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**FOR IMMEDIATE RELEASE**

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**REPORT OF FINDINGS- 16-040-9020  
JOSEPH REHABILITATION CENTER  
HUMAN RIGHTS AUTHORITY- South Suburban Region**

**INTRODUCTION**

The South Suburban Regional Human Rights Authority (HRA) has completed its investigation into an allegation concerning Joseph Rehabilitation Center. The complaint stated that a resident is not allowed visitation with persons of choice in his home. If substantiated, this allegation would violate the Illinois Administrative Code (CILA Rules, 59 Ill. Admin. Code 115.100 et seq.) and the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.).

Joseph Rehabilitation Center located in Tinley Park manages four Community Integrated Living Arrangements with a population of approximately 24 residents. This agency has been providing services to individuals with disabilities since 2003.

**METHODOLOGY**

To pursue the investigation, the agency's Clinical Director/Administration Manager, the Program Director and a Direct Services Professional were interviewed. The complaint was discussed with the resident's guardian and his mother. Sections of the adult resident's record and a copy of his Guardianship Order, dated May 3<sup>rd</sup>, 2010, were reviewed. This order appoints the resident's father as the guardian over his personal care and finances. The agency's consumer's rights statement posted on its website was also reviewed.

**COMPLAINT SUMMARY**

The complaint stated that the resident's mother is no longer allowed to visit the resident in his home. It was reported that the agency's Program Director told the resident's mother that visits would have to take place outside of the home and that she did not have to understand why and hung up the phone. It was reported that the guardian subsequently told the resident's mother that he had requested the visits should be restricted to outside of the home. It was reported that leading up to the visitation restriction in the CILA home that the resident's mother had witnessed a staff person hitting another consumer with a broom during a visit on March 7<sup>th</sup>, 2016. She was reportedly asked to leave the home after she had reported the alleged incident to an administrative staff person and was told that the police would be called if she did not comply.

**FINDINGS**

**Information from the record, interviews and program policy**

The resident's record documented that he has lived in a Community Integrated Living Arrangement (CILA) managed by the agency for about three years. He is diagnosed with Autism Spectrum Disorder and Profound Intellectual Disability and requires 24-hours supervision. He is non-verbal and uses gestures to communicate. His parents are divorced and

his father is the legal guardian. For 2016, a visitation log sheet documented that the resident's mother had visited the individual twice in February, five times in March, and seven times in April. Sometimes, her visits would last for up to five hours and another family member was present during two of them. The visitation log further documented that they had three visits in July, seven in August, and one in September and the duration of these visits were two hours or less. The HRA reviewed progress notes documenting that the resident was happy when he had visits with his mother. She would sometimes bring him food and he would listen to music on her cell phone. One time she reportedly cooked dinner for him during a visit in the home. They would spend time in the resident's bedroom. Some of the progress notes indicated that his mother took him outside of the home for visits. Some of them described the resident as being agitated and screaming during or after visits with his mother and the Authority noticed that these are some of his maladaptive behaviors as per his record. There was mention of the resident's mother being restricted from visiting in his home found in the progress notes and the incidents reports reviewed. However, his services plan indicated otherwise.

The resident's services plan, dated September 14<sup>th</sup>, 2016, documented that his mother's behaviors during visits in the home had placed other consumers at risk. These behaviors included talking to the consumers to obtain confidential information from them, taking pictures of them, and infringing on their personal space. His services plan documented that the individual sometimes appeared agitated during visits with his mother and for days after them. Also, his mother's behavior in the home reportedly affected the other consumers' moods. It was documented that the resident's mother had harassed the staff including the Qualified Intellectual Disabilities Professional (QIDP) and had threatened to report the agency to the Office of the Inspector General (OIG) and other governmental agencies. According to the resident's services plan, the OIG had determined that his mother's allegation involving a staff person abusing another consumer was unfounded. However, she continued to make allegations against the same staff person and said that she was not going to stop until the resident is allowed to live with her.

In May of 2016, the resident's services plan documented that the guardian told the resident's mother that she should respect the privacy of other consumers in the home. He told her to take the resident on community outings instead of hanging out in the home for hours because this "clearly bothered the other consumers." On that same month, the guardian reportedly sent a letter to the agency clarifying who has permission to make decisions concerning the resident. In the letter, he wrote that he wanted to protect the resident from "exploitation" and warned the staff to be vigilant. He was concerned that the resident's mother was planning on giving him cannabis because she believed that it would help his autism disorder. His services plan documented that all restrictive measures required a physician's order and informed consent and approval of the agency's Human Rights Committee when appropriate. It stated that all restrictions would be discussed and reviewed including the rationale for them. Additionally, the resident's services plan documented that visits between the resident, his mother and maternal family members were now taking place in his home.

When the complaint was discussed with the agency's staff, the Authority was informed that the resident's mother had started visiting the individual in 2015. His mother's behavior became problematic when the guardian had put up a picture of his new wife and family on the wall in the individual's bedroom. The HRA was informed that the resident's mother had filed about eleven complaints of possible abuse and neglect against the agency's staff. The staff interviewed said that she had "continued to harass" the staff after the OIG had investigated her allegations. According to the Clinical Director/Administration Manager, the resident's

housemates were complaining about his mother talking to them during her visits in the home. One housemate reportedly told the staff that she was asking them questions. The HRA was informed that the resident's mother took pictures of the staff and his housemates many times. Also, she would bring her grandchildren to the home and they would take pictures too. She would read written communications intended for the staff on the bulletin board in the home's kitchen. According to the staff, the guardian had requested that visits between the resident and his mother should occur outside of the home. The Program Director remembered the resident's mother asking why she could not visit her son in his home and told her to talk to the guardian.

The guardian told the Authority that the resident's mother was disruptive in the home. For example, he said that she was looking at documents, talking to other residents, and making accusations about the staff. He reported that the resident's mother had called various agencies and claimed that she was the legal guardian and that they were still married. He said that he believes that she loves her son and that she can have visits with him. However, her visits would have to take place outside of the home until her behavior improves. The Clinical Director/Administration Manager told the Authority that visitors must respect consumers' privacy. Later, she reported that this issue was discussed with the resident's mother and now visits are taking place in the CILA's living room or dining room area.

The Joseph Rehabilitation Center "Consumer and Family Statement of Rights" states that consumers and their family are important. Consumers' family members are welcomed to visit the agency's homes anytime.

#### CONCLUSION

Section 115.250 of the Administrative Code states that individual entering a CILA program shall be informed of the following:

- (a) (1) The rights of individuals shall be protected in accordance with Chapter 2 of the Code, except that the use of seclusion will not be permitted.

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

- (a) All recipients of services shall be provided with adequate and humane care and services, pursuant to an individual services plan. The plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipients' substitute decision maker, if any, or any other individual designated in writing by the recipient.

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

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.

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 complaint stated that a resident is not allowed visitation with persons of choice in his home. Although the investigation revealed that the resident's guardian had requested that visits between the individual and his mother should occur outside of the home, the HRA cannot substantiate the complaint as presented above. It appears that her visits were limited to outside of the home for about two months because her behavior was perceived as being harmful and

harassing towards others in the CILA home. The Code allows communication to be reasonably restricted only in order to protect the resident or others from harm, harassment or intimidation concerning that communication, provided that notice is given upon admission. The HRA is pleased that the visitation issue reportedly has been resolved. However, the agency violates the Code's Section 5/2-201 listed above because there was no restriction notice found in the resident's record.

**RECOMMENDATION**

1. Complete restriction of rights notices whenever guaranteed rights within the Code are restricted under Section 5/2-201 of the Code.

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## **RESPONSE**

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

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# Joseph Rehabilitation Center, LLC

2 Olympus Drive, Tinley Park, IL 60477

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August, 31 2017

To Illinois Guardianship and Advocacy Commission  
P. O. Box 7009  
Hines IL, 60141-7009

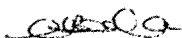
**Re: Case # 16-040-9020**

I am writing to acknowledge as well as provide a response to the IGAC report on the case referenced above. I thank the agency for taking the time to review this case and for providing recommendations. It was not the intention of Joseph Rehabilitation Center (JRC) to infringe on the rights of any individual. It is within our policy to ensure the protection of our consumer's human rights. Our interpretation of the situation at the time hinged on following what the guardian requested based on his past history with the person who filed the report and for the safety of the consumer. It was apparent to us at the time that the measure the guardian took and we implemented protected the rights of the consumer and therefore did not warrant a notice on restriction of rights.

Nevertheless, JRC is fully committed to complying with Section 5/2-201 of the state's code by ensuring the completion of Rights Notices whenever "guaranteed rights within the code are restricted."

Thank you.

Cordially,



Tutu Balogun, OTD, OTR/L  
JRC Clinical Director

Letter sent via fax to: 708-338-7505

Cc: L. Davis/JA Balogun