the outpatient program. He could continue seeing the same agency therapist and psychiatrist at the veterans' medical center. He could keep his apartment if he chose because the agency was not responsible for the lease. And, the staff would provide assistance to ensure a smooth transition over the next six weeks. The resident repeated that he still needed help from the housing staff, but he was not able to identify what services specifically.

The staffing report further documented that "to date the housing staff have been concerned because [the resident] does not work on his treatment plan goals." However, this contradicts the report that the resident had made a lot of progress in the housing program. At the meeting, the resident repeated that the program had not been helpful. He reportedly became angry when asked why he wanted to stay in the program, and he was encouraged to work with his Case Manager regarding the housing goals that he wanted to pursue. The resident was also informed that the requested treatment information should be provided by the following week. By documentation, there was no indication that he informed the staff of his needs as requested.

The agency's staff met on July 25th, 2008 to review the resident's progress again, but he did not attend the meeting. There was no clear evidence that the resident was invited to the review. A summary report of the resident's treatment plan reflected improvement in paying bills timely and planning and shopping for healthy meals. He was reportedly proficient in cooking, cleaning, and home management. He was more knowledgeable about his medications and their side effects. The resident still required help with anger management, accessing community resources and leisure and social activities. His plan indicated that the resident would successfully transition from the housing program by December 15th, 2008. The same day, the Director of Behavioral Health wrote that the resident had agreed on July 15th, 2008 that he no longer required help with meal planning, grocery shopping and paying bills. The resident could continue receiving psychiatric services from the VA, and he had purchased a new car.

According to progress notes, the resident cancelled a scheduled meeting on August 19th, 2008 with the Director of Behavioral Health and his Case Manager because he had an appointment with the VA. On August 22nd, 2008, the resident gave written consent for the Coordinator of Community Housing to talk to the guardian over his estate. According to the note, the guardian expressed concerns because the resident had reported that all services would be discontinued by the agency. The staff person explained that housing services would be discontinued; the resident was non-compliant with service recommendations; and the resident said that the program was more harmful than helpful. The complaint contends that the resident did not want to attend group therapy because he started having flash backs due to a peer's sexual gestures during sessions. There were many entries suggesting that the resident's concerns regarding his peer group were addressed. The guardian mentioned that the resident had been overpaid by the VA; the decision was under appeal, possibly having to use his trust fund to repay

the debt. The Coordinator of Community Housing replied that the resident had been warned about collecting disability income from the VA and Social Security Administration. She asserted that the housing program was not only for rental subsidy but mental health services as well. According to the complaint, the resident was getting $700.00 from Social Security and $931.00 monthly from the VA. His monthly allotment from the VA was allegedly reduced to $231.00 to compensate for the overpayment.

The August 22nd, 2008 note further reflected that the guardian voiced concerns because medication had not been provided for two weeks according to the resident. The Coordinator of Community Housing reported that the resident had failed to keep his appointment for medication, and that two staff members had called him about this issue. According to the complaint, the agency's nurse would not give the medication to the resident on the scheduled day because a program staff person was not available. The August 19th, 2008 note previously mentioned also indicated that the resident was told to call his Case Manager after his appointment with the VA so that someone would be available to dispense his medication. The resident reportedly started yelling that he should not have to make an appointment, and that he was being discharged from the program because of his money.

The complainant provided the HRA with a case management note from his VA record showing that Cornerstone shared information with staff members at the VA's homeless program on August 22nd, 2008. The note written by a VA social worker referenced that the resident would be successfully discharged from the agency's housing program on September 1st, 2008. His monthly income consisted of $931.00 disability veteran pension and a large legal settlement. A trust fund and legal payee had been arranged by the agency. The record contained two notices of the agency's privacy practices signed by the resident acknowledging receipt of them on January 25th and June 18th, 2008. The January 25th acknowledgement form documented that the resident wanted to be notified when personal information was shared with the VA. The resident revoked his written consent for sharing information with the outside provider on July 17th, 2008.

According to a memo, the resident was transferred to the agency's outpatient therapy program on September 1st, 2008. The memo repeated that housing services were discontinued because of the resident's significant progress in the program. It stated that the recipient had transportation to access services from a local veterans' medical center. On November 24th, 2008, the Coordinator of Outpatient Services called the resident about a message that he had left for the agency's President regarding filing a grievance. He was reportedly informed about the grievance process. Another copy of the agency's complaint procedures and assistance with filing the grievance were offered. On January 13th, 2009, Cornerstone's social worker (the agency's Complaint Officer) recorded that the resident called because he wanted to file a grievance with the agency. She called the resident's therapist who confirmed that he had received a copy of the grievance policy and assistance with completing the process was offered. His therapist also reported that the resident had not filed a written grievance nor requested assistance from her. The next day, the Complaint Officer informed the resident that he needed to file a written grievance with the agency. Upon questioning, the resident was not sure whether he had a grievance form. A copy of the form was emailed to him on that same day.

The Coordinator of Outpatient Services sent a letter dated January 26th, 2009 to the resident because of a failed appointment on November 6th, 2008. The resident was asked to contact the staff person if he wanted to continue with services. Contrary to the complaint, the letter included three community referrals if the resident wanted to seek services from another provider. On February 4th, 2009, the resident met with the Coordinator of Outpatient Services, and he voiced concerns about being transferred from the housing program. The resident disagreed that he had successfully completed the program. He was asked whether he wanted to continue with outpatient therapy because he had not attended sessions for several months. The resident reportedly said that he was pursuing counseling with another provider, and he agreed to case closure. He was informed that the discharge process would be started immediately.

According to a Discharge Summary Report dated February 10th, 2009, the resident did not want to continue receiving services from the agency. He was encouraged to seek psychiatric services at the veterans' medical center or continue with his community provider. Again, the report documented that the resident was given contact information concerning three community providers if needed. He was discharged from the agency's outpatient program on February 12th, 2009.

In response to the complaint, the Director of Behavioral Health said that the criteria for Cornerstone's Community Housing Program were: 1) a resident must be diagnosed with a mental illness, and, 2) be homeless. She explained that the resident involved in the complaint met both requirements. He was referred to the agency by a homeless shelter, and he had no income at intake. Upon questioning, the HRA was informed that a resident's progress determines his length of stay in the agency's housing program. Some residents might stay in the program for a few months and some of them for years. Those individuals in the agency's transitional housing program usually stay for about two years. According to the staff, the resident's rent calculation was based on his income from Social Security, and he refused to report Social Security disability income to the VA. According to the complaint, the resident's rent was determined from his veteran pension income.

The Director of Behavioral Health denied that the resident was transferred from the housing program because of his trust fund. The program reportedly has a couple of residents who have trust funds, and they continue to make their needs known. She explained that the pre-discharge staffing on July 15th, 2008 was initially scheduled to ascertain the resident's input concerning the housing services that he still needed. The resident reportedly was unable to provide this information during the meeting. He was given 30 days to identify his needs but never did. She said that many residents have graduated from the agency's housing program. The resident chose to remain in his apartment, and his roommate helps pay the rent. The investigation team was informed that the resident did not file a grievance with the agency although he was asked many times if he wanted to do so.

According to the guardian, the resident's trust fund was set up shortly after his admission to Cornerstone, and the money can only be used to supplement his care over and above that which the government provides. The guardian said that he did not understand why the resident was discharged from the agency's housing program, but he then agreed that the resident had made some progress toward independence such as having personal transportation. Contrary to

the complaint, the guardian reports that he is looking for a condominium for the resident that will be purchased out of his trust fund.

Additionally, the Director of Behavioral Health said that the agency's veterans housing program is in partnership with the VA's homeless program through a federal grant. She explained that cases are reviewed monthly with the VA's staff and sometimes more often depending on the case. She said that the August 22nd, 2008 note regarding the meeting with representatives from the VA was very vague. There was some discussion about the documentation suggesting that the resident no longer wanted to continue with outpatient services and that community referrals were provided.

According to Cornerstone's client rights statement #9, services shall be provided pursuant to an individual services plan.

Cornerstone's Notice of Privacy Practices states that the agency is required by law to keep consumers' health information private. The notice describes how consumers' personal information may be disclosed and how they can get access to this information. According to the notice, the provider may use and disclose medical information for treatment, payment, health care operations and other situations. Consumers have a right to restrict or limit the information used or disclosed. The request must be in writing, but the agency does not have to agree with the request. If agreed, the agency must keep the agreement, except in a medical emergency. The agency's Complaint Officer's contact information is listed on the notice. According to the notice, each consumer shall sign an "Acknowledgement of Receipt" that will be kept in the consumer's record.

According to the agency's confidentiality rights statement #1, all records and communication shall not be disclosed except as provided by the Mental Health and Developmental Disabilities Confidentiality Act.

Cornerstone's policy states that discharge can occur when the interdisciplinary process has determined that: 1) the individual's medical needs cannot be met in their current program, 2) the individual's behavior represents a serious danger to self or others, 3) the individual does not follow program requirements, 4) the individual's needs can best be met outside of the agency, 5) the individual or legal guardian requests discharge, or, 6) the individual is relocating.

CONCLUSION

Section 5/2-102 (a) of the Mental Health Code states that a recipient shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan.

According to assessment and termination criteria under HUD's Supportive Housing Program Section 583.300,

> (d) Each recipient of assistance under this part must conduct an ongoing assessment of the supportive services

> required by the residents of the project and the availability of such services, and make adjustments as appropriate.
>
> (i) The recipient may terminate assistance to a participant who violates program requirements or conditions of occupancy. Recipients must exercise judgment and examine all extenuating circumstances in determining when violations are serious enough to warrant termination. In terminating assistance to a participant, the recipient must provide a formal process, at a minimum, that consist of: 1) Written notice to the participant containing a clear statement of the reasons for termination; 2) A review of the decision, in which the participant is given the opportunity to present written or oral objections before a person other than the person (or a subordinate of that person) who made or approved the termination decision and, (3) Prompt written notice of the final decision to the participant.

Pursuant to the Illinois Administrative Code Section 132.142 (d) (5),

> The client or guardian has the right to present grievances up to and including the provider's executive director or comparable position. The provider shall maintain a record of such grievances and the response. The executive director's decision concerning the grievance shall constitute a final administrative decision (except when such decisions are reviewable by the provider's governing board, in which case the governing board's decision is final).

According to the Illinois Administrative Code Section 132.145 (f) (2), the client's record shall include referrals to other services and the provider's efforts regarding linkage to such services.

The Mental Health and Developmental Disabilities Confidentiality Act Section 110/5 (a) states that records and communications may be disclosed only with the written consent of those persons who are entitled to inspect and copy a recipient record.

According to the Code of Federal Regulations Section 164.520 (a)(1), the agency is required to give adequate notice concerning how residents' protected medical information may be used and disclosed for treatment, payment, health care operations and other situations.

According to the agency's housing contract, residents shall receive training to live as independently as possible. In July 2008, Cornerstone administrative staff determined that the resident could perform daily living tasks sufficiently to graduate from the housing program. The resident reportedly disagreed with the proposed treatment plan, and he was given an opportunity to identify housing services needed. The record lacked evidence that the resident complied with

the staff's request and contained contradictory information concerning his transfer to the agency's outpatient program. According to a Pre-Discharge Staffing Report, the resident had made a lot of progress in the program, but he was non-compliant with treatment goals. The Coordinator of Community Housing wrote that the resident did not comply with service recommendations. Documentation also suggested that the resident graduated from the program. The Director of Behavioral Health denied that the resident was transferred from housing because of his trust fund as the complaint contends.

By documentation, the staff recommended that the resident should continue receiving mental health services from the agency's outpatient program and his psychiatrist at the VA medical center. There was clear documentation that the resident did not want to continue receiving services after he was transferred to the agency's outpatient program. The complaint also acknowledged that the resident did not want to continue with group therapy because of a sexually inappropriate peer in the group. Progress notes recorded that the resident's concerns regarding peers in his group were addressed. The Coordinator of Outpatient Services documented on January 26th, 2009 that three community referrals for continuity of care were provided. This was also mentioned in the Discharge Summary Report. The resident was discharged from the agency's outpatient program on February 12th, 2009, pursuant to policy. There was no documentation that the resident filed a grievance with the agency under the Illinois Administrative Code Section 132.142 (d) (5).

Although the resident's record contained confusing information, the HRA cannot substantiate that the resident was terminated from the agency's housing and program without adequate cause. No violations of the Code's Section 5/2-102 (a), the Illinois Administrative Code Section 132.145 (f) (2) or the agency's discharge policy were found. However, the agency violates termination processes as established in the Supportive Housing Program rules in Section 583.300 (i) because the record lacked a clear statement of the reason for the termination. The complaint that the agency did not provide referrals for aftercare services is also unsubstantiated.

A June 25th, 2008 acknowledgement of receipt of Cornerstone's Notice of Privacy Practices documented that the resident wanted to be notified when personal information was shared with the VA. There is evidence that the agency met with the outside provider on August 22nd, 2008 after the resident's written authorization was revoked on July 17th, 2008. However, the case note in question was not provided by the VA. According to the agency's Notice of Privacy Practices, consumers have a right to restrict or limit the information disclosed, but the agency does not have to agree with the written request. The Code of Federal Regulations Section 164.520 (a)(1) allows the agency to use and disclose personal information for treatment, payment, health care operations and other situations. The privacy rule allows the agency to share very basic service continuity information without consent, but the provider needs to honor objections regarding other information. The Director of Behavioral Health reported that the agency's veterans housing program is shared with the VA.

The Authority does not substantiate that the resident's right to confidentiality was breeched by the agency's staff. No violations of the agency's confidentiality rights statement #1 or Section 110/5 (a) of the Mental Health and Developmental Disabilities Confidentiality Act or Section 164.520 (a)(1) were found.

RECOMMENDATION

1. Cornerstone shall follow the Department of Housing and Urban Development, Community Facilities Supportive Housing Program Section 583.300 (i) and clearly document in residents' records the reason for termination.

RESPONSE

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

Cornerstone Services, Inc.
EST. 1969

Administrative Servic
Residential Servic
777 Joyce Ro
Joliet, Illinois 604
Phone 815/727-66
FAX 815/723-11

August 25, 2009

Judith Rauls, Chairperson
Regional Human Rights Authority
West Suburban Regional Office
P. O. Box 7009
Hines, IL 60141-7009

Re: HRA No. 09-040-9009

Dear Ms. Rauls:

Thank you for your letter of August 19, 2009 regarding the outcome of the above-referenced case. We are generally pleased that the Authority has determined that our actions in this case were proper and that the complaint was without justification.

Your report includes a recommendation to which we are required to respond, and we would like to do so in this letter.

Your recommendation indicates, in part, that we should "...clearly document in residents' records the reason for termination". More troubling to us is that you appear to have determined that Cornerstone "...violates termination processes as established in the Supportive Housing Program rules...because the record lacked a clear statement of the reason for the termination". We believe both of these statements to be in error and contradicted by the facts as shown in several documents included in the record.

On September 1, 2008, the complainant was transferred from our community housing program to our outpatient services program. On the document that formalizes this transfer, which is signed by me, the following is given as support for the transfer: "Successfully graduating from community housing due to B. making significant improvements with him living independently". The document clearly states that the reason for the transfer was because he had accomplished his goals in the program. Numerous other documents in the record support this as well.

On February 12, 2009, the complainant was discharged from our outpatient services program. On the document that formalizes this discharge, which is again signed by me, the following is given as the reason for discharge: "The client's attendance in therapy fell off after discharge from the community

PRESIDENT/CHIEF EXECUTIVE OFFICER
James A. Hogan

A United Way Agency

EMPLOYMENT SERVICES
800 Black Road
Joliet, Illinois 60435
815/727-6667

COMMUNITY SERVICES
777 Joyce Road
Joliet, Illinois 60436
815/741-7607

INDUSTRIAL OPERATIONS
2401 W. Jefferson Street
Joliet, Illinois 60435
815/773-7100

COMMUNITY SERVICES/PEP
134 E. Van Buren Street
Joliet, Illinois 60432
815/727-3627

BEHAVIORAL HEALTH SERVICES
800 Black Road
Joliet, Illinois 60435
815/727-6667

housing program. He expressed dissatisfaction with the discharge and stated that he could no longer attend services with this provider. He chose not to continue with this provider." The document clearly states that the reason for discharge was personal choice. He also expressed dissatisfaction with the transfer out of the community housing program, but as you have indicated in your report, he chose not to file a grievance over that action even though there is abundant evidence that he was in possession of a copy of the grievance procedure.

In summary, we believe that we have very clearly stated the reason for discharge in several documents included in the record, most notably in the discharge summary itself. We therefore feel that we have indeed complied with the recommendation, and that both the recommendation and the observation in the report that suggests that we are not in compliance are faulty findings that are not supported in the documentation.

If the Authority chooses to make this report public, we request that our response also be made public.

Sincerely,

Don Hespell
Vice President/Chief Operating Officer

Cc: Deanna Watson
Diane Clodi
Brenda Pagano
Jim Hogan