
Revised October 2, 2019

Widespread Abuse, Neglect and Death in Small Settings Serving People with Intellectual Disabilities

Since 1997, VOR has been tracking media coverage highlighting the increasing need for more effective federal and state protections in the ever-expanding community system of care for people with Intellectual and Developmental Disabilities

Georgia

Report: Deaths, Lack of Housing Plague Georgia System for Disabled, Mentally Ill The Augusta Chronicle - August 26, 2019

An independent reviewer found that despite Georgia's claims of compliance, a state health care system for the developmentally disabled and mentally ill is still inadequate.

Georgia claims it is in compliance with a settlement with the federal government to improve the care of those with developmental disabilities and mental illness, but an independent source found their death rate is climbing and that the state still failing to meet its responsibility to house thousands suffering from these disorders.

Earlier this year, the state twice asked the Justice Department to find it had complied with and should be released from a 2010 settlement over its treatment of the developmentally disabled and mentally ill in its care. But in her report to the U.S. District Court filed last week, independent reviewer Elizabeth Jones found a number of areas where the state was lacking and in fact doing worse than in previous years, particularly with the deaths of developmentally disabled patients in community care.

An Augusta Chronicle investigation in 2015 found nearly 1,000 deaths among those patients in community care in both 2013 and 2014, and the state has twice halted moving them from state hospitals into community care over the lack of adequate care among those providers. In its last Annual Mortality Review that covered fiscal year 2017, Jones noted that the death rate has continued to climb each year, from 12.5 per 1,000 in fiscal year 2015 to 16.4 per 1,000 in 2017.

“Perhaps most significantly,” Jones notes, the death rate for those the state has already identified as high risk is anywhere from twice to four times as high.

<https://www.augustachronicle.com/news/20190826/report-deaths-lack-of-housing-plague-georgia-system-for-disabled-mentally-ill>

**National (Administration for Community Living)
Government Report Finds Living Centers For People With Disabilities Have Not Conducted
Inspections In Years
Forbes - August 14, 2019**

The U.S. Department of Health and Human Services (HHS) of the Office of Inspector General (OIG) released a report that reveals that the Administration for Community Living (ACL) has not conducted its required oversight of independent living programs for the last five years.

Americans with disabilities often face severe obstacles in life, such as getting a job, finding adequate transportation methods and living independently at home. Therefore, these independent living service programs play an integral role in bridging the gap between the inaccessibility of society and the livelihoods of people with disabilities. If the systems that are supposed to support them do not do their due diligence, then this already disadvantaged population is left even more vulnerable.

Since July 2014, the ACL has been regulating two separate independent living programs: the Centers for Independent Living and Independent Living Services. These programs aim to support the independence of people with disabilities nationwide by providing tools, resources and support for integrating the disability population fully into their communities. Services rendered by these programs include providing discretionary grants to nonprofit organizations and improving nursing homes and other assisted-living institutions.

Under section 706(c)(1) of the Rehabilitation Act of 1973, which governs both programs, the ACL must conduct onsite compliance reviews of at least 15% of the Centers for Independent Living programs that receive funds under this law. Without these congressionally mandated site reviews, program funds are vulnerable to fraud, waste and abuse.

Upon receiving a hotline complaint in June 2017 alleging that the ACL was not conducting required oversights, the HHS of the OIG conducted an audit of 284 Centers for Independent Living and two Independent Living Service programs that receive federal grants from the ACL. The department was not aware that the onsite inspections were not being conducted until the receipt of the hotline complaint.

The ACL was appropriated \$156.6 million for independent living program services during the audit period of October 1, 2015, through September 30, 2017. Although the ACL awarded \$151.5 million to grantees for independent living program services, it did not allocate sufficient funds from the remaining \$5.1 million to support onsite compliance reviews.

<https://www.forbes.com/sites/sarahkim/2019/08/14/government-report-finds-living-centers-for-people-with-disabilities-have-not-conducted-inspections-in-years/#6444fa9912bd>

Oregon

\$4.5 million lawsuit alleges abuse of developmentally disabled man at state-licensed group home

The Oregonian - August 11, 2019

In September 2014, Margaret Lamb dropped off her 21-year-old son at a green, one-story house in Gresham with mixed feelings.

She knew her son required more care than she could provide as a working single mother. She hoped the state-licensed group home for developmentally disabled adults would provide Matthew Lamb with the specialized attention he needed.

But she didn't realize she would spend the next four years trying to get him out.

She's now suing the company that operated her son's group home as well as Multnomah County and the state of Oregon, alleging they failed to care for Matthew Lamb, protect him or properly investigate her complaints about his treatment. The suit seeks up to \$4.5 million in economic and noneconomic damages.

<https://www.oregonlive.com/pacific-northwest-news/2019/08/45-million-lawsuit-alleges-abuse-of-developmentally-disabled-man-at-state-licensed-group-home.html>

Indiana

13 Investigates uncovers pattern of abuse, neglect in group homes for the disabled

WTHR-TV13 - July 29, 2019

Indiana's most vulnerable residents are often cared for in group homes with round the clock staff. No one disputes it can be a tough job, but when you have an industry with high turn over rates and improperly trained workers, group homes can become places of extreme abuse.

13 Investigates' Sandra Chapman uncovered troubling issues for a provider with a network of group homes across the state and the country. One of these group homes is in a house located on Atwood Court in Fishers. The home is operated by ResCare, one of Indiana's largest residential care providers, and is where Indiana's most vulnerable are supposed to be protected.

Records show that protection wasn't extended to Anthony Harris who lived at the ResCare group home in Fishers. Harris has cerebral palsy and is completely disabled and non-verbal.

A caregiver admitted to viciously beating Harris in 2017.

Emergency workers found Harris bloodied, beaten and, according to his attorney, tortured inside his room. He suffered all of the injuries at the hands of Michael Anderson, the man ResCare hired to care for him.

Emergency room nurses from Community Hospital were the first to alert police.

In a 911 call obtained by 13 Investigates, a nurse tells the dispatcher: "His face is all bruised up. His eye is swollen and the CAT scan, it seems like he might have been abused in the group home or somewhere. And there's another patient that came from the same group home, same situation. His face is all bruised up," she said, referring to Harris' roommate who was also attacked.

"There was blood everywhere. It had been splattered. It was a horrific scene," said Scott Benkie, the Harris family attorney.

<https://www.wthr.com/article/13-investigates-uncovers-pattern-abuse-neglect-group-homes-disabled>

Missouri

Missouri reaches more than \$1 million settlement in disabled man's death

KSHB-TV41 - July 26, 2019

After the death of a developmentally disabled man in Missouri's care, the state has paid more than \$1 million to settle a federal lawsuit.

Carl DeBrodie's badly decomposed body was found in a garbage can encased in concrete in a Fulton, Missouri, storage locker in April 2017.

DeBrodie, 31, had been staying at Second Chance Homes, a Fulton facility contracted by the Missouri Department of Mental Health's Division of Developmental Disabilities.

"They went through that provider enrollment process, and then they were basically out there and could start making themselves available for families and guardians to select as a provider," said Valerie Huhn, director of the Division of Developmental Disabilities. The money to pay for providers such as Second Chance Homes comes from both federal and state tax dollars.

According to the now-settled federal lawsuit and ongoing criminal cases, Second Chance Manager Sherry Paulo and her husband, Anthony Flores, had DeBrodie fight another client for their amusement.

"We want the person or whoever done this to my son to pay," said Carolyn Summers, DeBrodie's mother.

Those court records also say that in the fall of 2016, DeBrodie had a seizure from his injuries in those fights.

Flores and a client placed DeBrodie in a bathtub and turned on the shower in an effort to get him to snap out of it, according to court records.

"And there was never any type of outside medical care requested or attempted to be given," said Rudy Veit, Summers' attorney in the federal lawsuit.

DeBrodie died in the bathtub.

"He stayed in that tub for a length of time until they moved him to a different location, which was a trash can," Veit said.

https://www.kshb.com/news/local-news/investigations/missouri-pays-more-than-1-million-settlement-for-disabled-mans-death?fbclid=IwAR37Z9JJx_5_KHSnC9DkZH77y4l-RY2Vg_Ex5mPgillH5DoWH_PE9z8-1E

New York

Why New York says parents weren't told of incidents at group homes Albany Democrat & Chronicle - July 23, 2019

The state's Office of Mental Health failed to properly notify parents of incidents of abuse at several facilities despite a law requiring timely notifications, according to a new audit from the state's Comptroller's Office.

New York adopted "Jonathan's Law" in 2007 to expand the access to information regarding allegations of neglect and physical, sexual and psychological abuse at state-operated or licensed facilities to parents, guardians and other qualified persons.

The law was named after Jonathan Carey, a 13-year-old non-verbal and developmentally disabled child from the Albany area who died while in state care in 2007. His parents made several attempts to obtain information regarding several injuries he sustained during his time at the facility to no avail.

A review of 210 incidents across eight facilities between April 2015 and Jan. 9, 2018, found 42 incidents with no evidence to support a telephone communication was ever made within the required 24-hour window, the audit from Comptroller Thomas DiNapoli found.

Some facilities also failed to provide requested information to a qualified person within the required timeframe, the audit said.

<https://www.democratandchronicle.com/story/news/politics/albany/2019/07/23/why-new-york-says-parents-werent-told-incidents-group-homes/1796379001>

Maryland

Service Provider Sued Over Alleged 'Dickensian' Conditions The Baltimore Sun - July 10, 2019

A residential and educational facility for students with disabilities operated under “Dickensian” conditions, failing to provide children with required medication or appropriate supervision and attempting to cover up assaults, according to a lawsuit filed this month by the Maryland Attorney General’s office.

AdvoServ Inc. ran a program for people and students with disabilities in Delaware. Dozens of Maryland children with cognitive disabilities and mental illnesses were sent to their facilities for treatment and education after the state determined their needs couldn’t be met at home or in their local schools.

But even though the state paid AdvoServ more than \$230,000 a year to care for each child, the lawsuit alleges their facilities failed to “provide even minimally adequate care to the children under their protection.”

Maryland ended its contract with AdvoServ in 2016. The state planned to sever ties with the company by October of that year but still hadn’t removed the 31 Maryland children in their care when a 15-year-old girl died at the Bear, Del., facility that fall.

The company — whose facilities across the country have a long and troubled history — has since changed its name to Bellwether Behavioral Trade. Representatives did not immediately return calls seeking comment.

The attorney general’s office said the state paid AdvoServ more than \$13 million to care for children between June 2015 and October 2016, and is seeking to recover unspecified damages and penalties from the company.

<https://www.baltimoresun.com/education/bs-md-frosh-disability-services-lawsuit-20190710-sxymb6pigncrrhcinaacknsfci-story.html>

South Carolina

SC Mental Health patient suffocated by hospital staffers who failed to follow training The Charlotte Observer - July 14, 2019

A state Department of Mental Health patient suffocated to death earlier this year at the bottom of a dogpile of agency employees who failed to follow the department’s training on physically restraining patients.

At least three of the employees involved in the death of 35-year-old William Avant had not been trained properly, according to an ongoing probe by state health regulators reviewed by The State as part of the newspaper’s weeks-long investigation into Avant’s death.

Avant, a Georgetown, S.C., native who had been in Mental Health’s inpatient care for more a dozen years, was killed on Jan. 22 when Mental Health staffers improperly pinned him face down on a Columbia hospital floor and lay atop his back for four minutes, preventing his diaphragm from expanding to deliver oxygen to vital organs. Hospital staffers failed to check Avant’s breathing as he died beneath them, records show.

Their actions were explicitly prohibited — in red, all-capital letters — in the department’s training manual, raising questions about the agency’s management of employees, including training, and how well Mental Health cares for its 100,000 patients, including 1,500 inpatients who are some of the state’s most vulnerable residents.

<https://www.charlotteobserver.com/news/state/south-carolina/article232536702.html?fbclid=IwAR0xOIZmxFJg6oVbRVcFKcECrg4BFZoTtP9hwiq0av-d67E1c4ZQ5f9gJQ>

New York

Judge Orders Expanded Oversight for Mentally Ill New Yorkers In Supported Housing ProPublica - July 12, 2019 (Follow up to story appearing December 6, 2018)

Not enough people are covered by an oversight system meant to safeguard residents of a New York housing program for people with mental illness, a federal judge found this week, after reviewing a report commissioned in response to a ProPublica and Frontline investigation.

Since January 2014, more than 750 people with severe mental illness have moved out of troubled New York City adult group homes and into subsidized apartments under a federal court order. The idea was to give them a chance to live outside institutions, with services coming to them as needed through a program called supported housing.

But last December, ProPublica and Frontline revealed that more than two dozen people who had moved out struggled to live safely on their own. Many had been repeatedly hospitalized. One went missing; another was in jail. At least six had died under suspicious circumstances, and the state had only recently developed a system to track such incidents.

The story prompted U.S. District Judge Nicholas Garaufis to order a report from Clarence Sundram, the independent court monitor assigned to oversee the transition. Garaufis asked Sundram to gauge the effectiveness of the incident reporting system implemented in the summer of 2018.

<https://www.propublica.org/article/judge-orders-expanded-oversight-for-mentally-ill-new-yorkers-in-supported-housing#>

**New York
Residents Cowered While Workers at a Group Home Smacked and Pushed Them
The New York Times - June 9, 2019**

Some of society's most vulnerable people have long been preyed upon by abusive workers in group homes. New York vowed reforms, but they didn't happen.

The people who worked at the brick building that housed 24 developmentally disabled residents called it the "Bronx Zoo."

One worker regularly hit a resident while he ate, making him cower in fear at mealtimes. Another worker would repeatedly "smack, punch and push" a female resident, sometimes when she tried to watch staff members cook. A female worker sat in the lap of a male resident who used a wheelchair, placing his hands on her breasts and moving provocatively while other employees laughed and cheered, according to records and depositions.

The abuse first came to light five years ago, leading to a public outcry and an investigation by the state, which runs the facility, called the Union Avenue I.R.A., in the Bronx. But in a new review of the case, The New York Times found that when officials tried to fire 13 employees for abuse or neglect at the home, they failed each time. The workers were shielded by the state arbitration process, whose shortcomings often return abusive employees to the job.

The Bronx case is emblematic of a larger problem across New York. Hundreds of pages of disciplinary records from 2015 to 2017, obtained by The Times under the state open-records law, show that more than one-third of the employees statewide found to have committed abuse-related offenses at group homes and other facilities were put back on the job, often after arbitration with the worker's union.

The residents in the state's far-flung network of more than 1,000 group homes are particularly dependent on their caregivers. In many cases, they are unable to communicate and live in group homes almost their entire lives. Some are also immobile, while others have been all but abandoned by their families.

Recycling abusive employees has long been an endemic problem. Eight years ago, The Times reviewed thousands of pages of disciplinary files for 233 workers. In a quarter of substantiated abuse cases, employees were transferred to other homes rather than fired, including in cases involving sexual assaults. The newly obtained disciplinary records involved 120 employees. They show that while the transfers appear to have decreased, the state still keeps problematic workers at their jobs.

The findings are the latest sign that attempts to change the oversight of care for the developmentally disabled by Gov. Andrew M. Cuomo's administration has stumbled.

<https://www.nytimes.com/2019/06/09/nyregion/new-york-group-home-abuse.html>

New Jersey

Bellwether's license to operate group homes in New Jersey revoked North Jersey Online - May 22, 2019

New Jersey will shut down the state's largest for profit provider of residential and day programs for individuals with developmental disabilities for operational violations and failure to make needed improvements.

Following an investigation by an independent monitor, a moratorium on admissions and a period of enhanced oversight triggered by reports of alleged operational violations at facilities statewide, Bellwether Behavioral Health will lose its licenses to operate in New Jersey, according to the state's Division of Developmental Disabilities.

Bellwether did act to address state officials' concerns, and "has not been able to demonstrate the systemic improvement needed to continue operations in our state," said Jonathan Seifried, the division's assistant commissioner.

The state report on the independent monitor's findings released Wednesday found 12 of Bellwether's 14 group homes operating on provisional licenses in New Jersey were deficient in cleanliness. Half smelled of urine, five had rotten or expired food in the refrigerator and one was found to have mixed up residents' medications, according to the report.

Some homes had as many as 60 deficiencies, the report states.

<https://www.northjersey.com/story/news/new-jersey/2019/05/22/bellwether-nj-license-operate-group-homes-new-jersey-revoked/3768714002/?fbclid=IwAR1cOoVsPKIcvDDF8Sip801ZuxLhoWqbj82tvVlQrYL6S6iW65Z-G62pmf8>

Washington

DSHS to pay \$8M after neighbors' pleas to help vulnerable Seattle man brought no action The Seattle Times - May 20, 2018

Vernon Gray was living with rats when a social worker showed up to his Central District home, where a layer of garbage coated the floor and a squalid odor caused people to gag when they stepped onto the property.

That was in 2009, when the state's Adult Protective Services received its first report about him. Gray, who has a developmental disability, had been living in the house alone since his mother died in 2000. Neighbors begged the state to intervene, explaining he was unable to take care of himself. They continued after Gray became homeless in 2013.

Adult Protective Services (APS) investigated Gray's situation three times since 2009, but each time, he was left on his own. The agency, which is within the Department of Social and Health Services (DSHS), investigates reports of vulnerable adults who have been abused, abandoned or neglected. Attorney David Moody argued in a tort claim that the state failed to protect Gray, now 64.

On Thursday, the department agreed to an \$8 million settlement, which Moody said is the largest paid by the state in an adult protective services case. The state agreed to settle the case before a lawsuit on Gray's behalf was filed.

This is the latest in a series of troubling and costly incidents at DSHS, which oversees a state mental-health system that has been stung by damaging federal and state court rulings and federal decertification of its main psychiatric hospital.

<https://www.seattletimes.com/seattle-news/sorry-for-what-happened-to-mr-gray-says-dshs-about-to-pay-8m-after-neighbors-pleas-to-help-vulnerable-seattle-man-brought-none>

California

Cases of abuse, neglect of California disabled clients going unchecked: whistleblower

KTVU-TV2 - April 25, 2019

Cases involving starvation, neglect and sexual abuse targeting developmentally disabled clients in California are not being addressed thoroughly or going unchecked altogether, according to a former North Bay care employee who worked with patients.

Roberto Franco, an ex-employee of the North Bay Regional Center in Napa, said he is blowing the whistle on the multi billion dollar care industry that he believes is overwhelmed with cases and allowing serious incidents to fall through the cracks. “It’s crazy because I’ve been trying to tell people about these things I’ve seen,” he told 2 Investigates.

By law, the California Department of Developmental Services (DDS) is responsible for ensuring more than 330,000 people with developmental disabilities receive services and support. Every year, the department allocates billions of taxpayer dollars to 21 different regional centers statewide to carry out its responsibility. Those regional centers hire and pay service providers to directly house and care for clients whose disabilities include autism, epilepsy, intellectual disabilities and cerebral palsy.

Franco was fired from the North Bay Regional Center (NBRC) in January 2018 for being “unprofessional and insubordinate,” according to his termination letter. But he believes regional center management penalized him for being persistently outspoken about client issues. As a service coordinator, it was his job to monitor client care and report problems.

All caretakers, providers and agencies are legally required to report incidents where a client is hurt or could be hurt. These reports are processed by regional centers and DDS.

<http://www.ktvu.com/news/2-investigates/cases-of-abuse-neglect-of-california-disabled-clients-going-unchecked-whistleblower>

Oregon

US Senate Launches Investigation Of Group Home Provider

The Oregonian - April 3, 2019

The U.S. Senate has launched an investigation into a national corporation’s homes for people with disabilities in response to a report about substantiated abuse at one of the company’s facilities.

The Oregonian reported in January that Oregon regulators shuttered a Mentor Network home in Curry County following extensive evidence that a client with a disability had been severely neglected. State regulators found that managers repeatedly ignored caregivers’ concerns about the person’s festering pressure wound, including that it smelled of “rotting flesh.”

“When vulnerable Americans are abused or even killed in the care of a taxpayer-funded care provider, that organization must be held accountable,” Sen. Ron Wyden, D-Ore., said in a statement this week.

The Senate Committee on Finance, chaired by Sen. Chuck Grassley, R-Iowa, sent letters Tuesday to the Oregon and Iowa branches of the The Mentor Network, demanding copies of a raft of compliance records by month's end. The company operates in 36 states, serving about 13,000 people in group homes and 19,000 in non-residential settings.

The Senate investigation comes on the heels of renewed oversight by state regulators in Oregon who have been closely monitoring Mentor Oregon since finding problems in Curry County in late 2017. This marks the second attempt by the state Department of Human Services to force Mentor Oregon to make its facilities safer for residents.

<https://www.oregonlive.com/pacific-northwest-news/2019/04/us-senate-launches-investigation-of-oregon-homes-for-people-with-disabilities.html>

Virginia

A caregiver raped two intellectually disabled women, police say. Both gave birth to children. The Washington Post - March 2, 2019

The mission of the center in Fairfax County is to “employ and support” people with disabilities, but a prosecutor said a worker sexually assaulted a 29-year-old woman with Down syndrome in its offices.

Police began an investigation in October 2017 after a doctor made a disturbing discovery: The woman was five months pregnant, authorities said. She later gave birth.

The pattern played out again nearly a year later. Police say another client at the MVLE Community Center, a 33-year-old woman with intellectual disabilities, was raped. The case was reported to police in August 2018 after her doctor discovered she was pregnant. She also gave birth.

Last month, Bernard Betts-King, 60, a behavioral specialist at MVLE, was charged with sexually assaulting both women. DNA tests showed he was likely the father of the second woman's child, court papers say. DNA results are pending in the other case.

Advocates say the case underscores a problem that has received less attention in the #MeToo era: the sex assault of the intellectually disabled. Numbers produced by the federal Bureau of Justice Statistics for an NPR investigation last year found those with intellectual disabilities are sexually assaulted at seven times the rate of people without disabilities.

https://www.washingtonpost.com/local/public-safety/a-caregiver-raped-two-intellectually-disabled-women-police-say-both-gave-birth-to-children/2019/03/02/06146a2c-36ba-11e9-854a-7a14d7fec96a_story.html

Note: Betts-King pleaded guilty in July:

<https://www.nbcwashington.com/news/local/Virginia-Therapist-Bernard-Betts-King-Pleads-Guilty-to-Raping-Impregnating-2-Clients-With-Disabilities-513086811.html>

California

El Dorado Hills school where special-needs student died will close The Los Angeles Times - January 22, 2019

An El Dorado Hills school at the center of an investigation over the death of a 13-year-old autistic student announced this week that it plans to close its doors permanently on Friday.

Guiding Hands School, a private school that has served students with disabilities since 1993, made headlines when a student, identified as Max Benson, died after being placed in a face-down restraint by school staff in November.

The California Department of Education said the boy was held down for an hour and 45 minutes, according to Sacramento Superior Court records.

<https://www.latimes.com/local/lanow/la-me-ln-guiding-hands-school-closure-20190122-story.html>

New Jersey

Missing developmentally disabled man found dead Atlantic City News (BreakingAC) - December 28, 2018

A developmentally disabled man who disappeared from a day program in Vineland more than two weeks ago was found dead Wednesday, police said

While the death is being investigated, the group manager of the Mays Landing home where Robert Nicholson IV lived blames negligence.

Nicholson, 28, left the facility Dec. 10. A landscaper found his body Wednesday, near a retention pond at 3001 E. Chestnut Ave., across from Vineland's high schools.

It was only Nicholson's second day at the facility, where he was supposed to be a "line of sight" patient, meaning he is to be supervised at all times, said Heather Grosso, his house manager.

<https://www.breakingac.com/2018/12/missing-developmentally-disabled-man-found-dead/?fbclid=IwAR2BGzyANRTulbN3N1ZaFtk0nKhqZRK4roinka3wpUOZrHD00JNC1D5TQAs>

California

Is California Failing Its Most Vulnerable Adults? Type Investigations - December 11, 2018

A joint investigation by The Investigative Fund at The Nation Institute and FiveThirtyEight has found that from 2013 to 2017, there were at least 2,400 reported allegations of abuse and neglect in the more than 4,500 day programs like Jackie's in California.

The goal of adult day care programs is to help clients build their capacities by doing activities in their communities, rather than by being sequestered in live-in institutions. But our findings, along with a series of industry association reports that found funding gaps have affected the quality of care at day programs, suggest that the state's adult day care system has its own problems. This summer, 51-year-old Timothy Cortinas was found dead in a car in West Covina, California; a lawsuit alleges that he was left alone in the vehicle for hours by a day care staff member as temperatures inside the car climbed to over 100 degrees.

<https://www.typeinvestigations.org/investigation/2018/12/11/california-developmental-disabilities-services>

New York

Living Apart, Coming Undone: Report from ProPublica & Frontline ProPublica - December 6, 2018

Abraham Clemente, who is 69 and has schizophrenia, kept the shower and sink running for the "oxygen." He blamed a kitchen fire on a doll nailed to a cabinet. He believed he could crush and smoke his antipsychotic medication to achieve its intended effect.

Yet the state of New York determined Clemente was capable of living on his own.

He is one of hundreds of severely mentally ill New York City residents who have been moved out of institutions into private apartments over the past four years under a landmark 2014 settlement. The approach is meant to be a national model for the rights of the mentally ill to live independently.

It begins with the assumption that most people in adult homes — group facilities that often house hundreds of residents — can live on their own with the right help. Adult home residents are given a subsidized apartment, called scattered site supported housing, and assigned a team of social workers and others to help navigate bureaucracies, housing problems and everyday tasks.

But more than 200 interviews and thousands of pages of medical, social work and housing records reviewed by ProPublica and the PBS series Frontline, in collaboration with The New York Times, show that for some residents, the sudden shift from an institution to independence has proved perilous, and even deadly.

<https://features.propublica.org/supported-housing/new-york-mentally-ill-housing-group-homes>

Follow up report published July 12, 2019:

<https://www.propublica.org/article/judge-orders-expanded-oversight-for-mentally-ill-new-yorkers-in-supported-housing#>

New York Sex Offenders Placed in Homes for Seniors and the Disabled WRGB-CBSTV6 - October 29, 2018

From nursing homes to state-operated homes for the disabled, violent sex offenders have local group homes listed as their home address, and residents have no idea.

The New York Sex Offender Registry indicates a 58-year-old sex offender, who served his time after he was convicted of sexually abusing a 9-year-old girl, is now living at a Clifton Park group home on Lapp Road operated by the NYS Office for People with Developmental Disabilities.

“It’s a predator’s dream, they can prey on the most vulnerable, and then you have a system that’s all about hiding what’s happening from the general public and the families,” Michael Carey said.

Michael Carey oversees the Jonathan Carey Foundation, an advocacy group for the disabled. The foundation is named after his developmentally disabled son who was killed by a care worker in 2007. His team has spent weeks examining the sex offender registry. Far from done, they’ve already found 80 sex offenders who list a group home as their primary residence. He says mixing sex offenders in with disabled patients is a recipe for sexual assault.

“Many of them can absolutely never tell their parents because they’re non-verbal. This is an emergency situation, this is something the governor should be immediately putting a stop to. It’s beyond outrageous, it’s unconscionable and it’s also illegal,” Carey said.

Carey believes knowingly placing a sex offender in the same home as a disabled patient is a violation of the state law, endangering the welfare of a disabled person, and also puts care staff at risk.

“There are no cameras, and the staff aren’t properly trained,” Carey said.

<https://cbs6albany.com/news/local/cbs-6-investigates-sex-offenders-placed-in-homes-for-seniors-and-the-disabled>

Related Links:

<https://www.adirondackdailyenterprise.com/news/local-news/2018/09/sex-offenders-in-group-homes-for-disabled-isnt-new-in-tupper-lake/>

<https://www.lohud.com/story/opinion/perspective/2018/09/27/new-york-must-safely-house-developmentally-disabled-sex-offenders/1430061002>

Wisconsin

Office of the Inspector General, Department of Health and Human Services: Wisconsin Did Not Comply With Federal Waiver and State Requirements at all 20 Adult Day Care Centers Reviewed

Department of Health and Human Services, Office of the Inspector General – October, 2018

Wisconsin did not comply with Federal waiver and State requirements in overseeing centers that serve vulnerable adults who receive services through the Family Care program (the program). All 20 of the centers we reviewed did not comply with State certification requirements. In total, we found 208 instances of noncompliance with health and safety and administrative requirements.

<https://oig.hhs.gov/oas/reports/region5/51700030.pdf>

Florida

Autistic man abandoned at Naples hospital has no place to go Naples Daily News - August 27, 2018

A public guardian and a state agency thought they had a solution for a severely autistic young man whose mother abandoned him more than a year ago at a Naples hospital.

Placement in a local group home lasted four days before the 22-year-old — referred to as “John Doe” in court records — was back at NCH Downtown Baker Hospital, said Patrick Weber, the public guardian in Collier County.

Doe's care requires intensive services in a 24-hour setting, and no group home in Collier is equipped for that, experts say.

<https://www.naplesnews.com/story/news/health/2018/08/27/nch-still-caring-autistic-man-who-has-no-discharge-options-locally/1067492002>

Indiana

Group home owner, 4 workers, charged in beating of resident, prosecutors say The Indy Star - August 15, 2018

The owner of an Indianapolis group home for adults with intellectual and developmental disabilities and four workers have been charged in the beating of a resident that was caught on video, prosecutors say.

Safe Journey LLC owner Amelia Hagedorn, 50, has been charged with criminal confinement with bodily injury and battery resulting in bodily injury to a disabled person, the office of Marion County Prosecutor Terry Curry said Tuesday night in a news release.

Three Safe Journey employees face the same charges. A fourth was charged with failing to report the incident.

<https://www.indystar.com/story/news/crime/2018/08/14/owner-indianapolis-based-safe-journey-charged-hurting-resident/994327002/>

New Jersey

Murphy Administration Demands Action from Major Group Home Operator after Safety Problems Revealed NJcom - August 9, 2018

Gov. Phil Murphy's administration has halted new admissions at New Jersey's largest group home operator for people with developmental disabilities and demanded "immediate correction of all concerns" involving safety and staffing shortages uncovered in 18 months of inspections. The state Department of Human Services intends to appoint an independent monitor and to continue random unannounced inspections at all 62 properties operated by for-profit Bellwether Behavioral Health, state Department of Human Services spokesman Tom Hester said.

According to the report, Bellwether homes in Branchburg in Somerset County drew 156 rescue squad calls over two years, including seven involving employees accused of assaulting residents. Police are routinely called several times a day to intervene when staffing is low, the report said.

In addition to having the largest capacity of any group home provider in New Jersey, at 494 beds, Bellwether has also recorded the largest number of allegations of abuse and neglect. According to state data from March 2017 to March 2018, the state investigated 71 complaints, and substantiated 33. Six residents were repeatedly victimized, the data said.

https://www.nj.com/healthfit/index.ssf/2018/08/group_home_operator_for_disabled_will_get_no_new_a.html

Illinois

Audit rips Illinois' oversight of group homes for adults with disabilities The Chicago Tribune - July 19, 2018

A damning state auditor general report released Thursday found systemic failures in Illinois' licensing and oversight of thousands of taxpayer-funded group homes for adults with disabilities, problems first exposed in a 2016 Tribune investigation that documented substandard conditions and widespread harm.

The nearly 230-page report also questioned whether the state did enough in recent years to ensure the safe transition of more than 400 vulnerable adults from large developmental centers into the smaller group homes. And auditors found the state used "questionable procurement strategies" when it awarded multimillion-dollar contracts to the company managing that transition.

The audit focuses on the state's oversight of more than 3,000 group homes — one-third of which are in Cook County — that serve about 10,000 adults with developmental and intellectual disabilities. It covers a four-year period ending June 30, 2016.

The auditors cited findings by the Tribune's investigative series "Suffering in Secret," which in late 2016 detailed deaths and mistreatment that occurred inside the group homes and day programs and found the public often was unaware of the tragedies because of secrecy and inaccurate reporting. Tribune reporters identified 1,311 cases of documented harm dating back to summer 2011 — hundreds more cases than the state had publicly reported. In response, state officials retracted erroneous reports and promised widespread reforms.

<http://www.chicagotribune.com/news/watchdog/ct-met-illinois-group-home-audit-20180719-story.html#>

The Auditor General's Report is available online: https://www.auditor.illinois.gov/Audit-Reports/Performance-Special-Multi/Performance-Audits/2018_Releases/18-CILA-Perf-Full.pdf

California

Temecula caregiver shot 3 developmentally disabled men before setting home on fire, coroner records show

Orange County Register - June 22, 2018

A drunken James Steven Jennex sent a text message to a friend apologizing in advance for his actions and then fired a bullet into the heads of each of three developmentally disabled men in his care before setting his Temecula-area home ablaze and killing himself with a .357 revolver blast to the head.

The fire, on Aug. 29, 2016, at the Renee Jennex Small Family Home, killed a fourth developmentally disabled man and burned all five people beyond recognition. Investigators pulled a gas can from the rubble.

Those facts, never before revealed by the Riverside County Sheriff's Department, were included in autopsy reports obtained from the Coroner's Office by this news organization through a Public Records Act request.

<https://www.ocregister.com/2018/06/22/coroner-records-temecula-caregiver-apologized-before-killing-4-developmentally-disabled-men-himself/>

Missouri

Lawsuit Claims Caregivers forced developmentally disabled Missouri man to fight to the death June 1, 2018

A developmentally disabled Missouri man was forced to fight another man for the "amusement" of people who ran the private care home where he lived and was left to die in a bathtub from injuries he suffered in the clash, his mother has alleged in a lawsuit.

Carl DeBrodie in a photo from a missing person's flyer. The body of the developmentally disabled Missouri man was found in a concrete-encased container in the Fulton area on April 24, 2017.

Carolyn Summers, the mother of Carl DeBrodie, 31, also alleges in the lawsuit filed Tuesday that government agencies responsible for her son didn't provide required care and didn't check on DeBrodie for months. DeBrodie's body was found in April 2017 encased in concrete in a container inside a storage area, months after he went missing.

https://www.stltoday.com/news/local/crime-and-courts/caregivers-forced-developmentally-disabled-missouri-man-to-fight-to-the/article_c2da602d-c3d1-5437-83bc-dbb8642f6ee6.html

January, 2018:

JOINT REPORT from U.S. Department of Health and Human Services' Office of Inspector General (OIG), Administration for Community Living (ACL), and Office for Civil Rights (OCR):

"Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight"

This report, released by three agencies operated by the U.S. Department of Health and Human Services, acknowledged the systemic shortcomings in protecting residents of HCBS waiver group homes from incidents of abuse and neglect. **OIG found that up to 99 percent of these critical incidents were not reported to the appropriate law enforcement or state agencies as required.** The report stated, "Group Home beneficiaries are at risk of serious harm. **OIG found that health and safety policies and procedures were not being followed. Failure to comply with these policies and procedures left group home beneficiaries at risk of serious harm. These are not isolated incidents but a systemic problem – 49 States had media reports of health and safety problems in group homes.**"

OIG highlighted the lack of reporting critical incidents of abuse and neglect in privately operated group homes, including "deaths, physical and sexual assaults, suicide attempts, unplanned hospitalizations, near drowning, missing persons, and serious injuries. Critical incidents requiring a minor level of review generally include suspected verbal or emotional abuse, theft, and property damage. For critical incidents that involve suspected

abuse or neglect, the HCBS waiver and State regulations also require mandated reporting.” It found that in the states under study, “the State agencies did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities.”

For more information on the Joint Report go to the ACL website at:

<https://www.acl.gov/aging-and-disability-in-america/joint-report-ensuring-beneficiary-health-and-safety-group-homes>

The report is available for download at:

<https://oig.hhs.gov/reports-and-publications/featured-topics/group-homes/group-homes-joint-report.pdf>

or:

<https://www.vor.net/images/stories/2017-2018/ACL-group-homes-joint-report.pdf>

Connecticut

Autistic Man's Abandonment In Hospital Emergency Room Is Tip Of Deepening Problem The Hartford Courant - January 1, 2018

A young man with autism and an intellectual disability was abandoned by his family in July and has languished at Manchester Hospital, with no medical diagnosis, for five months as the state’s disabilities agency maintained that there were legal barriers to taking him into state care.

The 21-year-old has behavior problems, and he has shuttled between a hospital room, the busy emergency room, and an area normally reserved for psychiatric patients, according to an advocacy group that has taken up his cause at the behest of a hospital staff deeply concerned that they are not equipped to care for him. After the first article was published, the man was placed into a group home. A week later, he was sent back to Manchester Hospital. The group home was not capable of dealing with his behavioral problems.

His presence in the emergency room is indicative of a statewide quandary, as hospitals have become the dumping ground for a growing number of profoundly disabled children and young adults. “Virtually every Connecticut hospital has recently dealt with or is presently dealing with one or more patients like this,” said Carl Schiessl of the Connecticut Hospital Association.

A series of four articles illustrate the problems encountered:

December 22, 2017: <http://www.courant.com/news/connecticut/hc-ct-news-disabled-man-languishes-manchester-hospital-1223-story.html>

December 26, 2017: <http://www.courant.com/news/connecticut/hc-news-disabled-man-languishes-manchester-hospital-folo-20171226-story.html>

December 27, 2017: <http://www.courant.com/news/connecticut/hc-news-manchester-autistic-man-back-emergency-room-1228-story.html>

January 1, 2018: <http://www.courant.com/news/connecticut/hc-news-autistic-man-abandonment-statewide-crisis-1229-story.html>

Maine

Federal Audit: DHHS Failed to Investigate Deaths, Suspected Abuse of Disabled Adults – Bangor Daily News - August 10, 2017

The Maine Department of Health and Human Services failed to investigate the deaths of all 133 people with developmental disabilities who died between January 2013 and June 2015 while under the care of community-

based providers across the state, and, as a result, failed to report suspicious deaths to law enforcement agencies to determine if crimes had been committed, according to a federal audit released Thursday, August 10, 2017.

Article from the Bangor Daily News: <http://bangordailynews.com/2017/08/10/mainefocus/federal-audit-dhhs-failed-to-investigate-deaths-suspected-abuse-of-disabled-adults/>

Inspector General's Audit: <https://oig.hhs.gov/oas/reports/region1/11600001.pdf>

Oklahoma

Company that Operates Oklahoma Group Homes for Children and Disabled Has History of Problems

News OK June 18, 2017

Deaths, as well as allegations of abuse and assault have emanated from group homes operated by Sequoyah Enterprise Inc., a private company that contracts with state agencies to care for some of Oklahoma's most vulnerable residents. Since 2011, two residents have died at Sequoyah's group home for disabled adults in Stillwater, sparking criminal charges and civil litigation. State agencies have terminated two group home contracts with the company in the past five years after a series of compliance issues. However, the Oklahoma Department of Human Services and the Office of Juvenile Affairs continue to contract with the company to operate group homes across the state. Sequoyah provides about \$6.1 million in contracted services annually to DHS.

Terry Lynn Brown, 44, died Jan. 4 at the hands of his roommate at Sequoyah's DHS-funded group home for disabled adults in Stillwater, a police report reveals. There was only one staff member inside the building the night group home resident Justin Taylor Bean, 23, allegedly strangled Brown, police said. Security cameras inside the building did not work — the lenses were smeared with Vaseline. Bean, a 6-foot-3-inch, 372-pound man, used a professional wrestling move known as a "sleeper hold" to strangle Brown, according to a police report. Employees told police that Bean had a history of violence against other residents and staff.

Terry Brown's mother, Joyce Brown, has filed a wrongful-death lawsuit against Sequoyah, claiming the company failed to adequately train its staff and provide enough supervision of the disabled adults living in the home. "The company has a repeated history of neglect of training, improper staffing and improper management," said her attorney, Greg Denney. "They have a poor business model that is causing people to die."

In September 2011, Samuel Johnson, a 21-year-old resident of Sequoyah's Stillwater home, drowned during an outing with other group home residents and staff to nearby Lake McMurry. Johnson had Fragile X syndrome, a genetic condition that causes a range of developmental disabilities. A plan that outlined Johnson's care needs for Sequoyah staff said he was required to wear a life jacket while swimming, according to documents from a lawsuit his family later filed against Sequoyah. "The staff did not have a life jacket for Samuel. The staff member who drove didn't even have a driver's license," Johnson's family claimed in the lawsuit. "The staff was reported to have been smoking marijuana and socializing with one staff member's boyfriend at the time they should have been supervising the residents."

Tracy Messineo, former director of human resources for Sequoyah Enterprises, filed a federal lawsuit against the company in 2015. In her lawsuit, Messineo claimed she was fired after she discovered the company did not require new hires to receive required DHS training and clear background checks before going to work with disabled adults. Some of the employees had to be terminated after their background checks later revealed criminal histories, the lawsuit claimed.

<http://m.newsok.com/article/5553139>

Virginia

Department of Justice Investigating Deaths of Former Central Virginia Training Center Residents April, 2017

Following three deaths, a U.S. Department of Justice investigation is underway into the decision to transfer Central

Virginia Training Center residents to another state facility, according to Secretary of Health and Human Resources William A. Hazel Jr.

Of six individuals transferred from CVTC to Hiram W. Davis Medical Center in Petersburg since October as part of a plan to address a nursing shortage and eventually close the Madison Heights facility, three have died, Hazel said in a phone interview Thursday.

The Department of Behavioral Health and Developmental Services transferred twins Tyler and Taylor Bryant to Hiram Davis on Jan. 17 despite their mother's insistence they remain at CVTC, where they had lived for 20 years. Tyler Bryant died March 16 at the age of 23 at Chippenham Hospital in Richmond.

At least one other patient also was transferred while her family protested.

DOJ, which has regularly overseen a settlement agreement with the state leading to the decision to close CVTC in 2020, has hired "three experts from out of state to come in to do the investigation," Hazel said.

"We do welcome that, and I think I can speak for Dr. [Jack] Barber and myself, they can't get here fast enough," Hazel said, referring to DBHDS Interim Commissioner Jack Barber. "... The reality is they appear to be gearing up for a full-scale investigation."

DOJ declined to comment Thursday in an email from a spokesperson.

Martha Bryant said she emailed DOJ in August after receiving a letter her sons would be transferred without her consent from CVTC, which serves people with severe developmental disabilities. While DOJ responded, an investigation at this point is reactive rather than proactive, she said. "It didn't protect anybody. It's after the fact," Bryant said in a phone interview Thursday.

Bryant questions the state's oversight of its medical centers and said her sons' medications were changed or "drastically reduced" upon their transfer. Taylor Bryant still resides at Hiram Davis.

http://www.newsadvance.com/news/local/departments-of-justice-investigating-deaths-of-former-cvtc-residents/article_7534fd32-1aff-11e7-8598-d32247b1a2ad.html

Illinois

Chicago Tribune series "[Suffering in Secret](#)" documents the State of Illinois' hiding information about abuse and neglect of adults with disabilities living in group homes (CILA's). November – December, 2016

This three-part series reveals the under-reporting of the actual number of incidents of abuse and neglect and suspicious deaths in Illinois by state and county officials, and how flawed investigations often covered up the details of these incidents. The series goes on to conclude that in the rush to close institutions, Illinois glossed over serious problems in group homes.

In a [follow up story](#), the Tribune reported that state lawmakers have proposed six new laws that would strengthen licensing requirements and oversight for thousands of group homes for adults with disabilities. The legislative measures, state officials said, are part of a continuing overhaul of the state's sprawling and fragmented group home system, which shelters more than 12,000 adults with intellectual and developmental disabilities.

One proposed bill seeks to expedite and alter the hiring process for new investigators at the inspector general office for Human Services. The bill would reclassify the job and allow Human Services administrators to more heavily weigh previous investigative experience rather than seniority in a state job. Another proposed bill would empower Human Services to extend the provisional period of a new group home license to two years from one. The extra period of time would allow Human Services' Bureau of Accreditation, Licensing and Certification more time to ensure that new group home businesses are providing necessary services to some of the state's most vulnerable adults.

1. <http://www.chicagotribune.com/news/watchdog/grouphomes/ct-group-home-investigations-cila-met-20161117-1.htmlstory.html>

Massachusetts

Department of Health and Human Services, Office of the Inspector General's Report:

[Massachusetts Did Not Comply with Federal and State Requirement for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries](#)¹

July, 2016

The Office of the Inspector General of the Department of Health and Human Services has been performing reviews in several States in response to a congressional request concerning the number of deaths and cases of abuse of developmentally disabled residents of group homes. This request was made in response to media coverage throughout the country on deaths of developmentally disabled individuals involving abuse, neglect, or medical errors.

The objective of this review was to determine whether the Massachusetts Executive Office of Health and Human Services, Office of Medicaid (State agency), complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries residing in group homes from January 2012 through June 2014.

The Office of the Inspector General reviewed 769 emergency room claims for 334 beneficiaries aged 18 through 59 who were residing in group homes. These beneficiaries had 587 hospital emergency room visits and were diagnosed with at least 1 of 149 conditions that we determined to be indicative of a high risk for suspected abuse or neglect.

The report found that Massachusetts' State agency did not comply with Federal waiver and State requirements for critical incidents involving developmentally disabled Medicaid beneficiaries. Specifically, the State agency did not ensure that:

- ³⁵₁₇ Group homes reported all critical incidents to DDS (**15 percent unreported**)
- ³⁵₁₇ DDS obtained and analyzed data on all critical incidents
- ³⁵₁₇ Appropriate action steps were identified in all incident reports that could prevent similar critical incidents (**29 percent unidentified**)
- ³⁵₁₇ DDS always reported all reasonable suspicions of abuse or neglect to DPPC (**58 percent unreported**)

The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents because group home staff did not always follow procedures for reporting critical incidents. In addition, the staff of DDS and group homes lacked adequate training to identify appropriate action steps for all reported critical incidents and to correctly identify and report reasonable suspicions of abuse or neglect. Furthermore, DDS did not have access to the relevant Medicaid claims data, and DDS policies and procedures did not establish clear definitions and examples of potential abuse or neglect that should be reported.^[SEP] The State agency did not adequately safeguard 146 out of 334 developmentally disabled Medicaid beneficiaries because the DDS system of reporting and monitoring critical incidents did not work as expected.^[SEP] In addition, we noted another issue that while outside the scope of our review is worthy of the State agency's attention. This issue involves the failure of hospital-based mandated reporters to report to DPPC all critical incidents with reasonable suspicion of abuse or neglect.

1. <https://oig.hhs.gov/oas/reports/region1/11400008.asp>

Connecticut

Department of Health and Human Services, Office of the Inspector General's Report:

[Connecticut Did Not Comply with Federal and State Requirement for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries](#)

May, 2016

A 2012 report issued by the Connecticut Office of Protection and Advocacy for Persons with Disabilities triggered an investigation of incident reporting of HCBS waiver beneficiaries residing in Connecticut group homes. The Inspector General of the Department of Health and Human Services conducted the audit, reviewing 347 emergency room claims for 245 beneficiaries aged 18 through 59 residing in group homes. They had 310 hospital emergency room visits and were diagnosed with at least 1 of 40 conditions that were similar to many of the causes of death identified in OPA's 2012 report.

The Office of the Inspector General's report found that Connecticut's State agency, the Department of Developmental Services, did not comply with Federal waiver and State requirements for critical incidents involving developmentally disabled Medicaid beneficiaries. Specifically, the State agency did not ensure that

- ³⁵₁₇ Group homes reported all critical incidents to DDS **(14 percent unreported)**
- ³⁵₁₇ DDS recorded all critical incidents reported by group homes **(22 percent unrecorded)**
- ³⁵₁₇ Group homes always reported incidents at the correct severity level **(57 percent incorrect)**
- ³⁵₁₇ DDS collected and reviewed all data on critical incidents
- ³⁵₁₇ DDS always reported reasonable suspicions of abuse or neglect **(99 percent unreported)**

The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents because staff at DDS and group homes lacked adequate training to correctly identify and report critical incidents and reasonable suspicions of abuse or neglect, DDS staff did not always follow procedures, DDS lacked access to Medicaid claims data, and DDS did not establish clear definitions and examples of potential abuse or neglect.

The State agency did not adequately safeguard 137 out of 245 developmentally disabled Medicaid beneficiaries because the DDS system of reporting and monitoring critical incidents did not work as expected.

In addition, the report noted several issues that while outside the scope of our review are worthy of further discussion and action. These issues involve:

- ³⁵₁₇ DDS's revision of its definition of "severe injury,"
- ³⁵₁₇ Hospital-based mandated reporters' failure to report to OPA all critical incidents, and
- ³⁵₁₇ Inadequate care contributing to the death of developmentally disabled Medicaid beneficiaries.

<https://oig.hhs.gov/oas/reports/region1/11400002.asp>

New Hampshire

History of Abuse causes closing of Lakeview Neurorehabilitation Center

[Corruption runs in the family at American Neurorehab Centers](#) [Reveal News Organization, November 4, 2015](#)

After years of reported abuse, violence, and sexual assaults, the Lakeview Neurorehabilitation Center in northern New Hampshire was finally closed.

State inspectors already knew a lot about Lakeview's problems. Since the mid-1990s, they had been warned about fraud, abused clients, falsified records, medical negligence and aggressive marketing to vulnerable parents. They

even knew about the suspicious death of one Lakeview client in 2012. But they did not crack down until a disability rights watchdog group published the details of that death in a 2014 report, which also detailed the systemic abuse of other clients.

New Hampshire Public Radio and Reveal found a history of not just mistreatment, but also violence, abuse and sexual assaults at Lakeview based on an extensive review that included six years of 911 call logs, hundreds of pages of reports from states and watchdogs, and interviews with dozens of former staff members, inspectors and families. That review also uncovered Lakeview's connections to a network of similar facilities across the country – and to owners who have evaded accountability for 40 years.

The Lakeview property originally was the vacation home of the Brennick family. In the late 1970s, the Brennicks converted the home – with its gorgeous view of lakes and mountains – into a neurological rehab center called Highwatch. The Brennicks had their roots in nursing homes – an industry plagued by corruption, fraud and abuse in the 1960s and '70s, when patriarch Charles Brennick ran a chain of a few dozen homes in New England called Medico.

Brennick's nursing home business went south in the mid-1970s, on the heels of a national scandal over poor care across the industry. He attempted to rescue Medico with an unorthodox strategy: He lugged suitcases full of cash to Las Vegas, sometimes \$1 million at a time, attempting to gamble his way out of bankruptcy.

The plan failed, but Brennick came out of a bankruptcy reorganization with a different tactic. He renamed his company, going from Medico to New Medico, and transformed his nursing homes into brain injury rehabilitation centers.

By capitalizing on a wave of brain injury survivors, thanks to developments in emergency medicine, Brennick built the nation's largest chain of rehab centers: more than three dozen New Medico centers across 15 states. Highwatch in New Hampshire was one of them. The facilities offered intensive physical therapy, speech therapy, job training and more, at a cost of about 10 times the amount nursing homes typically charged, according to Sue Bessette, a former nurse and independent investigator who helps prosecute nursing home fraud and abuse cases. The company reportedly grossed about \$350 million in 1989.

“If you looked at what they were offering ... it sounded like heaven. It was wonderful,” Bessette said.

But allegations of abuse, neglect, Medicaid fraud and unethical marketing practices spanned the nationwide New Medico chain. In 1992, Congress investigated the \$10 billion brain injury rehab business, with Brennick's company receiving the most scrutiny.

State investigators and whistleblowers detailed a complex profit-seeking strategy in a 1992 congressional hearing. New Medico sent marketers into intensive care units to recruit potential patients. The final congressional report called these recruiters “ambulance chasers in the classic sense.” New Medico's patients were kept as long as insurance companies would cover their care, then discharged, regardless of their recovery progress.

The company pushed families to send patients far from home, even when there was a New Medico center in their state. This out-of-state treatment allowed New Medico to bill Medicaid at higher rates, netting hundreds of dollars more per patient each day, according to the congressional investigation.

In 1991, for instance, 400 New York residents with brain injuries were being treated outside of New York, even though New Medico operated several facilities in the state. The out-of-state care cost New York millions. The NHPR/Reveal investigation found that this crisscrossing of patients between states would endure, becoming a hallmark of today's neurological rehab circuit.

<https://www.revealnews.org/article/corruption-runs-in-the-family-at-american-neurorehab-centers/>

New data indicates continued tragedy in the wake of deinstitutionalization The Voice, Spring 2015

On October 29, 2010, the State of Georgia and the Department of Justice (DOJ) entered a settlement agreement calling for the closure of all facilities serving people with developmental disabilities (ICFs/IID) and the deinstitutionalization of 9,000 people with mental illness. Since then, two DD facilities have closed; two remain open.

In 2013, tragic outcomes in community settings prompted a court-approved moratorium on community transfers from DD. Yet, for the second year in a row, [Georgia reports](#)¹ an alarming number of “unexpected deaths” in 2014, along with thousands of other “critical incidents” such as hospitalization, injuries and interaction with law enforcement.

According to the State’s Annual Quality Management Report, in 2014 there were 141 unexpected deaths. The report also indicates high rates of hospitalizations (1,327), incidents requiring law enforcement intervention (376), significant injuries (326), elopements (293), and alleged physical abuse (258) of individuals with disabilities in community settings. In each category incidents increased as compared to 2013, ranging from an increase of 5.8% (elopements) to 22.9% (allegations of physical abuse).

Although the State’s report combines data relating to individuals with mental health and those with developmental disabilities, critical incidents impacting individuals with developmental disabilities in community settings account for 70% of all incidents in 2014.

Georgia

Girl's death among 500 in one year in community care

By Tom Corwin and Sandy Hodson, The Augusta Chronicle, March 21, 2015

Months after her daughter died, LaTasha Gordon’s voice still shook with quiet fury as she talked about questions she still has about why her severely developmentally delayed child died in state-sponsored community care. “I want justice because I want to know what happened,” Gordon said. “Because they weren’t taking care of her the way they were supposed to.”

Christen Shermaine Hope Gordon was one of 500 patients in 2013 who died in community care while under the auspices of the Georgia Department of Behavioral Health and Developmental Disabilities. The 12-year-old was one of 82 classified as unexpected deaths, including 68 who, like her, were developmentally disabled. In 2014, an additional 498 patients who were receiving community care died, including 141 considered unexpected.

Despite her mother’s objections, Christen was also one of more than 499, as of January, moved from department facilities to community providers such as group homes under a 2010 settlement with the U.S. Justice Department over the conditions in the state hospitals. Christen is one of 62 of those transfers who have subsequently died.

<http://www.augustachronicle.com/news/health/2015-03-21/girls-death-among-500-one-year-community-care>

Georgia

A look at 'unexpected' deaths in community care homes

By Sandy Hodson, The Augusta Chronicle, March 21, 2015

¹http://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/document/2014%20Interim%20QM%20Report%20Final.pdf

(Pages 18-20)

The Augusta Chronicle requested the investigative reports of all 2013 deaths of developmentally disabled people living in community-based care homes. The reports were prepared by the state's Department of Behavioral Health and Developmental Disabilities. The following summaries are for those people whose deaths were categorized as unexpected. The deaths of three patients detailed in the series are not included. If family members objected, those summaries were excluded.

<http://www.augustachronicle.com/2016-05-27/stub-1072>

Texas

Failing Marci: A disabled woman's story of triumph and tragedy Fort Worth Star-Telegram, February 27 and March 1, 2015

Marci Garvin depended on the Medicaid Home and Community-Based Services (HCBS) system to receive necessary services and supports, but the same system and people who supported her may have contributed to her death.

Marci was long lauded as a shining example of what people with severe disabilities could achieve. She attended public school, went on outings, and had a job shredding paper at the Star-Telegram.

When Marci died in the spring of 2013, however, the 39-year-old's final months painted a far different picture. When she was hospitalized on March 9, 2013 – two full days before her death – nurses counted more than 20 major bedsores. She was covered in urine, feces and bugs. She weighed less than 60 pounds, almost half her normal weight. Oversight, which was supposed to come from the Mental Health Mental Retardation office of Tarrant County, which managed her community services, was lacking and, in recent years, virtually non-existent.

<http://www.star-telegram.com/news/local/community/fort-worth/article11365760.html>

<http://www.star-telegram.com/news/local/community/fort-worth/article11850362.html>

The Modern Asylum

New York Times Editorial

by Christine Montross, a staff psychiatrist at Butler Hospital in Providence, R.I February 18, 2015

Last month, three ethicists from the University of Pennsylvania argued in the *Journal of the American Medical Association* that the movement to deinstitutionalize the mentally ill has been a failure. Deinstitutionalization, they wrote, has in truth been “transinstitutionalization.” As a hospital psychiatrist, I see this every day.

A new model of long-term psychiatric institutionalization, as the Penn group suggests, would help them. However, I would go even further. We also need to rethink how we care for another group of vulnerable patients who have been just as disastrously disserved by policies meant to empower and protect them: the severely mentally disabled.

In the wake of deinstitutionalization, group homes for the mentally disabled were established to provide long-term housing while preserving community engagement. Rigorous regulations evolved to ensure patient safety and autonomy. However, many have backfired.

Group homes have undergone devastating budget cuts. Staffs are smaller, wages are lower, and workers are less skilled. Severe cognitive impairment can be accompanied by aggressive or self-injurious impulses. With fewer staff members to provide care, outbursts escalate. Group homes then have no choice but to send violent patients to the psychiatric hospital.

So institutionalization is already happening, but it is happening in a far less humane way than it could be.

Oklahoma

17 Deaths Raise Questions About Care Of Oklahoma Developmentally Disabled

Adwatch November 1, 2014

The deaths of 17 developmentally disabled people transferring or already transferred out of two large state-run institutions are raising questions about whether the closing of the centers put residents' health at risk.

The deaths occurred after the state decided in November 2012 to shutter the facilities in Enid and Pauls Valley over the objections of some of the residents' guardians and parents. Almost all of the nearly 230 adult residents were to move to small, privately owned "community homes," where services are offered by various providers.

State Sen. Patrick Anderson, R-Enid, said he wants to know whether the impending closure of the facilities and the residents' transition into community homes contributed to the deaths.

Anderson wrote a letter to Attorney General Scott Pruitt on Oct. 24, one day after the most recent death. He called for a review of the deaths, which occurred in 2013 and 2014. The residents began moving out of the Northern Oklahoma Resource Center of Enid, or NORCE, and the Southern Oklahoma Resource Center in Pauls Valley, or SORC, in March 2013.

Among those who died, seven were living at NORCE, two were living at SORC, and eight had transitioned into community homes.

By comparison, there were seven total deaths at NORCE and SORC in 2012, four in 2011 and one in 2010, at the Enid facility, state officials said. The deaths in 2013 and 2014 occurred as the population of residents and staffing levels were being reduced.

<http://m.newson6.com/story.aspx?story=27183441&catId=112042>

New York

Sex offenders in group homes, July 31, 2014

WHEC News (NBC)

Convicted sex offenders moved quickly into neighborhood group homes. A dozen sex offenders had been staying at the Monroe Developmental Center in Brighton until the state closed it down. News10NBC tracked seven of those sex offenders to two group homes in West Seneca with families living on the same street. News10NBC is learning how many times police have been called to those group homes since the sex offenders moved in. News10NBC discovered since the beginning of the year, police have been called to two group homes dozens of times. On two occasions, the calls were for sex offenders who had gone missing.

(The link to this article is no longer active, but there is a related article in 2019)

Georgia

[Mentally disabled suffer in moves from Georgia institutions: State unlikely to meet deadline from federal settlement](#), June 21, 2014

By Alan Judd, Atlanta Journal-Constitution

482 people have been deinstitutionalized since 2010. About three-fourths of the facilities have been cited for violating standards of care or investigated over patient deaths or abuse and neglect reports since 2010. Officials documented 76 reports of physical or psychological abuse, 48 of neglect, and 60 accidental injuries. In 93 other cases, group home residents allegedly assaulted one another, their caregivers or others. Forty people died after moving into group homes. At least 30 of those deaths had not been expected.

<http://alanjudd.wordpress.com/2014/07/10/mentally-disabled-suffer-in-moves-from-georgia-institutions/>

Wisconsin

Department of Human Services Statement of Deficiencies and Plan of Correction Watertown Police Department Incident Report May 9, 2014 and June 4, 2014

The Wisconsin Department of Human Services (DHS) rewarded an Intermediate Care Facility \$12,000 for each resident moved out of its Intermediate Care Facility to one of its group homes if the resident did not die within the first 6 months of being transferred.

Two residents did die.

Chuck died 3 days after his transfer after falling down the steps while strapped and seated in his wheelchair. The DHS investigated but no fine was issued. The only penalty for Chuck's death was to install a lock. See, <https://www.forwardhealth.wi.gov/prod/kw/dqa/CMTX11POCS.PDF>.

Another resident died of pneumonia about 2 weeks after being transferred. Because the death was deemed to be of natural causes, DHS did not investigate at all.

Georgia

Report: Developmentally disabled need better care, April 10, 2014 Georgia Health News

A U.S. Justice Department Settlement Agreement with the State of Georgia calls for the transfer of nearly 1,000 residents with intellectual and developmental disabilities (I/DD) and the closure of all state-operated ICFs/IID, and the transition of 9,000 individuals with mental illness from facility-based care. Hundreds of individuals have been transferred as a result of the October 2010 Settlement Agreement. An independent reviewer now reports that Georgia is failing to provide adequate supervision of individuals with developmental disabilities who are moved from state hospitals to community group homes. The reviewer, in a report dated March 23, says there is an "urgent need to ensure competent and sufficient health practitioner oversight of individuals who are medically fragile and require assistance with most aspects of their daily lives." The reviewer, Elizabeth Jones, notes in the report that two individuals with developmental disabilities died shortly after being moved from Southwestern State Hospital in Thomasville, which recently closed, to community settings. The report also points out that state officials terminated three providers of services for poor quality of care.

<http://www.georgiahealthnews.com/2014/04/report-sees-lax-supervision-developmentally-disabled/#sthash.ijdPgpcS.dpuf>

Related Georgia News: In February 2014, the Georgia Department of Behavioral Health & Developmental Disabilities Office of Quality Management released its [Annual Quality Management Report](#) finding that, in 2013, there were 82 unexpected deaths, 1,200 hospitalizations, 318 incidents requiring law enforcement services, 305 individuals who were expectantly absent from a community residential or day program, and 210 alleged instances physical abuse of mentally ill and developmentally disabled individuals.

<https://dbhdd.georgia.gov/documents/georgia-quality-management-system>

Tennessee

The Tennessean, February 27, 2014

State Fights back against abuse of disabled adults ([State Fights back against abuse of disabled adults \("Broken Trust" series\)](#))

by his caretaker, captured in disturbing cellphone video footage obtained by The Tennessean, is a rare occurrence, "something so egregious and so horrendous it bothers every one

of us to know it's occurred," the Department of Intellectual and Developmental Disabilities' chief attorney said Wednesday. Yet, problems have increased significantly among former residents of Tennessee's developmental centers.

National
U.S. Department of Justice's Bureau of Justice Statistics
U.S. Census Bureau's Crime Victimization Survey, February 25, 2014
Crime Odds Nearly Triple For Those With Disabilities

The U.S. Census Bureau's National Crime Victimization Survey found that there were 1.3 million nonfatal violent crimes against persons with disabilities in 2012, up from the roughly 1.1 million estimated for 2011, reported the U.S. Department of Justice's Bureau of Justice Statistics. The Survey asks about experiences with crime — whether reported or unreported to police — among those age 12 and older living in the community.

Individuals with disabilities encountered violent crime at nearly three times the rate of those in the general population, the report found. Simple assaults were the most commonly cited crime against this group followed by robbery, aggravated assault and rape or sexual assault.

Those with cognitive disabilities had the highest rate of victimization and about half of violent crime victims with disabilities had multiple conditions, the Bureau of Justice Statistics said.

<http://www.bjs.gov/content/pub/pdf/capd0912st.pdf>

Tennessee
The Tennessean, February 10, 2014
When people with intellectual disabilities leave facilities, results can fall short ([“Broken Trust” series](#))

An audit by the state comptroller last fall, and a federal court monitor's report tracking former residents of three of the state's institutions, found that troubling problems trail many of the state's formerly institutionalized residents. While the state saves millions of dollars each year by serving people outside institutions, officials at private agencies concede that a lack of adequate state funding has at times hampered their efforts to help people achieve the best quality of life. Identified problems include 257 reported allegations of abuse, neglect and exploitation; isolation; delays in doctor-recommended treatments in some cases and “numerous instances” of inadequate dental care; and a dramatic increase in deaths after people leave institutions (deaths among people with intellectual disabilities transferred from institutions nearly doubled between 2009 and 2013, from 19 to 34); incarceration; and missing former residents.

Georgia
Georgia Department of Behavioral Health & Developmental Disabilities, February 2014
Annual Quality Management Report for January 2013 – December 2013

Outcomes due to Settlement implementation, which requires the downsizing and closure of facilities for people with intellectual and developmental disabilities and mental illness, are troubling. According to the Georgia Department of Behavioral Health & Developmental Disabilities' "[Annual Quality Management Report](#)," January 2013 - December 2013, there have been 1,200 hospitalizations of individuals (mental health and developmental disabilities) residing in community residential programs; 344 individuals requiring treatment beyond first aid; 318 incidents requiring law enforcement services; 305 individuals who were expectantly absent from a community residential or day program; and 210 alleged physical abuse of an individual. A total of **82 unexpected deaths of individuals** with mental illness and developmental disabilities were reviewed

during 2013.

National

**Reader's Digest, February 2014 (reprinted from *Mother Jones*, May/June 2013)
Schizophrenic. Killer. My Cousin.**

It's insanity to kill your father with a kitchen knife. It's also insanity to close hospitals, fire therapists, and leave families to face mental illness on their own. "You can call the police," the deputy director of Sonoma County's National Alliance on Mental Illness (NAMI), David France, said when I asked him what options are available to a parent whose adult child appears to be having a mental breakdown. "The police can activate resources," like an emergency psych bed in a regular hospital, or transport and admission to a psychiatric hospital in a county that, unlike Sonoma, has one. But only if the police decide your child is a danger to himself or others can they arrest him with the right to hold him for three days—what in California is called a 5150, after the relevant section of state law. Otherwise you can be turned away for lack of space even if your loved one is willing to be admitted, or be left no good options if they're not. Ninety-two percent of the patients in California's state psych hospitals got there via the criminal-justice system. **Timeline:** [Deinstitutionalization And Its Consequences: How deinstitutionalization moved thousands of mentally ill people out of hospitals - and into jails and prisons.](#) **Map:** [Which States Have Cut Treatment For the Mentally Ill the Most?](#)

<http://www.motherjones.com/politics/2013/04/timeline-mental-health-america>

<http://www.motherjones.com/politics/2013/04/map-states-cut-treatment-for-mentally-ill>

California

The Press Democrat, February 22, 2014

Police: Embezzlement from disabled went on for years

For at least seven years, embezzlement suspect Larry Gene Sark forged signatures onto the backs of thousands of checks made out to developmentally disabled clients of the North Bay Regional Center, a case management agency which arrange for community-based services for people with developmental disabilities. He then deposited them (totaling more than \$400,000) into his personal bank account, according to a Santa Rosa police investigation. The money was taken from 51 Sonoma County residents.

California

Parent Hospital Association / Sonoma Developmental Center, February 20, 2014 More Information Needed on Level of Abuse and Neglect at Community Homes

Concern is growing among family members and advocates that the safety of those developmentally disabled folks still resident in California's state-run developmental centers is threatened -- not because of conditions at the centers but by the prospect losing the centers' protections when residents are moved into the community.

<http://blog.parenthospitalassociation.org/2014/02/more-information-needed-on-level-of.html>

California

Los Angeles Times, February 18, 2014

L.A. Suit Accuses Unlicensed Care Facilities of Abuse

Los Angeles City Atty. Mike Feuer has filed a lawsuit against the two unlicensed assisted-care facilities and their owners, a pastor and his wife, for allegedly abusing their physically and mentally disabled residents by forcing them to live in "deplorable, overcrowded and substandard living conditions" and taking the residents' government benefits." Among the allegations are: Swarms of flies filled the living areas. Broken furniture was

scattered, bedroom doors were missing and plaster was falling off the walls, according to court documents. Some residents slept in bunk beds crowded into small rooms with 1-inch pads instead of mattresses. One resident lived in a "storage room" and others in an attic.

<http://www.latimes.com/local/la-me-care-abuse-20140219-story.html>

Ohio

NewsChannel5 (Cleveland), November 8, 2013

Neglect and abuse of Ohio's disabled slips under the radar

According a *NewsChannel5* investigation, providers failed to conduct criminal background checks or consult an existing abuser registry that resulted in individuals with criminal and abusive records being hired, resulting in great risk and injury to the people they were left alone with. A state legislator is now calling for reform.

³⁵
¹⁷ **PART I: Ohio Department of Developmental Disabilities often fails to act, leaving disabled at risk**

The Ohio agency that oversees those with developmental disabilities often fails to act despite serious health and safety violations by service providers. More than 2,000 people with disabilities were victims of abuse last year - ranging from physical and sexual assaults to neglect – across Ohio. Among the findings were 76 cases involving sexual abuse, 373 involving physical abuse and 1,072 cases of neglect. All were found to be substantiated by the Ohio Department of Developmental Disabilities. Even so, service providers are rarely put out of business.

³⁵
¹⁷ **PART II: Hundreds of Ohio service providers for disabled repeatedly ignore health, safety regulations**

Hundreds of Ohio service providers for disabled repeatedly ignore health, safety regulations. Of 1,587 compliance reviews of service providers performed by the Ohio Department of Developmental Disabilities, 600 failed to follow state regulations.

³⁵
¹⁷ **PART III: Sexual abuse, neglect triggers increased scrutiny of service providers for Ohio's disabled**

As a result of the NewsChannel5 investigation, Ohio State Senator Mike Skindell is proposing new legislation that would require the Ohio Department of Developmental Disabilities to post inspection and compliance reports online.

<http://www.newsnet5.com/news/local-news/investigations/newschannel5-investigates-neglect-and-abuse-of-ohios-disabled-slips-under-the-radar#ixzz2lc8EMFSY>

Part 1: <http://www.newsnet5.com/news/local-news/investigations/ohio-agency-overseeing-developmentally-disabled-often-fails-to-act-leaving-disabled-at-risk>

Part 2: <http://www.newsnet5.com/news/local-news/investigations/hundreds-of-ohio-service-providers-for-disabled-repeatedly-ignore-health-safety-regulations>

Part 3: <http://www.newsnet5.com/news/local-news/investigations/sexual-abuse-neglect-triggers-increased-scrutiny-of-service-providers-for-ohios-disabled>

Illinois

WJBD News, October 1, 2013

Guardian of Wards of State At Murray Center Finds Large Number of Problems at Community Waiver Homes

In an affidavit, the guardian ad litem for the wards of the state at Murray Developmental Center is citing a laundry list of problems with the Community Integrated Living Arrangement or CILA waiver homes where some

of the wards have been moved on 'pre-transitional visits'. Stewart Freeman says he fears that severe abuse and maybe even a possible premature death could occur in the future if adequate oversight is not maintained. He said based on his inspections, he has concerns about the placement and welfare of his wards that are unable to communicate and have such severe disabilities that they are vulnerable to abuse or neglect. Freeman pointed to one case where a client was not given proper medications for seizures for three days and as a result had a seizure which resulted in a hospitalization. Freeman noted the client had not had a seizure for three years while housed at the Murray Developmental Center. In an affidavit, Freeman testifies that at least two of his clients should be immediately returned to Murray Center based upon their needs and the conditions in the CILAs. He said from what he has discovered to date, he does not have a high opinion of the CILAs and their ability to care for his medically fragile clients and clients with behavioral issues. Among the problems Freeman found were inadequate security, inadequate staffing with long day and hour shifts, lack of staffing experience, lack of supplies and home supports such as fire proofing, padding, and bedding, unsafe conditions such as exposed hazards, lack of knowledge as to client care, low pay, little training and little to no decoration or personalization for the residents. Freeman said two former employees of Rescare/CAIL come to his office to discuss their working conditions. Both described working at the facilities as chaotic. One of them, Rhonda Gibson, said scheduling was left to the last minute and at one point she worked 38 days straight; she produced pay stubs indicating that she had worked 140, 150 and even 180 hours over a two week period. The other former worker, Dylan Altom, indicated he had worked for 36 days straight. Freeman said Altom had been terminated from a prior care facility for individuals with developmental disabilities amid allegations that he had abused and currently faces a felony charge in connection with the earlier incident.

New Jersey

The Record, September 25, 2013

Arrest of disabled New Milford man sheds light on police dilemma

Recent decades have seen a movement away from institutionalization of the mentally and developmentally impaired, toward less restrictive — and less expensive — care. But this often places a burden on parents, particularly once their disabled children age out of juvenile services. In New Jersey, there are 28,000 adults who qualify for state developmental disability services. Caregivers often depend on the patience and familiarity of local police and community members, who can choose to handle small incidents discreetly; otherwise, their disabled adult children get swept into the justice system.

Walter Bartolomucci Jr., who has a mental disability, has been arrested many times, the most recent a few weeks ago. And what happened after that illustrates the challenges faced by authorities who increasingly must deal with developmentally disabled adults who run afoul of the law.

“It just puts a spotlight on the system,” New Milford Police Chief Frank Papapietro said. “What do we do with people with mental illness who commit criminal acts? Do they even know what they have done?” Roughly 15 percent of the Bergen County jail’s population — roughly 800 people, on any given day — has major mental illness. Authorities are aware of the problem, Hughes said, but policies and training for dealing with the developmentally disabled are hard to standardize across a county with nearly 70 police forces.

Services for developmentally and intellectually impaired adults over age 21 “are definitely in short supply,” said Rocco Mazza, communications director for Bergen County Human Services. “The state needs to take a look at how they can address that.”

http://cached.newslookup.com/cached.php?ref_id=218&siteid=2178&id=3223552&t=1380166893

California

NBC Bay Area (The Investigative Unit), June 4, 2013

Safety Measure Not Required in Thousands of Homes for Elderly, Disabled

The Investigative Unit uncovers thousands of California residential care facilities are not required to have

certain protections that fire officials say save lives in emergencies. Residents have died in such fires.

According to California law, residential care facilities with more than six residents must have a sprinkler system, but smaller facilities, with six or fewer residents, only need sprinklers if more than one person is deemed bedridden.

The Investigative Unit found the majority of adult residential care facilities and elderly residential care in California fall under this category, meaning thousands of vulnerable residents could be living in facilities without a sprinkler system. According to state records, as of Jan. 1, in the nine Bay Area counties (Santa Clara, San Mateo, Alameda, San Francisco, Contra Costa, Marin, Napa, Solano and Sonoma) 951 out of 1,080, or 88 percent, licensed adult residential care facilities and 1,516 out of 1,916, or 79 percent, licensed residential care facilities for the elderly have six or fewer residents.

“I feel like I was betrayed,” Connie Cruz, whose 24-year-old mentally disabled daughter, Monica Calderon died in the Mount Carmel Residential Care Facility fire, told NBC Bay Area.

<http://www.nbcbayarea.com/investigations/Safety-Measure-Not-Required-in-Thousands-of-Homes-for-Elderly-Disabled-210004611.html>

South Carolina

The Post and Courier, April 10, 2013

Study shows S.C. residential care facilities ‘unsafe and deplorable’

Four years after an initial study found many South Carolina community residential care facilities were dirty, infested with insects and filled with residents who were mistreated by staff, a follow-up report by a nonprofit group shows little has changed.

The first report, titled “No Place to Call Home,” was published in 2009. The follow-up report, “[Still ... No Place to Call Home](#)” was released Tuesday. Together, the reports demonstrate a “depressing lack of progress,” the study said. Some of the findings in the new study include:

*Dead bugs and roach feces; stained mattresses and furniture; inadequate food supplies; not enough medicine or medical equipment; lack of toiletries, including shampoo and toothpaste; and staff who yelled at residents.

http://www.postandcourier.com/archives/study-care-facilities-unsafe-deplorable/article_46646482-c789-5987-b0a0-21cb5100358e.html

Connecticut

Hartford Courant, March 3 – 5, 2013

[Tracking Abuse Among A Vulnerable Population Is A Difficult Task: Courant Investigates Deaths Of Disabled In State Care](#)

According to a *Hartford Courant* investigation, from 2004-2010, there have been 76 deaths of developmentally disabled individuals in Connecticut where investigators cited abuse, neglect, or medical errors. This equates to approximately 1 of every 17 people who died over that time period. Of this amount, 53 people or nearly 70 percent died during care at private group homes or other private facilities.

http://articles.courant.com/2013-03-03/news/hc-dds-nonfatal-0304-20130303_1_disabled-woman-group-home-disabled-man

Connecticut

Hartford Courant, March 4, 2013

Senator Urges Federal Probe Into Abuse, Neglect Of Developmentally Disabled

U.S. Sen. Chris Murphy is calling for a nationwide investigation into the "alarming number of deaths and cases of abuse" of developmentally disabled individuals at government-financed residential facilities.

Murphy [sent a letter to the inspector general](#) of the Department of Health and Human Services Monday, requesting an immediate investigation, with an emphasis on preventable deaths at privately run group homes.

"Privatization of care may mean lower costs but without the proper oversight and requirements for well-trained staff," Murphy wrote to Inspector General Daniel R. Levinson. "While individuals with developmental disabilities may not be able to speak for themselves, we are not absolved of the responsibility to care for them in a humane and fair manner."

<http://www.courant.com/news/connecticut/group-home-deaths/hcp-dds-murphy-reaction-0305-20130304-1,0,5600814.story>

National

Modern Healthcare Magazine, January 12, 2013

Safe at home: Feds. states take steps to prevent home-care crime

In Brunswick County, N.C., police charged former home health provider Lisa Veronica McGee McClain, 43, with stealing a 74-year-old patient's personal information. McClain, employed by a local home-care agency, allegedly removed \$260,000 from the patient's bank account between 2009 and 2011. She was arrested last year in Washington on a warrant for the thefts, but was erroneously released, leaving her still at large today, according to Brunswick County Sheriff's Office Detective Edward Carter.

As healthcare companies look toward aggressive growth in the most intimate of settings—patients' own homes—more Americans are asking how much they really know about the new home-care aide who walks through the front door.

The HHS' inspector general's office is studying the issue and will report later this year on how many home-health agencies employ workers with criminal backgrounds. An October report on such agencies found 92% employed at least one staffer with a criminal conviction.

The greater scrutiny of home-care worker backgrounds comes as the go-go home healthcare industry gears up for substantial growth in the coming decade. Home-care aide employment is expected to balloon by 70% between 2010 and 2020. The industry currently employs about 1.2 million people providing services to an estimated 8.6 million Americans per year, according to data from the Joint Commission and the Labor Department.

<http://vor.net/images/SafeAtHomeModernHealthcareJan2013.pdf>

National

Modern Healthcare Magazine, January 15, 2013

Scrutiny of community mental health centers is scant in fraud-prone states: federal report

According to a [U.S. Health and Human Services \(HHS\) Office of Inspector General Audit](#), nationally, 206 community mental health centers received \$219 million in 2010 to provide about 25,000 Medicare patients with intense outpatient health services designed to help beneficiaries trying to avoid psychiatric institutionalization. But past HHS inspector general work has found about half of the community-based providers had submitted "questionable" bills in 2010, two-thirds of which hailed from eight cities in Florida, Louisiana and Texas.

Despite years of warnings, the **private** contractors hired by the Government that monitor for problems in Medicare community mental health centers still aren't actively looking for problems in some the states most prone to fraud for those services, such as Louisiana and Texas, a new review of 2010 data by the U.S. Department of Health and Human Services' Office of Inspector General shows.

<http://vor.net/images/ScrutinyofMentalHealthCentersScantModernHealthcareJan2013.pdf>

Washington

The Seattle Times, December 18, 2012

Report: State ignoring abuse at group homes

A watchdog organization says the state is failing to protect some of Washington's most vulnerable people — those with developmental disabilities who live in group homes. Disability Rights Washington says overworked investigators focus on rule compliance, often overlooking the substance of complaints.

Of almost 3,000 abuse, neglect or safety-violation complaints filed in the past two years, more than 1,000 were closed by the Department of Social and Health Services (DSHS) without any investigation, according to DRW.

Even those cases that were opened often sat for weeks or months before an investigation began.

“What we found is an abuse-response system that is fatally flawed,” said David Carlson, DRW’s director of legal advocacy. “We need a safety net that keeps people safe. DSHS is not doing that.”

<http://www.seattletimes.com/seattle-news/report-state-ignoring-abuse-at-group-homes/>

Texas

Fox News, August 16, 2012

House Fire At Special Needs Group Home Kills Three

Arson investigators are on the scene of a house fire right now sifting through what’s left of a group home for special needs men. The San Antonio Fire Department says the fire started just before 11 pm. One person died inside the house and two others died at the hospital. There is one other person being treated at the hospital and they are in stable condition. Fire investigators say they don’t know how the fire started. Neighbors called in the fire after seeing flames coming from the home last night. Several residents were trapped in the home as the fire spread. There are reports that some of the residents were jumping from windows to save themselves. 13 mentally disabled adults were living at the home at the time.

Kentucky

Associated Press, July 22, 2012

Ex-group home employee sentence to 20 years

A former group home employee has been sentenced to 20 years in prison in the beating death of one of the home's residents. Tyler Brock, who is 22, pleaded guilty in June to second-degree manslaughter in the 2011 death of 35-year-old Shawn K. Akridge, a disabled resident at a group home. Judge Hunter Daugherty called the attack "heinous" and said it "defies explanation" on Friday before issuing the sentence.

Illinois

Belleville News-Democrat, June 27, 2012

Hidden suffering, hidden death: State agency won't investigate after 53 deaths of those in its care

The state agency created to prevent neglect and abuse of disabled adults who live at home rejects hundreds of hotline calls for help each year and doesn't investigate when people die after severe mistreatment. The Office of the Inspector General for the Illinois Department of Human Services received broad powers through legislation in 2000 that expanded its responsibility for protecting physically and mentally disabled people who live outside community facilities and state institutions. The OIG, which operates independently, investigates neglect and abuse complaints made to a statewide hotline operated by the agency. But when the subject of a hotline call is hospitalized and dies soon after, the OIG closes the case without investigating the circumstances surrounding the death because of the agency's interpretation of state law. According to OIG documents, the agency is prohibited from investigating the moment a death occurs. The OIG considers such an investigation a "service," and the dead are "ineligible for services" under the agency's interpretation of Rule 51 -- a legislative directive that governs the Adults with Disabilities Abuse Project, the OIG documents state. 53 cases since May 2003 that fit this pattern: Neglect or abuse of a critically ill, disabled adult in their home, followed by an ambulance ride to an emergency room and death, usually within a few days or weeks. In some cases, disabled, often critically ill people were starved, left to suffer in pain, denied medication or forced to lie for days in their own feces and urine. Some who died were unable to move when ambulance attendants found them.

<http://www.morrisherald-news.com/2012/06/27/hidden-suffering-hidden-death/azbkysa>

Connecticut

***Hartford Courant*, June 15, 2012**

State Investigating More Charges Against Group Homes Operator

An organization that receives about \$2 million per year in public funds to care for developmentally disabled people in several group homes in Hartford and Glastonbury is again under state review over allegations of poor care. In an unsigned letter to the executive director of Humanidad Inc. and to the state Department of Developmental Services, a group of Humanidad employees allege that staffing shortages are creating a dangerous situation, that the homes lack basic resources such as groceries and activity programs, and that clients in general are receiving subpar treatment.

http://articles.courant.com/2012-06-15/health/hc-humanidad-group-home-0616-20120615_1_humanidad-dds-abuse-or-neglect

Virginia

***The News & Advance*, June 11, 2012**

Investigator sees problems in private group homes

A Lynchburg-based investigator for the state Department of Social Services, testifying in a federal court hearing Friday, opened a window into the little-viewed world of what can happen inside Virginia's system of caring for people with disabilities. The investigator, Ted Campbell, said he has encountered incidents involving unexplained injuries to intellectually disabled people, caregivers who are fired and investigations cut short. Among the incidents Campbell described in testimony before U.S. District Court Judge John Gibney was one involving a woman who had moved from Central Virginia Training Center in Madison Heights into a privately operated home within the past few years. She left the training center in good health, but a couple months later was found to have a large bed sore that hadn't been cleaned. Investigators' attempts to follow up on the case ran into roadblocks. The incident is a single case involving just one of the 8,000 or more Virginians with intellectual disabilities who have left training centers over the past several years to receive care from other providers. A report from Adult Protective Services, a branch of the state Department of Social Services, indicated 1,200 residents were victims of abuse or neglect during fiscal year 2011 in privately operated nursing facilities, assisted-living facilities and other living places. That report did not specify which of those victims were former residents of Virginia's training centers.

http://www.newsadvance.com/news/local/investigator-sees-problems-in-private-group-homes/article_30ba6823-a1ef-5cd0-88b4-78e6f3e0031a.html

Virginia

WSLS-10 (NBC), May 23, 2012

Home caretaker charged with abusing disabled patient in Grayson County

Her title was in-home caretaker with Wall Residences, Inc. (a 10 year employee), but Melanie Melton was doing anything but her job, according to sheriff's officials. Court documents show she was indicted on charges of abuse against an incapacitated person and investigators highlight that the abuse was, "So gross, wanton, and culpable as to show a reckless disregard for human life." The person Melton was caring for was "dehydrated from improper feeding, and had unattended bed sores so bad they turned to gangrene," said Chief Deputy Mike Hash, with the Grayson County Sheriff's Department. The abuse is said to have happened between April 1 and April 25, at Melton's home in the Baywood Community of Grayson County. We went to her house to ask her about the charges, but no one answered the door. She turned herself into authorities more than a week ago after being indicted by the grand jury. The victim was treated at a nearby hospital and is said to be recovering.

Georgia

Atlanta Journal-Constitution, May 22, 2012 Lax enforcement in personal care homes

Deficiencies in care, living conditions and record-keeping have piled up in scores of Georgia personal care homes (35,000), with the state rarely shutting down violators or levying heavy fines (just 544 cases with an average fine of \$500), The Atlanta Journal-Constitution has found. An analysis of five years' worth of inspections found numerous troubling instances — from live cockroaches in the kitchen of one home to another in which eight residents were out of medication. Unlike nursing homes, personal care homes do not provide intensive medical care. Instead, they provide lodging, food, bathing and other grooming services, and can help residents manage their medications. Many are in individual homes in residential neighborhoods. Common problems included residents who were so frail or ill that they needed services beyond those provided by personal care homes. Other common issues were failure to document required employee training, failure to conduct regular fire drill evacuations, failure to obtain background checks on employees and inadequate staffing. But some cases were far more serious, leading to resident death.

<http://www.ajc.com/news/local/lax-enforcement-personal-care-homes/N1dDdFaq3dTGv4UsjxcLPM/>

New York

New York Times, May 8, 2012 Monitoring Care for the Disabled

The stories of abuse, suffering and unexplained deaths among those sent to homes for the disabled in New York State are horrifying. A worker sits on an autistic boy and crushes him to death. Another worker sexually abuses a 54-year-old disabled woman. A quadriplegic drowns as an aide leaves him in a tub of water. As reported in *The Times* over the last year, there have been numerous cases of abuse and at least 1,200 deaths attributed to unnatural or unknown causes in publicly financed homes for the disabled in the last decade. Many cases have barely been investigated, with incompetent workers often being moved to a different facility, without being prosecuted.

<http://www.nytimes.com/2012/05/08/opinion/monitoring-care-for-the-disabled.html>

http://www.nytimes.com/2011/11/06/nyregion/at-state-homes-simple-tasks-and-fatal-results.html?_r=1&pagewanted=all

Virginia

Virginia Attorney General's Office news release, May 7, 2012

Martinsville group home owner guilty in abuse, death of Parkinson's patient

Attorney General Ken Cuccinelli announced today that Richard C. Wagoner, Jr., was found guilty of abuse and neglect of an incapacitated adult that resulted in death. Wagoner owned and operated The Claye Corporation, a group home for adults in Martinsville. The victim, Joseph Tuggle, 57, an intellectually disabled adult suffering from Parkinson's disease who received care in a group home operated by The Claye Corporation, was placed under a faucet running scalding water and suffered second- and third-degree burns on his legs, face, buttocks, and arm. Ten days later, Mr. Tuggle was found dead in his bed with scabbed burns. The medical examiner determined that Tuggle died from sepsis and pneumonia secondary to thermal injury. His death was ruled as a direct result of the injuries he sustained on February 8, 2011. Caregivers failed to call 911 and, at Wagoner's orders, did not transport Tuggle to the hospital. "Not only did Wagoner fail to properly prevent conditions in which an incapacitated and helpless patient could suffer from such abject neglect and abuse, he also explicitly and deliberately deprived Mr. Tuggle of the care he needed to survive these injuries," said Virginia's Attorney General Ken Cuccinelli. "This kind of gruesome irresponsibility and depravity is despicable, and it's my hope that today's announcement will send a clear, stern message that this behavior simply will not be tolerated in Virginia." The case was investigated by the Martinsville Police Department and the attorney general's Health Care Fraud and Elder Abuse Section. The Elder Abuse section specializes in investigating allegations of abuse and neglect of incapacitated adults, employing both nurse investigators and criminal investigators to assist localities in determining the root cause of injuries and holding responsible persons accountable for their crimes.

Illinois

Associated Press, May 5, 2012

Verdict in Illinois Group Home Death Leaves Questions

The violent death of Paul McCann led to improvements in how Illinois intends to protect the mentally disabled in group homes, but the trial of the first man accused of killing him suggests to some that justice and equality are still a challenge for them. Jurors trying the case of caretaker Keyun Newble, 26, charged with killing McCann at an eastern Illinois group home, heard about the brutal injuries the 42-year-old suffered. He had 13 broken ribs and lungs filled with fluid, part of what a doctor called "massive internal injuries" suffered as apparent punishment for stealing cookies. Newble was charged with murder, which would have sent him to prison for at least 20 years. But the judge allowed the option of a lesser charge, involuntary manslaughter, and the jurors took it, making him eligible for a sentence as short as three years. For advocates of the disabled, the April 27 verdict was insulting. McCann's family reacted with confusion. Both are trying to make sense of the verdict's message just as officials are trying to better safeguard the lives of disabled people who need care from the state. Gov. Pat Quinn has made it a priority to close institutions for disabled people like McCann and transfer them into situations closer to their families, such as in group homes. But the effort has drawn criticism from some affected families.

Massachusetts

COFAR Blog, May 4, 2012

Commonwealth's DPPC faults care plan in group home resident's death

A state investigative agency (the Disabled Persons Protection Commission) has concluded that a Tyngsborough group home resident died last year as a result of having ingested an inedible object, and that there was sufficient evidence to conclude that his death was due to a lack of adequate supervision by caregivers. The 50-year-old man, who had formerly lived at the Fernald Developmental Center, had reportedly ingested a plastic bag. The July 6 death of the resident is **one of three cases of death involving former developmental center residents**, all men in their 50s. In both of the sudden death incidents, the men had been transferred to state-operated group homes operated by Northeast Residential Services, a division of the Department of Developmental Services. DDS has refused to discuss or provide any information about these deaths, citing confidentiality and privacy regulations. In a third case, a 51-year-old resident of a Northeast Residential Services home died on February 7, 2012 after having been sent back to his residence twice by Lowell General Hospital. That man had formerly lived at the Fernald Center as well.

<https://cofarblog.wordpress.com/2012/05/04/dppc-faults-care-plan-in-group-home-residents-death>

Texas

Dallas Morning News, May 4, 2012

Group homes need city standards in Dallas

City Councilmen are considering reforms to improve the quality of life of individuals in group home care. Calls for finally moving beyond the status quo of just regulating zoning and building code violations and do something to ensure that these vulnerable citizens have a decent place to live are being debated. Council members discussed how poorly run group homes are one of the worst problems in their districts, noting that some operators in southern Dallas are in “the business of housing,” that is, caring more about making money off needy residents than in providing services. Other council members and Mayor Mike Rawlings also seem to understand that the city can no longer ignore the mediocre care, crowded sleeping quarters and shoddy facilities that characterize some of the 300-plus group homes in Dallas. City staffers, however, appear to be resisting the ordinance. As things stand, too many group home residents here lack access to decent services, live in facilities where operators take their money and give them little to live on, and confront drugs or violence in their quarters. These residents are the ones who too often are wandering the streets, panhandling and sometimes becoming a menace to themselves and others.

Louisiana

Advocacy Center, March 20, 2012

Investigation Reveals Serious Neglect at Group Homes Across State

The Advocacy Center has released the results of a three year investigation into conditions at group homes for people with intellectual and developmental disabilities across the state. The report, “When A House Is Not A Home: An investigation into conditions, care, and treatment in select group homes for people with intellectual disabilities in Louisiana,” reveals that residents in the surveyed group homes live in dismal, unsanitary surroundings, they learn very little and have limited exposure to the community. These residents experience problems with receiving appropriate and timely health care, they face poor transportation opportunities, are provided with unhealthy and unappetizing meals and generally lead a life filled with meaningless daytime activities and no chance of employment. According to Lois Simpson, Advocacy Center Executive Director, “Thirty years ago, when group homes for people with disabilities, were first conceptualized, they were supposed to be family-like, comfortable environments where people with disabilities could live and be a part of the greater community. Instead, many of these homes exist as isolated, poorly maintained, inadequately staffed, and unsafe environments where people merely exist.”

California

5 Killed in California Home Care Facility Fire

Associated Press November 6, 2011

A late night fire at a California home care facility for the disabled killed five people; staff escaped unharmed. Four bodies were found shortly after the fire, and a fifth body was found by investigators Sunday morning. The cause of the fire has not been determined, but investigators with the federal Bureau of Alcohol, Tobacco, Firearms and Explosives are investigating. Records with the California Department of Social Services show the home was licensed with the state and was operating under the name of the Mt. Carmel Adult Residential Facility, a single family group home.

<http://www.foxnews.com/us/2011/11/06/4-dead-in-california-home-care-facility-fire.html>

New York

1,200 Deaths and Few Answers The New York Times November 6, 2011

As part of the Times' *Used and Abused* series, "1,200 Deaths and Few Answers," exposes 1,200 preventable mortalities in state-run group homes over a period of 10 years. Deaths are attributed to no statewide system of staff training and oversight to prevent reoccurring tragedies such as choking, drowning in bathtubs, wandering, and falling. It is remarkable that these deaths, averaging more than 100 a year, occurred during a period of significant deinstitutionalization in New York, and occurred without raising any apparent concern or investigation by P&A or DOJ, which is charged to protect and advocate for these vulnerable citizens. The apparent apathy could speak to P&A and DOJ's bias in favor of community settings, no matter the outcome.

<http://www.nytimes.com/2011/11/06/nyregion/at-state-homes-simple-tasks-and-fatal-results.html>

Washington State
Resident dies after transfer Kitsap Sun
October 17, 2011

A 30-year-old former resident of the Frances Haddon Morgan Center, an ICF/MR, died Sunday after swallowing liquid laundry detergent, state officials confirmed Monday. He had transferred from the center in March. The Morgan Center, a home for patients with autism and other disabilities, is in the process of closing as part of state budget cuts. The center is scheduled for closure by the end of the year, with residents expected to be out by the end of November.

DSHS Secretary Susan Dreyfus, speaking Monday during a meeting of a task force on programs for the developmentally disabled, said the man suffered pica, from a disorder under which he experienced compulsions to ingest almost anything. "I have ordered a thorough investigation. ... Tragic as this is, I wish I could say it won't happen again," Dreyfus told the task force by phone from Washington, D.C. "But that would not be truthful on my part."

Virginia
2nd Bedford Co. bus attack lawsuit video shows child sprayed with aerosol Richmond Times-Dispatch
October 6, 2011

A new video claims to show a second instance where a 11-year-old boy with autism was physically abused by former Bedford County Schools employees. A first instance of similar abuse led to a \$20 million lawsuit filed against Bedford County Schools and two former employees. The lawsuit claims that in September of 2009, a Bedford County bus driver and special needs adult aide, repeatedly hit and abused 11-year-old Timothy Kilpatrick. The initial report included surveillance video from a Bedford County school bus given to the Times-Dispatch by the attorney representing the Kilpatrick family, Brent Brown. That video appears to show one adult woman repeatedly hitting Kilpatrick with a flyswatter, then later with her fists. It also shows a second adult woman walk back from the front of the bus, and smack Kilpatrick hard on the head and across the face.

http://www.richmond.com/news/article_cd90aa59-272a-54d2-99c7-5847018bd1f3.html

Pennsylvania
Police find four adults chained in Northeast Philadelphia apartment Philadelphia Inquirer
October 16, 2011

Three people were arrested and charged with kidnapping, assault and other crimes after Philadelphia police found four adults with intellectual disabilities shackled in "deplorable conditions" in a basement storage closet of a Northeast apartment building recently. The three men and a woman were found by a janitor chained to a water heater, in a 15-by-15-foot room, locked behind a steel door. All were malnourished, said Officer Tanya Little, a police spokeswoman. They were in stable condition, Little said, though they suffered from malnutrition. "The conditions they were living in were deplorable," she said. "It was not good." Investigators are looking into the possibility that the captors were part of a national ring that preyed on disabled individuals for the purpose of

collecting social security checks. The Philadelphia discovery speaks to the lack of overall oversight of the community system. These individuals were held captive in an apartment building's basement, with children riding their bikes and pedestrians on the street above. [Editor's note: Community integration?]

<http://www.foxnews.com/us/2011/10/19/police-investigating-philadelphia-dungeon-rescue-10-others-including-children.html>

Utah

**Teen attacked at group home ABC 4 News
September 21, 2011**

A sixteen-year old was brutally attacked at a place his mother thought was safe. The teen was severely beaten by another patient at a group home in late August. "It was more like an animal attack rather than what a human would do," said Stacie Pitcher, mother of Brock, the teen attacked. She said she didn't know the older patient – a 200 pound 22 year old – who also suffers from extreme autism was so violent. State regulations require round the clock supervision at these group homes. However, the attack on Brock was in the living room in plain sight when the employee finally appeared. Police are investigating and will not say whether the employee is the focus of their case. "That could be part of the investigation," said Sgt. Drew Sanders. "I can't comment as to whether it is or not."

Massachusetts

**Mentally challenged men die after transfer to group homes Telegram
& Gazette
Saturday, August 13, 2011**

An advocacy group for the developmentally challenged says the death of a 54-year-old man, less than a week after he was transferred from the state-run Templeton Developmental Center, bolsters their argument to keep state facilities open. David Kassel, spokesman for the nonprofit Massachusetts Coalition of Families and Advocates Inc., said he has been in contact with the deceased man's guardian, who is concerned about a possible medication error leading to his death after he was transferred to a state-operated group home in Tewksbury run by Northeast Residential Services. The man died of a blood clot to his lung four days after he was transferred, Mr. Kassel said. The man had lived for years at the Templeton Developmental Center. He had been in excellent health prior to his transfer, according to a letter of concern from state Sen. Stephen M. Brewer, D-Barre, to the state Department of Developmental Services. DDS, citing confidentiality and privacy regulations, declined to provide information about the former Templeton resident's case to Mr. Kassel, who said his organization obtained information about the death from its sources and the examiner's office. In another case that Mr. Kassel said brought into question the quality of group-home care, a man who had lived most of his life at the Fernald Developmental Center in Waltham died last month of aspiration pneumonia after swallowing a plastic shopping bag at the group home in which he had been living for about a year. Mr. Kassel said he obtained information about the man's death through the Disabled Persons Protection Commission and the man's death certificate. "These people have lived most of their lives at the developmental centers," Mr. Kassel said of the former Templeton and Fernald residents. "They died within a relatively short period of time after having been transferred to group homes. In each case, we have some questions about the level of supervision that they received in the group homes — whether that might have contributed to their deaths." The state plans to close the Templeton, Fernald and Monson development centers and the Glavin Regional Center in Shrewsbury by the end of fiscal 2013.

<http://www.telegram.com/article/20110813/NEWS/108139970>

Illinois

**More abuse, neglect reported in Ill. group homes
Associated Press May 20, 2011**

Across Illinois last year, more than 130 cases of abuse and neglect were investigated and confirmed in group homes for adults, a 33 percent increase compared to 2006, according to government documents obtained by *The Associated Press*. The reports of mistreatment and outright cruelty at the hands of low-wage workers with scant supervision, illustrate a mostly overlooked problem in Illinois.

<http://www.deseretnews.com/article/700137118/More-abuse-neglect-reported-in-Ill-group-homes.html>

Florida
Neglected to Death The Miami Herald
April 30 – May 4, 2011

Created more than a quarter-century ago, Florida's Assisted Living Facilities were established in landmark legislation to provide shelter and sweeping protections to some of the state's most vulnerable citizens: the elderly, mentally ill, and people with intellectual disabilities. But a Miami Herald investigation found that the safeguards once hailed as the most progressive in the nation have been ignored in a string of tragedies never before revealed to the public. A string of deaths highlight critical breakdowns in a state enforcement system that has left thousands of people to fend for themselves in dangerous and decrepit conditions. The Miami Herald's investigation found that the Agency for Health Care Administration, which oversees the state's 2,850 assisted-living facilities, has failed to monitor shoddy operators, investigate dangerous practices or shut down the worst offenders. Time and again, the agency was alerted by police and its own inspectors to caretakers depriving residents of the most basic needs — food, water and protection — but didn't take action. "It's a cheap, easy, unregulated system of care," said Miami-Dade Mental Health Court Judge Steve Leifman

The full series, plus video coverage explaining the investigation and featuring interviews with families, victims and state officials, can be found here: http://www.miamiherald.com/neglected_to_death/.
See also,

NEGLECTED TO DEATH | Part 1: Once pride of Florida; now scenes of neglect
<http://www.miamiherald.com/2011/04/30/v-print/2194842/once-pride-of-florida-now-scenes.html#ixzz1LW5aFDpd>

NEGLECTED TO DEATH | Part 2: Assisted-living facility caretakers unpunished: 'There's a lack of justice' <http://www.miamiherald.com/2011/05/03/v-print/2199740/assisted-living-facility-caretakers.html>

NEGLECTED TO DEATH | Part 3: At homes for the mentally ill, a sweeping breakdown in care
<http://www.miamiherald.com/2011/05/04/2201715/at-homes-for-the-mentally-ill.html - ixzz1LW6isfi1>

Missouri
Empty Promises: Lack of Community Oversight Persists,
People with Intellectual and Developmental Disabilities Remain at Risk
VOR April 15, 2011

In 2009, the Missouri Department of Mental Health (DMH) reported that 8% of clients who *voluntarily* moved from habilitation centers (licensed ICFs/MR) to community settings were ultimately returned to habilitation centers because community placement was found unsuitable; and thirty-two people who live in community settings were admitted to the habilitation center for short term stays. Furthermore, a review of recent DMH inspection records of community providers and other quality indicators suggests severe problems with quality and safety in these settings. Information we found revealed the following:

- According to DMH safety reports in 2009 the average age at death of individuals in community placement was 46; for individuals in habilitation centers it was 55.
- DMH certification reports reveal that 373 community provider staff did not meet minimum training

requirements for medication administration, First Aide, CPR, or training for complex medical needs or behaviors from 2008-2010.

- DMH reported over 5,000 medication errors, 5 of them causing hospitalization, permanent harm, or death in private community settings in 2009.
- Community providers still violate minimum safety standards with impunity – according to DMH only two have had certification revoked in the last five years.
- Only 27 full time employees are responsible for investigating abuse, neglect, and misuse of funds for over 62,000 people receiving services under the Department of Mental Health. Budgetary pressures make it unlikely there will be more resources for investigations, Even as the number of people being served continues to grow.

ON THE WEB: “Empty Promises”

<http://vor.net/images/EmptyPromises.pdf>

Oregon

The Oregonian

Oregon's safety net for vulnerable elderly in long-term care riddled with holes

March 26, 2011

[Editor’s note: Oregon closed all its Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR) settings in 2010].

The vast majority of people suspected of sexually attacking residents in one of the state's 2,300 nursing homes, assisted-living centers or other long-term care facilities are never arrested or prosecuted. What's more, the state rarely penalizes facilities. Since 2005, state workers in charge of monitoring the safety of the elderly and disabled received at least 350 reports of possible sexual abuse, ranging from unwanted kissing to rape. An investigation by The Oregonian found that workers with the Oregon Department of Human Services determined that about 80 percent of those reports were unprovable. Commonly, DHS investigators concluded that the alleged victims were unreliable witnesses because they had dementia or were heavily medicated. The newspaper's review revealed a public safety net riddled with holes, starting with the failure of some long-term-care facilities to keep vulnerable residents safe from their attackers. The review also found the DHS' investigation and enforcement lacking at times.

http://www.oregonlive.com/news/index.ssf/2011/03/oregons_safety_net_for_vulnera.html

Illinois

CBS Channel 2 – Chicago

State Ignored Evidence Vs. Group Home Before Resident’s Death

March 21, 2011

State records also reveal regulators knew Graywood’s substantiated abuse rate was double the state average, yet DHS failed to close it down. Two men died in 3 years, and since 2003, there have been 33 substantiated cases of resident abuse. The provider in question ran a multimillion dollar operation under contract with the state; a contract that continued even with the rate of death and abuse.

<http://chicago.cbslocal.com/2011/03/21/state-ignored-evidence-vs-group-home-before-residents-death/>

New York Times

At State-Run Homes, Abuse and Impunity

March 12, 2011

40 years after New York emptied its scandal-ridden warehouses for the developmentally disabled, the far-flung network of small group homes that replaced them operates with scant oversight and few consequences for employees who abuse the vulnerable population. A New York Times investigation over the past year has found widespread problems in the more than 2,000 state-run homes. In hundreds of cases reviewed by The Times, employees who sexually abused, beat or taunted residents were rarely fired, even after repeated offenses, and in many cases, were simply transferred to other group homes run by the state.

<http://www.nytimes.com/2011/03/13/nyregion/13homes.html>

Illinois

Chicago Tribune, January 30, 2011

Disabled Joliet man beaten to death in group home, authorities say

A group home in Illinois, Graywood Foundation, is being investigated for two homicides in three years at the hands of group home employees. In one case, a resident with developmental disabilities was beaten and kicked to death. In early February, two other Graywood employees go on trial for the 2008 murder of another Graywood resident.

Michigan

The Detroit News, January 10, 2011

Repeated violations found at Oakland County group homes

A state agency has found repeated legal violations, health and safety problems and mistreatment of residents since 2008 at four Oakland County group homes for people with mental disabilities. Problems at the group homes were documented in special investigative reports by the Michigan Department of Human Services' Bureau of Children and Adult Licensing. Problems cited included lax supervision of residents, failure to provide proper medications and medical services and lack of proper cleaning and upkeep. In one instance, the state found, a resident drank Windex and was treated at a hospital in August 2008. In another, a staff member did not perform CPR or call 911 after a patient suffered a seizure; the resident later died. According to state records, a male worker was fired after sexually assaulting two female residents in September 2009. In another instance, a resident repeatedly left the home and burglarized neighbors' houses. In another instance, residents got two doses of the same medicines after a staffer failed to initial a drug log. In another case, records showed two residents repeatedly missed medical appointments. A former supervisor has filed a lawsuit alleging that she was fired after questioning residents' care and conditions at the home. Under state law, a group home license can only be revoked after showing the violations were "willful and substantial." The license of the four Oakland County group homes remain in effect.

California

Pasadena Star-News, January 7, 2011

At least two suspected of sex assaults on disabled identified

More than 100 hours of video footage, which was dropped off at Sheriff's Headquarters Bureau in Monterey Park in March, show what appear to be 10 female patients at residential care facilities being raped. At least one of the suspects was believed to be an employee of a residential care facility and another of the suspects appeared to be a patient. All of the victims appear to be severely disabled. One of the suspects also appears to have been disabled because he used a wheelchair. The attacks involved force with no consent from the disabled victims.

Indiana

Associated Press, October 27, 2010

Parents told to drop disabled kids at shelters; State budget cuts have left families with few affordable care options

10,000 Indianans with developmental disabilities are waiting for home and community-based services, some for more than 10 years. Additional budget cuts are predicted. To accommodate employment, parents of adults with developmental disabilities seek services during the day for their family member. They are told to utilize homeless shelters. All this in a state where the Arc of Indiana brags it is the "largest state without state institutions for people with developmental disabilities."

http://www.nbcnews.com/id/39879832/ns/us_news-life/t/ind-parents-told-drop-disabled-kids-shelters/

Nebraska

Associated Press, July 11, 2010

After moves and deaths at BSDC, no lessons learned

18 months ago the State of Nebraska moved 47 "medically fragile" residents from Beatrice State Developmental Center with virtually no warning and no plan. Since then 12 of these residents have died. Medical reviews that could have shed light on potential dangers of moving developmentally disabled people from a state institution haven't been conducted as state officials said they would. And a committee has been slow to review the deaths of some of those patients as required by the federal government. All told, state officials -- including Nebraska's chief medical officer -- say they haven't learned anything from what death rates, experts, and parents of developmentally disabled people who have died indicate was a disastrous decision. "I don't know if there's anything I've learned from that particularly," Dr. Joann Schaefer, the state's chief medical officer, said recently of moving 47 people from the center in 2009. The lack of lessons-learned exists at the same time officials continue to urge people with severe mental retardation to leave BSDC.

http://journalstar.com/news/state-and-regional/nebraska/after-moves-and-deaths-at-bsdc-no-lessons-learned/article_b9982a9e-8d3f-11df-a554-001cc4c03286.html

New Mexico

Albuquerque Journal, February 23, 2010

Judge Slashes Rape Damages Award; calls ResCare's conduct "reckless," but not intentional or malicious

Larry Selk, who cannot speak or perform daily functions on his own, was raped in 2004 while living in College House, a group home operated by a ResCare's subsidiary in Roswell, NM. The likely perpetrator was a group home employee who had been hastily hired after much of the College House staff was fired for using drugs and there was an urgent need for replacement staff. The man was hired with virtually no background check, which could have discovered problems in his past, and put on the job essentially untrained, according to trial evidence. A lawsuit was brought on Selk's behalf by his sister and legal guardian, Rani Rubio, resulted in a jury award of \$48 million in punitive damages. ResCare appealed, resulting in the judge slicing away a significant chunk of a jury's historically high punitive damages award. The punitive damages award was reduced from \$48 million to \$9.6 million in an order that also denied the company, ResCare Inc., a new trial. Second Judicial District Judge Nan Nash found that the punitive damage award was "unreasonable." "While (ResCare's) conduct was reckless, it was not intentional or malicious," Nash wrote in an order filed Friday. Nash left intact the compensatory damages — nearly \$1.5 million against ResCare New Mexico and \$3.2 million against

ResCare Inc.

Oklahoma

Tulsa World and Oklahoman, February 21 and 22, 2010

Residential care sites plagued by violations

Within three years, the Oklahoma State Department of Health found more than 830 violations in at least 70 small, unlicensed, residential care group homes for people with mental retardation, mental illness and the elderly, according to a joint investigation by the *Tulsa World* and *The Oklahoman*. Violations include 30 cases of inappropriate medical care and 24 cases of client abuse or neglect, four involving the death of a resident. From late 2006 to early 2009, inspectors documented residents who were covered in feces, stolen from, threatened with knives or left to sleep on dirty mattresses. Some were supervised by felons. Others lived in buildings infested with ants, cockroaches and mice. At least two people allegedly were raped.

http://www.tulsaworld.com/news/local/residential-care-sites-plagued-by-violations/article_4dc031c3-408d-5326-8e3d-bd3f43d75258.html

Wisconsin

Kenosha News, January 4, 2010

Woman found chained in home; Mother, brother charged in case

Authorities found an emaciated 38-year-old woman, half-naked and shivering on a urine-soaked blanket, chained to a weight bench, covered in feces and unable to communicate or use her legs, according to charges filed Monday against her mother and brother. The mentally disabled woman, who reportedly has the mind of a 5-year-old but had once lived normally, weighed 60 to 70 pounds when she was found. When rescuers cut the chain around her left ankle, authorities said the woman could not straighten her legs or walk.

Nebraska

Nebraska Radio Network, November 18, 2009

Former Beatrice State Developmental Center resident dies

Brady Kruse, a 35 year old former resident of the Beatrice State Developmental Center has died. Brady was one of the 47 “medically fragile” residents who were moved from the center last February. He had resided at Beatrice for 33 years before he was moved. He is the 10th death of those deemed “medically fragile”; that’s nearly 22%.

Massachusetts

I-Team WBZ (Boston), November 13, 2009

Was Disabled Man Abused At Group Home?

Several state agencies and the Middlesex District Attorney's office are investigating disturbing allegations of abuse and neglect at a group home. Danny Butler was found with bruises all over his body, black eyes and broken bones while in the care of a group home licensed by the state. But what happened and who's responsible are still unanswered questions that haunt Danny Butler's family. The 61-year old was living at a group home in Dracut, a home managed by the Mental Health Association of Greater Lowell and licensed by the former Department of Mental Retardation. On July 23rd, Danny was rushed to Lowell General Hospital because he was in respiratory distress. Dracut Police weren't notified about Daniel Butler's injuries until he began having difficulty breathing and ended up in the hospital. That's when doctors and family members discovered all of the

bruises and broken bones and called police. Medical records show Danny Butler had multiple bruises, facial injuries, emotional trauma and possible sexual abuse. Nancy Alterio, the head of the Disabled Persons Protection Commission says her agency had four allegations of abuse with this one victim. One major problem with this investigation is that Danny Butler has been silenced by the trauma. Ed Butler says right now Danny can't communicate beyond yes or no, and as soon as the sun goes down he gets agitated and restless and he's very afraid. Nancy Alterio said a lot of things can make it difficult to prove a case. When you don't have forensic evidence or testimony from victims or witnesses it's difficult to determine what actually did or didn't happen.

Illinois

Howe Transfers Lead to Higher Mortality Rate

October 31, 2009

According to the Department of Human Services Howe Transitions Status Report (which covers 7/1/07 - 10/31/09), of the 89 former Howe residents who have transferred to the community, 7 have died (7.87%), a figure that is 46% higher than the number of Howe residents who have died.

Washington, D.C.

Washington Post, October 8, 2009

District Suspends Referrals To Nonprofit's Group Homes; City Took Agency to Court This Week Over Safety Concerns

The District is halting new referrals to all group homes operated by a nonprofit organization that the city took to court this week over health and safety concerns at two of its homes for the mentally disabled. The nonprofit organization, Individual Development Inc., operates 11 facilities in the District. The city's latest move is a sign that its concerns go beyond the two homes that the city has petitioned to be taken over by a court-appointed receiver. Advocates for the mentally disabled, health inspectors for the District and the federal court monitor in a class-action lawsuit have been raising questions for years about the quality of care at IDI facilities. After one woman recently lost 26 pounds in a month, the advocacy group University Legal Services expressed concern. Independent investigations of two of the deaths by a consultant found significant deficiencies in the health care provided to two women at the IDI homes. The investigation of the third death is underway.

<http://www.washingtonpost.com/wp-dyn/content/article/2009/10/07/AR2009100703888.html>

Maryland

DOJ Findings Letter Relating to Rosewood Center

October 7, 2009

On January 15, 2008, Maryland Governor Martin O'Malley announced that the State intended to close Rosewood Center by June 30, 2009, a goal which was achieved. Because of the closure, a significant concern that underlies many of the [DOJ] findings is particularly troubling: Rosewood's assessments of its residents were inaccurate, incomplete, and untimely. The medical, psychiatric, nutritional, behavioral, habilitation, vocational, and communication assessments provided by Rosewood substantially depart from generally accepted professional standards. The harm from inadequacies of the assessments is multi-faceted . . . Moreover, we have grave concerns regarding the inadequacies in the State's and Rosewood's discharge planning and transition process, especially given the deficiencies we found in Rosewood's assessments. While at Rosewood, we requested copies of the monitoring reports that are periodically performed as to individuals who have recently been discharged. This information is crucial to effective discharge planning, as it affords Rosewood and the State the opportunity to identify problems in the transition process and to implement corrective actions. Because many of Rosewood's former residents who have recently been placed in the community are medically

and behaviorally fragile, these deficits expose these individuals to significant risk of harm.

National

U.S. Department of Justice, October 2009

First National Study on Crime Against Persons with Disabilities

Young and middle-age persons with disabilities experienced violence at nearly twice the rate as persons of the same age without a disability concluded a study released by the U.S. Department of Justice. Yet, the rate of violence did not differ by disability status for persons age 50 or older and persons age 65 or older, with or without a disability, had the lowest rates of violent crime, the study concludes. (DOJ, October 2009).

New Jersey

The Star-Ledger, July 16, 2009

Complaints of abuse spark investigation of group home

State officials are investigating a group home in Bridgewater where a worker is accused of beating a 35-year-old disabled resident and sending him to the hospital, a Department of Human Services spokeswoman confirmed. The alleged assault on James Mullins last month is one of three complaints pending against AdvoServ of New Jersey's group home on Severin Drive, Human Services spokeswoman Pam Ronan said today. In addition to Mullins' complaint, the state is investigating another alleging physical abuse and an allegation of verbal abuse. Although she declined to discuss the details of the investigations, Ronan said the complaints prompted the department's Division of Developmental Disabilities to make a surprise inspection on July 9. She said she could not comment on the findings until the report is shared with AdvoServ. With 18 group homes and one supervised apartment complex in New Jersey, the Delaware-based company is the state's largest private provider of residential services and program for developmentally disabled adults with severe behavioral problems and mental illnesses.

http://www.nj.com/news/index.ssf/2008/07/complaints_of_abuse_spark_inve.html

Washington, D.C.

Associated Press, December 15, 2008

Woman at D.C. group home is homicide victim

Authorities say a woman's death at a group home in Northeast D.C. has been ruled a homicide. D.C. Council member Muriel Bowser says police responded about 4 p.m. Sunday at the home for the mentally disabled in the 5400 block of Blair Road NE. Bowser says the home is operated by a contractor, and she is unaware of any complaints about the home. Authorities have not revealed the cause of death. Police Inspector Rodney Parks said Sunday evening that the case had been closed. The District's care of its disabled citizens as been in question since December 1999 when reporter Katherine Boo's Pulitzer Prize winning investigative series, "Invisible Deaths: The Fatal Neglect of D.C.'s Retarded" (see below).

<http://www.washingtonpost.com/wp-dyn/content/article/2008/12/15/AR2008121500070.html>

<http://www.washingtonpost.com/wp-srv/local/invisible/deaths5.htm>

Washington, D.C.

Washington Post, October 22, 2008

Disabled Man Died Before Needed D.C. Aid Arrived

"Mr. Johnson" badly burned himself while trying to cook. There were roaches on him when he showed up for medical appointments. He had difficulty using the toilet and rarely took his medication. But for years, the 65-year-old was deemed ineligible for help by the District agency that cares for mentally and physically disabled

residents. For bureaucratic reasons, he officially did not exist.

In February, the District finally approved funding for him. It was for his burial.

That detail made the District's acting attorney general, Peter Nickles, call it "a sad story, the ultimate sad story," and a case that "fell through the cracks." City officials yesterday acknowledged mishandling the case and vowed to investigate.

Mr. Johnson, the pseudonym used by lawyers who took up the man's case in recent years, was hit by a bus when he was a toddler, in the 1940s. Doctors concluded that he was left mentally disabled, and for decades he remained at home under his mother's care. When the mother died 15 years ago, the man's well-being fell to a volunteer who cleaned, shopped and tried to arrange medical care from the city's agency for the mentally disabled. But the volunteer's efforts could not keep the man from living in squalor, hurting himself, skipping his medication and ultimately dying in a diabetic coma.

The legal advocacy group said it wrote the report to shine a light on a bureaucracy's fatal focus on paperwork protocol that kept a person in need from getting help. "We have other clients like him who have been waiting around for services, and they are denied services simply because they don't have the right records, usually documents from D.C. public schools," said Mary Nell Clark, managing attorney for University Legal Services.

The group represents abuse victims in a 30-year-old lawsuit against the District over quality of care in group homes for the mentally and physically disabled.

<http://www.washingtonpost.com/wp-dyn/content/article/2008/10/21/AR2008102101359.html>

Illinois

Associated Press, March 21, 2008

Disabled pregnant woman used as target practice

Banished to the basement, the 29-year-old mother with a childlike mind and another baby on the way had little more than a thin rug and a mattress to call her own on the chilly concrete floor. Dorothy Dixon ate what she could forage from the refrigerator upstairs, where housemates used her for target practice with BBs, burned her with a glue gun and doused her with scalding liquid that peeled away her skin. Her attackers / housemates included Michelle Riley, 35, who they said befriended Dixon but pocketed monthly Social Security checks she got because of her developmental delays, Judy Woods, three teenagers (including Riley's 16-year old daughter), and Riley's 12 year old son. They torched what few clothes she had, so she walked around naked. They often pummeled her with an aluminum bat or metal handle. Dixon -- six months pregnant -- died after weeks of abuse. Police have charged two adults, three teenagers and a 12-year-old boy with murder in the case that has repulsed many in this Mississippi River town. Riley and Dixon, police said, had lived in Quincy, a Mississippi River town about 100 miles north of St. Louis, Mo. Quincy is where Riley worked as a coordinator for a regional center that helps the developmentally disabled with housing and other services. Dixon was a client. "The idea that someone would say, 'Have the handicapped people do it' is very disturbing," he said. "They just cut the grass and do the weeding. They work so hard."

http://www.pantagraph.com/news/torture-death-shocks-illinois-town/article_dd6dac4c-2ba4-58e1-9beb-07055df839aa.html

Washington, D.C

Washington Post (column), March 16, 2008

Putting Mentally Disabled at Risk Is No Way to Cut Corners

Demolishing a building that dates back to the days of asbestos is a complicated business. You need to examine the construction method and, often, call in the men in white suits. When the Federal Aviation Administration

decided to knock down an old guard shack last year on the grounds of the Washington Air Route Traffic Control Center in Leesburg, no such precautions were taken. Instead, managers called in a crew of mentally disabled people and put them to work at the site, which had been found in 1993 to contain asbestos. Now, the FAA says, the agency's inspector general, federal prosecutors in Alexandria and a grand jury are investigating whether the decision to give part of the job to people with severe disabilities was a purposeful attempt to circumvent procedures. A crew of about half a dozen workers from Echo Inc. (Every Citizen Has Opportunities), a Leesburg-based charity that trains and provides jobs for mentally retarded and other disabled people in Loudoun and Fairfax counties, has handled groundskeeping duties at the FAA facility for three decades, Echo Executive Director William Haney said. Haney said that when he heard about the asbestos incident, he asked the FAA for a written report on what role his workers had played but "never got anything." Haney was told that the workers' role in the demolition was "incidental," but, he said, "I just don't know what went on."

http://voices.washingtonpost.com/rawfisher/2008/03/putting_mentally_disabled_at_r.html

Oregon

The Oregonian, March 15, 2008

After Fairview, Protecting Johnny

Johnny Beckhardt may be the best-known person with a developmental disability in Oregon. The 28-year-old stars in a national ad campaign showcasing his independent lifestyle and work at Goodwill Industries.

The publicity has made Johnny a symbol of hope for people with mental retardation. It hasn't done much to protect him.

As a client in Oregon's troubled system of homes for developmentally disabled adults, Johnny has been victimized multiple times. Caregivers took financial advantage of him. A medical emergency nearly killed him. Most recently, officials moved Johnny from a Dallas group home after he reported what investigators feared was physical and sexual abuse.

Johnny's experience angers his 67-year-old father. Over the years, Butch has modeled the type of devoted parental advocacy that experts say is needed for someone like Johnny to thrive in the community. "I am always looking out for Johnny," said Butch. "I call every week. I keep in touch with his caregivers. But this system is so screwed up that even kids with involved parents are at risk."

Oregon's network of 1,100 group and foster homes serves about 4,600 developmentally disabled adults. An investigation by The Oregonian last year found that between 2000 and 2006, more than 2,000 were victims of abuse by caregivers, ranging from neglect of medical needs to rape, beatings, thefts, verbal abuse or improper restraint.

Half were victims more than once, and 14 died after workers failed to provide timely or necessary care. In the wake of the report, outraged legislators pledged to quickly adopt reforms. But their first step -- a bill to better track abusive caregivers and boost fines for negligent homes -- was abandoned in the crush of final business at last month's special legislative session.

People born with developmental disabilities such as Down syndrome, autism or cerebral palsy have long been known to suffer high rates of abuse and neglect. State officials say they are doing the best they can to police the homes but need more money to boost wages and train better caregivers.

Until that happens, the threat of being a victim continues for residents, most of whom don't have a parent or other relative standing at the ready to remedy lapses in their care.

"I wonder what happens," Butch Beckhardt said, "to those who don't have people looking out for them."

http://www.oregonlive.com/special/index.ssf/2008/03/after_fairview_protecting_john.html

South Carolina

The Item, March 9, 2008

DSN under the microscope

Allegations of abuse, financial fraud have cast a shadow over a county agency whose clients are among the most "fragile and vulnerable." The director of the Sumter County Disabilities and Special Needs Board has been removed from his position and charged with five counts of criminal sexual conduct and two counts of kidnapping. He and the local board are defendants in a lawsuit brought by former employees alleging a hostile work environment and improper termination. In an unrelated incident, an employee of the Sumter County DSN Board has been charged with breach of trust with fraudulent intent after allegedly bilking the organization of \$75,000. Whether coincidental or systemic, the nature and number of charges connected to the special needs agency are significant enough to warrant a closer look.

Even before the most recent charges, a group of lawmakers had decided there was sufficient cause to seek an audit of the entire department by the Legislative Audit Council. The state audit is expected to be finalized later this year.

The state Department of Disabilities and Special Needs serves those residents who have development disabilities, autism, head or spinal cord injuries or mental retardation. The state department, which opened in 1967 as the Department of Mental Retardation, acts as an umbrella to 39 local disabilities and special needs boards that serve the state's 46 counties, including Sumter County. The Sumter County board employs about 275 full- and part-time workers and serves about 600 clients. The board provides a variety of services, such as early intervention to help families assess children from birth to age 6; individualized rehabilitation to help clients have greater independence; helping clients find jobs; supervised living for adults able to live on their own; and community training homes for those who need a little more assistance. The board also hosts camps during the summer months. The Sumter agency was established by state law and county ordinances and is governed by a seven-member board, whose members are appointed by the governor upon recommendation of the local legislative delegation.

North Carolina

News & Observer, February 24 – March 2, 2008

Mental Disorder: The Failure of Reform

The series focuses on the aftermath of the 2001 mental health reform including aggressive deinstitutionalization, including findings of extensive financial fraud, astronomical community costs, and compromised treatment. It was predictable – people were displaced from psychiatric hospitals before community services were in place, costs were underestimated, privatization opened the door for opportunistic providers who took advantage of every loophole (and there were many). As a result treatment suffered and costs skyrocketed. According to the *News & Observer*, in January 2005, the state told the federal government those two services, community support for children and community support for adults, would cost less than \$5 million a month. By February 2007, when the Health and Human Services accountability team started an audit, the monthly bill was \$93.5 million. The full series can be found at: <http://www.newsobserver.com/2789/story/962049.html> and includes these articles: **Part 1:** Reform wastes millions, fails mentally ill; **Part 2:** Companies cash in on new service; **Part 3:** Serious mental therapy fades; **Part 4:** Hospitals, nearly forgotten, teem with abuse; **Part 5:** Patients die from poor care.

Oregon

The Oregonian, November 4 – 10, 2007

After Fairview: How Oregon fails disabled adults

In the seven years since Fairview Training Center closed, more than 2,000 developmentally disabled adults have been robbed, beaten, raped, neglected or cursed, most often by their state-paid caregivers. Clients have choked on food, suffered violent injuries or become ill with treatable health problems that caregivers ignored or missed. In half the deaths investigated by the state, The Oregonian found that caregivers didn't recognize clients' serious health problems or act quickly enough to call 9-1-1. Their stories, archived in a state database and detailed in hundreds of confidential files obtained by The Oregonian, show that one of every five clients in state-licensed foster or group homes have been victims of at least one serious instance of abuse or neglect during the past seven years. The officials who oversee Oregon's 8,000 caregivers and 1,200 adult group and foster homes say they are working to protect clients. But the state has failed to close troubled homes, even after clients were raped or died. Officials also have been slow to adopt reforms in areas they acknowledge would make the system safer.

http://oregonianextra.com/grouphomes/story_main_01.html

California

CBS 5 Investigates, November 8, 2007

Bay Area Homes For Disabled

A CBS 5 Investigation raises questions about the quality of care in some for-profit group homes for the developmentally disabled. Our investigation begins with an incident in 2004 that happened at one Bay Area group home. Inside that home, Theresa Rodriguez, a woman with mental and physical disabilities had been badly burned. The home was run by RCCA Services. As a result of the scalding, the house was cited and fined by the state. And CBS 5 Investigates found that home was just one of three RCCA facilities in San Mateo County cited by the state for failing to meet federal standards. Two of those were cited for insufficient staffing, among other problems, and one was forced to shut down. CBS 5 Investigates also discovered the state recently found deficiencies at two other RCCA homes in San Jose. In January 2007, inspectors cited one of them, a home called Purple Hills, for failing to provide "continuous active treatment" for fully half of its clients.

Washington, D.C.

The Washington Post, September 15, 2007

Promises, Promises: The District has three months to show it can help its developmentally disabled residents.

The Washington, D.C. government has made a lot of big promises about improving the treatment of the mentally retarded men and women in its care. Over the years, it has broken most of those promises, and the result has been the neglect, mistreatment and even the deaths of many vulnerable people. Now a judge is demanding that the District keep some little promises. If it fails, it will be clear that the District is simply incapable of providing proper care, and the court should feel compelled to take over the system. U.S. District Judge Ellen S. Huvelle, presiding over the 31-year-old class action lawsuit involving onetime residents of the notorious Forest Haven facility, has made no secret of her aggravation over the lack of progress in protecting the health and safety of developmentally disabled residents. Decrying "the tortured history" of the case, Judge Huvelle in March found D.C. officials in "systematic, continuous, and serious noncompliance with many of the court's orders." Still, she has resisted placing the Department of Disability Services in receivership. This week, she issued an order that refreshingly focuses on tangible steps to improve the health and safety of the some 650 surviving members of the plaintiff class. The beauty of the judge's approach is that it compelled the city and the plaintiffs to come up with specific goals that can be accomplished in the next 90 days. There's nothing pie in the sky about the list that Judge Huvelle accepted this week. It includes recruiting five providers of high-quality residential care, expanding a medical clinic program, figuring out which homes really are substandard, and identifying and treating the 25 most medically fragile residents. Key to recruiting and retaining qualified providers is the District's promise to increase the rates it pays. Cost-of-living increases inexplicably were frozen for five years. That D.C. Mayor Adrian M. Fenty (D) is agreeing to come up with the \$4.7 million city share (Medicaid and Medicare would pick up the rest of the \$15.6 million tab) is a hopeful sign of his administration's

commitment to reform.

<https://www.highbeam.com/doc/1P2-7597510.html>

California

The Orange County Register, February 7, 2007 Taped Attacks Spur Outcry

A caregiver worked at a dependent-care facility for at least five months before a cellular phone surfaced that contained videos police said show him beating and taunting developmentally disabled men who cannot speak. "This isn't an isolated incident," Anaheim police Detective Cherie Hill said. "I think there's a lot more going on than we already know." State-licensed care facilities are required to run background checks on potential employees, but many aren't licensed and aren't required to do such checks, Hill said. "What else happened that wasn't taped?" Anaheim police Sgt. Rick Martinez asked. "Nobody would've ever known had it not been for that video."

<http://www.oregister.com/2007/02/02/taped-attacks-spur-outcry>

Kentucky

The Lexington Herald-Leader, January 7, 2007 Deaths largely not investigated - Critics see gaping hole in care of state's mentally disabled

The woman, whose name was not released, is one of thousands of mentally disabled people who received care in group homes paid for by Medicaid. And she is one of 146 people who died over the past five years in the Supports for Community Living Home and Community-Based waiver program, a network of 137 agencies that provides community-based services such as housing and counseling to 2,874 mentally disabled Kentuckians. Since 2001, the state has initiated on-site investigations in only 18 of the 146 deaths in the community living program, a Herald-Leader investigation found. Long-term mortality rates for mentally disabled people in community facilities are unknown. The department only started tracking deaths of the mentally disabled in the community in 2001. Thirty-eight of the 146 deaths since then were unexpected or sudden, according to the reports providers sent to the department. If any of those 146 people had died in a state institution in Kentucky their deaths would have been investigated by the Office of Inspector General with the Cabinet for Health and Family Services, and Kentucky Protection and Advocacy would have been notified. A mortality review board, made up of doctors and other specialists, also reviews all deaths in institutions. But the same review process doesn't apply when deaths occur in Kentucky's privately run, community-based care facilities. In those cases, only deaths deemed suspicious trigger an on-site investigation. The lack of in-depth investigation of deaths in the community is a gaping hole in Kentucky's protection of the mentally disabled, said Marsha Hockensmith of Kentucky Protection and Advocacy.

California

The Sacramento Bee, January 1, 2007 Conflict is boiling over care: The death of a severely retarded man is the latest flashpoint in a battle between families and the state over its developmental centers

Donald Santiago's mother and sister didn't want the state to move him out of the Agnews Developmental Center in San Jose, the state hospital where he had lived for nearly four decades. But state officials got a court order to move him into Justin's Home in Union City in 2005 over his family's objections. Santiago, 63, died of pneumonia in a Fremont hospital three weeks ago. The death of Donald Santiago -- being investigated by the California Department of Health Services -- is one more flashpoint in a wrenching battle between some parents of Agnews residents and the state, which has been under legal pressure to close its institutions and integrate residents with disabilities into their communities. Following changes in state law, the number of people living in developmental centers in California has dropped from a high of more than 13,000 in the 1960s to about 2,900

today. Three developmental centers have been shut down. Agnews, one of five remaining state centers for people with developmental disabilities, is slated to close in 2008. Only 261 residents remain. Some family members say they fear the state is hastily moving people into existing community homes that are ill-prepared to care for the severely disabled and don't have medical staff on-site, as Agnews does. Donald Santiago had the mental capacity of a 2-year-old and a vocabulary of only a few words, according to his sister, Angie Abrue of Placerville. But the state argued that Santiago had expressed a desire to leave Agnews in a 2005 court hearing before a Santa Clara Superior Court judge. Brian Boxall, president of the Association for the Mentally Retarded at Agnews, a group representing families, said the court system never should have ordered the move in the first place. "My sense of anger is most focused on the judge, the (district attorney) and the public defender who all orchestrated his placement knowing that his group home operator had these kinds of citations," Boxall said. "In that respect, Donald really was a victim of the system." Eileen Goldblatt, whose organization has assisted others in getting court orders but was not involved in Santiago's case, sees it differently. "It was our understanding that he got to court because he really wanted to move," she said. "It's tragic that he then died. It's also nice that he got to move after so many years of living in an institution."

Missouri

St. Louis Dispatch, December 20, 2006

Gov. Blunt orders Department of Mental Health to tell parents of sex offenders

The Post-Dispatch reported Monday that the state was placing people convicted or accused of sex offenses into privately run group homes and state-run facilities with other mentally retarded residents and was not notifying parents of the other residents. Gov. Matt Blunt said Tuesday that he was concerned about the report and that he had ordered the department to notify parents or guardians of others who share the group home with convicted offenders. He also ordered the department to ensure that all convicted offenders are registered with local police, as required by law. But the department will continue to keep secret the placement of people accused of sex offenses but not prosecuted because of their disability, saying state and federal law prohibit them from saying anything. Ron Nicholson, whose son was in a group home with a man accused of molesting a girl, said the new policy continues to put residents at risk. The man in the group home with his son had been determined to be incompetent to stand trial, so parents would not be notified of his presence under the policy. "I think it's atrocious. I think it's indefensible and unconscionable," he said. "They're knowingly and secretly putting known risks into group homes with non-risk individuals." The debate centers on about 50 people, and 31 of those are convicted sex offenders, department spokesman Bob Bax said. In three cases, the department discovered this week that it hadn't told police of the offender. In the rest of the cases, the department had notified police, although police didn't always list the offender on registries, Bax said. He said he thought that was because not all sex offenders are required to register. The debate comes as the Department of Mental Health already is undergoing major changes in how it reports and investigates abuse and neglect of residents, after a June series in the Post-Dispatch that found widespread mistreatment of residents and inadequate investigations of allegations.

Utah

Parent Testimonial, October 2006

Son severely burned in group home

In October, 2006 my son, Philip, who has autism was severely burned in an accident at the group home where he was receiving services under the Home and Community Supports Waiver. He was left unattended in the kitchen and his rugby shirt caught fire on the gas stove. He was burned on his back across his waist and then up to his shoulder blades. The burns were assessed as second and third degree at the University Hospital Emergency Room. Enclosed [below] is a photo of my son's back about six weeks after the initial burn. Shortly after this photo, a skin graft was performed over the raw area.

Florida

The News-Press, September 20, 2006

Group Home Closed for Violations

Rodents and roaches. Chemicals left in unlocked cabinets. Electrical cords with wires exposed. A syringe in a kitchen drawer. Florida state inspections turned up those problems and others over nine months at 10 Professional Group Home, Inc. residences. The deaths of four residents and health and safety violations prompted the Florida Agency on Persons with Disabilities to shut down the Miami-based chain. The agency is required by law to monitor group homes once a year, but it does so at least once a month, officials report. Group homes are licensed by the agency and receive money through reimbursements from a Medicaid program for people with disabilities. There are 1,263 providers statewide. The homes are part of the state's emphasis on deinstitutionalization, taking people out of large institutions such as Gulf Coast Center. In one case, a Professional Group Home resident died just six weeks after he was moved from Gulf Coast center, where he had lived since 1994.”

North Carolina

The News & Observer – August 13, 2006

53 Deaths in Five Years Tied to Adult-Care Violations

More than 50 people living in adult-care homes in North Carolina died recently after preventable mistakes. State records say that inattentive care, medication errors and poor maintenance of the homes contributed to the deaths over a five-year period. Residents of these assisted-living facilities, rest homes and family-care homes have choked to death, frozen, been scalded and wandered into traffic, according to reports on file with the state Division of Facility Services. One suffered a fatal stabbing by a fellow resident. Another received the blood thinner Coumadin for five days instead of Claritin, an allergy medicine. In each case, the deaths arose out of "something the facility did or failed to do," said Jeff Horton, the division's chief operating officer. For about 27,000 North Carolinians living in adult-care homes, the death rate after these preventable incidents is more than six times that of state residents over age 65 who die from health-care complications such as surgery gone wrong. These cases, in which people died after the staff or home committed serious violations, are just the ones reported to the state. Advocates for residents say more occur without notice. Outside of family and government, the deaths rarely get attention. A change in state law last year resulted in reduced public access to investigations and information about penalties in the cases. Since 2000, the state has dealt with 67 cases of preventable deaths in adult-care centers. The N&O analyzed 53 cases for which complete data were available and the most serious level of violation occurred, according to state records.

Washington, D.C.

Washington Post – August 5, 2006

D.C. Cleansed Group Home Death Reports; Court, Council Didn't See Unfavorable Information

The District government has altered reports concerning deaths of mentally retarded residents of the city's group homes, deleting damaging information before the documents were turned over to court officials and others who review the cases. The deletions, discovered by a federal court monitor, included information that described serious case-management failings; delays in obtaining consent for medical procedures; concerns about health care; concerns about autopsy findings and procedures; and problems getting information needed to complete the death investigations. One report was changed to remove several sentences critical of a case manager's oversight, including a complaint that he had visited the resident only once in eight years. The case manager still works for the Mental Retardation and Developmental Disabilities Administration, according to the court monitor, Elizabeth Jones. Jones frequently has faulted the city for the care and oversight of roughly 2,000 mentally retarded wards, most of whom live in group homes. In November, she said a pattern of neglect led to four deaths since late 2004, and she warned that other lives were in danger. In her latest report, Jones says the city also deleted some recommendations from the investigative contractor, the Columbus Organization that urged the mental retardation agency to change policies or practices to avoid future harm to group home residents, many of whom also have physical disabilities.

<https://www.washingtonpost.com/archive/politics/2006/08/05/dc-cleansed-group-home-death-reports-span->

California
Inside Bay Area, July 3 – 5, 2006 Broken Homes

Some 26,000 of California's 200,000 developmentally disabled residents — people who are mentally retarded, have Down syndrome, are autistic or have other disabilities — get some type of community-based care, state data show, and many of them are in licensed care homes like The Circle-Los Altos, which are in residential neighborhoods all over the state. Many have been placed in care homes over the past dozen years, as the state emptied its institutions. Two state institutions for developmentally disabled people closed in the late 1990s and a third, Agnews Developmental Center in San Jose, is slated for closure in the near future. Many people are getting good services and leading happy lives in the community, those who work with them say. But others are being poorly cared for, according to the investigation of 300 care homes in Alameda, Contra Costa and San Mateo counties, which included more than 100 interviews and analysis of thousands of pages of public licensing reports and other documents spanning back to 1999. The investigation shows a care system whose low standards, poor funding and limited oversight spell trouble for the more severely disabled people it is now expected to serve — people the system was never set up for in the first place. And it shows that the state agency ultimately responsible for the welfare of the developmentally disabled — some of the state's most vulnerable people - has little direct involvement in their care. See, <http://www.insidebayarea.com/brokenhomes>

Missouri
Broken promises, broken lives, June 7 – 13, 2006 The St. Louis Post-Dispatch

A Post-Dispatch investigation has found abuse and neglect of mentally retarded and mentally ill residents in state centers and in private facilities the state supervises. Since 2000, there have been more than 2,000 confirmed cases of abuse and neglect with 665 injuries and 21 deaths.

Washington, D.C.
The Washington Post, June 24, 2006
Group Home Failures Persist - Care Still Lacking, D.C. Report Says

The District government continues to provide dangerous, substandard care to disabled residents at some of its group homes and has recently hampered oversight efforts by failing to provide full and timely information on critical operations, a federal court monitor has found. In her latest quarterly report, court monitor Elizabeth Jones describes numerous and chronic problems with the city's Mental Retardation and Developmental Disabilities Administration. She also questions whether she is getting complete reports on death investigations, saying that at least one document she received from the District was edited to remove information critical of the city. A review of five deaths between late 2004 and late 2005 showed that recommendations issued after death investigations weren't always shared with direct care providers, putting group home residents at risk, she said. "The continuing failure to remedy critical systemic issues of substandard care, treatment and oversight means that other clients will experience needless pain, delayed or non-existent attention to high risk situations involving health and safety, and unnecessary threats to their very existence," she wrote. "The urgency to remedy these systemic failures could not be greater."

<http://www.washingtonpost.com/wp-dyn/content/article/2006/06/23/AR2006062301602.html>

Connecticut
Hartford Courant, June 12, 2006
Agency criticizes agency responsible for mentally retarded

A state agency, reviewing deaths of mentally retarded clients, is critical of the quality of health services provided by the state Department of Mental Retardation. The Fatality Review Board for Persons with Disabilities has concluded that the DMR contributed to the deaths of dozens of mentally retarded people in its care because it failed to provide them with adequate health care services. The report, released Friday, pointed to what it said were key weaknesses in the DMR's health care services including inadequate coordination of services for people living in the community, the discharge of hospital patients into shoddy nursing homes and insufficient nursing care. The report summarizes the board's review of DMR client deaths from July 2003 through June 2005. The board reviewed the deaths of 361 clients, ranging from people who live in state institutions to those living independently or with family, and conducted 35 in-depth investigations. The board found abuse or neglect in many of the cases. The mental retardation agency is reviewing the findings of the board and plans to use them to enhance the agency's existing efforts to improve its health and safety programs, according to a statement the DMR released Friday. It said it has already enacted some of the board's previous recommendations.

Virginia

Times-Dispatch, December 18, 2005

New stakes for study of group homes

A legislative study of group homes is expected to produce proposals for new laws to toughen the regulation of group homes in Virginia and require a closer look of how public money is spent on the care of troubled youths.

For state and local policymakers, there is evidence that Virginia isn't doing a good enough job in making group homes accountable for the care they provide at public expense under the Comprehensive Services Act, or CSA.

"The state has a laissez-faire approach to regulation and monitoring," he said, "resulting in a system that is extremely costly and not necessarily providing the quality of care that the kids deserve."

A legislative subcommittee plans to introduce legislation that would:

³⁵₁₇ Make the state put the new law into effect immediately.

³⁵₁₇ Tighten the standards for licensing and regulating group homes.

³⁵₁₇ Order a study by the Joint Legislative and Audit Review Commission of the rates charged under the Comprehensive Services Act, which pays for treatment of children primarily through a combination of state and local funds. The federal Medicaid program also contributes money for care under the system.

The state licenses and regulates group homes, as well as other kinds of treatment facilities, through four different agencies that in some way handle children with problems. The system includes children in foster-care, special-education and mental-health programs, and the juvenile-justice system.

Washington, D.C.

The Washington Post, November 29, 2005

4 Deaths in D.C. Group Homes Raise Concerns About Neglect

The District government is failing to provide adequate care for mentally and physically disabled residents in its group homes, according to a court monitor who found that a pattern of neglect led to four deaths in the past year. One woman and three men "are dead because they did not receive timely and competent health care," court monitor Elizabeth Jones said in a newly released report. Jones expressed "grievous concerns" about the health and safety of hundreds of disabled people who live in the group homes, especially those with special health risks. The deaths, she warned, "reflect the lack of meaningful safeguards in the system." The four deaths might have been prevented if the city's Mental Retardation and Developmental Disabilities Administration had followed up on earlier recommendations for improving care in the homes -- and if the agency's case managers had been more vigilant in addressing critical problems, wrote Jones, whose staff reviewed medical records and death investigations. Sandy Bernstein, legal director for University Legal Services, which represents the plaintiffs in

the suit against the District, criticized what she called "short-term approaches" to dealing with such serious failings by the city. The suit covers about 700 plaintiffs, all former residents of Forest Haven, a now-defunct institution for the mentally retarded. Another 1,300 plaintiffs are special-needs clients of the agency.

<http://www.washingtonpost.com/wp-dyn/content/article/2005/11/28/AR2005112801887.html>

Washington State

Seattle Post Intelligencer, Nov. 16 – 18, 2005

Public Protection, Private Abuse (Mentally disabled preyed upon in state system)

11 articles in a three part series look at for-profit companies, contracted by the state, to closely supervise dangerous developmentally disabled people in the community. While the costly program does protect the public in many cases – most of the clients are sex offenders – it has left other vulnerable adults with developmental disabilities at risk of abuse and neglect.

The investigation of the Community Protection Program was based on multiple public disclosure requests to the Department of Social and Health Services which led to the release of more than 12,000 pages of documents. That included incident reports, recertification reviews of residential providers, financial reports and policy documents. <http://seattlepi.nwsource.com/specials/protect/>

South Carolina

The State, October 28, 2005

State needs investigators to handle abuse and neglect cases, group says

Reports of abuse and neglect of disabled South Carolinians are too often mishandled and those responsible are rarely held accountable, according to a watchdog group. Protection and Advocacy for People with Disabilities Inc. released a report on a two-year study Thursday, highlighting 50 cases that included physical and sexual abuse and deaths in state-funded community-based residential facilities. The authors, who focused the study on the state Department of Disabilities and Special Needs, say the report portrays a broken system that provides little protection for those who cannot protect themselves. The report found flaws in the way many of the cases were handled, stemming largely from the practice of allowing facility administrators to conduct their own investigations into abuse claims rather than alerting law enforcement immediately. The state should create an independent agency, preferably within the State Law Enforcement Division, to investigate all abuse claims immediately, the report says. The agency would include specially trained investigators who know how to work with mentally disabled adults. The issue of abuse at state-funded care facilities came to the fore in recent years when a series of audits of the Babcock Center uncovered cases of abuse, neglect and exploitation of its residents.

National

The Wall Street Journal, September 20, 2005

Difficult Choices: Needing Assistance, Parents of Disabled Resort to Extremes

Nationwide, an estimated 80,000 developmentally disabled people are waiting for in-home help or an opening in a group home. Some have been on waiting lists for more than a decade. In Texas, there are 46,000 people waiting for such help -- or about four times the number of people actually receiving assistance. Requests are increasing as the nation's 4.6 million developmentally disabled, like the rest of the population, are living longer. Meanwhile, their parents are aging too, making it harder to keep up with caretaking.

Long waits for help have prompted lawsuits in two dozen states, charging violations of a 1999 Supreme Court decision requiring states to make diligent efforts to serve disabled individuals in their community. Florida settled one suit in 2001, promising services to 17,000 people on waiting lists. By increasing spending, it did. Since then, the waiting list has ballooned again, to more than 15,000.

Indeed, even though public spending to provide community services to people with developmental disabilities grew by 17% between 2000 and 2002 – to about \$27 billion -- demand for those services continues to outpace availability. Federal funds, primarily Medicaid, provide 50% of that \$27 billion, with states kicking in 46% and local funds the remaining 4%.

"Unless you're in a crisis, you don't get services. I'm sure that's the case in most states," says Tony Paulauski, executive director of ARC of Illinois, part of a national, nonprofit organization for the developmentally disabled.

National

The Wall Street Journal, September 13, 2005

Safe Place: Disabled People Find Group Homes Can Be Broken too – Patients Gain Independence, But Oversight is Spotty; Challenges of Monitoring

Over the past three decades, there has been a concerted effort to move people with developmental disabilities out of large institutions, which had been long criticized for being overcrowded and isolated. A widely lauded effort to move people into smaller group homes has succeeded in bringing the developmentally disabled into communities where they can learn new skills, get jobs or attend special schools. But this progress has come at a price. It has strained the systems that support people living in the smaller settings and created big gaps in oversight.

Twenty-five years ago, people with developmental disabilities lived in about 16,000 publicly funded homes. Today, they are scattered in about 140,000.

"The systems of quality monitoring have really been taxed beyond what they can manage," says Charlie Lakin, who heads a University of Minnesota program that tracks services to the developmentally disabled. "By and large, a lot of it is pretty loosely organized and pretty loosely monitored."

Only a half-dozen states require that residential programs serving the developmentally disabled be accredited by an independent third-party organization. Developmental disabilities, which affect about 4.6 million people in the U.S., include a range of mental and physical impairments, such as cerebral palsy, autism and mental retardation. Babcock (South Carolina community provider) offers a stark look at the flawed monitoring of group homes, which sometimes leaves family members and other advocates feeling they need to police the care themselves.

The U.S. Department of Health and Human Services -- which pays about half of the \$27 billion spent annually on community services for the developmentally disabled -- is ultimately responsible for their protection. But the federal agency assigns the creation and enforcing of rules over such homes to each state. As a result, laws and monitoring vary by state. States aren't required to report all incidents of abuse or neglect to the federal agency. The federal government typically only gets involved if families, advocates or employees of homes provide credible concern about the thoroughness of a state investigation. HHS, which oversees the Centers for Medicare and Medicaid Services, is drafting new procedures following a 2003 report from the General Accounting Office, saying states should be required to report more information about how they protect people with developmental disabilities.

Thousands of nonprofit group homes offer well-supervised programs for the developmentally disabled. But problems exist to some degree in nearly every community, says Curtis Decker, executive director of the National Disability Rights Network, a nonprofit group. Investigators may overlook flaws, he says, because of a lack of other housing options. "They don't know what to do with these folks if they closed a place down." The number of abuse and neglect cases among the developmentally disabled isn't collected nationwide. Many states don't keep central databases on employees involved in such cases, allowing workers to move from one agency to another. "You put people in tough jobs, who are underpaid, not well-trained or supervised, and the potential for abuse is big," says Mr. Decker. "It's endemic to the country."

Missouri

Missouri State Auditor, September 2005

Report No. 2005-62: State mental health clients not fully protected from abuse and neglect due to problems with incident investigations and abusive workers still employed

This audit reviewed how well the Department of Mental Health tracks, investigates and handles incidents and investigations of individuals committing abuse or neglect against its 140,000 clients. All such allegations, including client deaths are tracked in the department's Incident and Investigation Tracking System, which reported 5,689 incidents from July 2003 through August 2004. This audit also followed up on recommendations from a 2001 audit and found systemic problems with abuse investigations. The audit found continuing problems in several areas, including continued employment of known felons and abusers, leading to more abuse, and overall lack of independence and consistency in abuse investigations.

Maryland

The Baltimore Sun, April 10-17, 2005

A failure to protect – Maryland's troubled group homes.

In an investigation of state oversight of group homes going back a decade, The Sun found that:

- ³⁵₁₇ Mistreatment of children has gone unpunished.
- ³⁵₁₇ People with criminal convictions can -- and do -- work at group homes.
- ³⁵₁₇ Taxpayers' money is often wasted on poor care, denying youths a range of services.
- ³⁵₁₇ Maryland subsidizes high salaries and perks.

The Sun examined the regulation of care, spending and staffing at 25 companies that ran 120 homes for children. Reporters studied 15,000 pages of inspection reports, case files and other records obtained under the state's Public Information Act and conducted more than 150 interviews.

Florida

The Miami Herald, March 26, 2005

Deaths at group homes being probed

In light of cost-cutting changes in nursing care, an investigation is under way into the deaths of four disabled Floridians at group homes. A federally-funded watchdog group is investigating the recent deaths of four disabled Floridians amid an aggressive state campaign to cut millions of dollars from programs that provide medical care for disabled people in community settings. In 2001, the state hired a private company, Maximus Inc., to look for ways to save \$24 million annually. The company's actions have been upheld in 97 percent of the appeals to state officials. Advocates for the disabled insist the quality of medical care for disabled people in group homes has suffered since September when Maximus and the state began requiring group homes to pay for nursing care from the state's Medicaid plan. That plan covers rotating nurses, not the more stable nursing care provided under a previous plan for disabled people.

National

People with Mental Retardation & Sexual Abuse - The Arc of the United States

(author: Leigh Ann Reynolds, M.S.S.W., M.P.A., Health Promotion & Disability Prevention Specialist)

More than 90 percent of people with developmental disabilities will experience sexual abuse at some point in their lives. Forty-nine percent will experience 10 or more abusive incidents (Valenti-Hein & Schwartz, 1995). Other studies suggest that 39 to 68 percent of girls and 16 to 30 percent of boys will be sexually abused before their eighteenth birthday. The likelihood of rape is staggering: 15,000 to 19,000 of people with developmental disabilities are raped each year in the United States (Sobsey, 1994).

North Carolina
The Charlotte Observer, January 16, 2005
Millions Wasted – The Cost of Kids' Lives

Since 2001, the state has wasted tens of millions of dollars paying group homes for workers who were never hired, making the industry so lucrative that hundreds of new homes opened – so many that the state couldn't regulate them. The error helped create a system that's failing some of the state's most vulnerable youngsters and cheating taxpayers who pumped more than \$165 million into homes last year. In the past three years, as group homes multiplied and regular inspections ceased, many group home owners exploited the system's weaknesses. Many ignored even the state's minimal standards, putting children at risk.

California
California Department of Developmental Services (DDS), October 27, 2004
California Releases Mortality Studies

During the late 1990s, a series of epidemiological studies of death rates in California mental retardation institutions compared community residential settings was issued by the University of California Riverside. These reports found risk of mortality to be 83% higher in community settings than in institutions (see, <http://www.lifeexpectancy.com>, link Articles, Comparative Mortality). These studies prompted the California Department of Developmental Services to commission two follow-up studies. Comparing quality of care provided by developmental centers, community care facilities, intermediate care facilities and other settings, the report indicates, "there were few statistically significant differences in the quality of care, "though it was noted that the developmental centers provided a 'higher quality of care.'" One problem in determining the adequacy of health care for this study was the lack of documentation. Except for developmental centers, the lack of documentation was an issue for all other types of facilities. Another issue pointed out by the authors of the report is the need for health education appropriately geared for the developmental level of the consumer. An earlier report (1994) noted that "residents at developmental centers were significantly less likely to die from preventable causes than those residing [in] skilled nursing facilities, intermediate care facilities, or community care facilities." The preventable deaths were primarily due to "inadequacies in the quality of care" followed by "inadequacies in the medical management of common health concerns."

<http://www.lifeexpectancy.com/articles.shtml>

Maryland
The Baltimore Sun, August 1, 2004
Safeguards meant to protect the disabled in Maryland group homes failed this time

Toby Adele Heller died of colon cancer 11 months after caretakers failed to follow a physician's advice to see a gastroenterologist. Toby's case exposes holes in the state system of care for 5,000 people with developmental disabilities living in licensed group home facilities. Employee turnover is high – 42 percent a year among aides – and wages are low. Even with the recent state-imposed increases, caregivers on average make less than \$10 an hour. Quality of care varies with their skills and compassion. And regulators rely heavily on the facilities and families of residents to report problems. But, with nearly 7,000 people on a waiting list for residential services, relatives are often afraid to complain, fearing that their loved ones would have nowhere else to go. Still, Toby's family, like other families, had every reason to expect that she was getting good care: The state was paying top dollar for her to receive round-the-clock staffing at a cost of \$127,672 a year. Her provider, Autumn Homes, received \$2.6 million from the state to provide services for 32 clients in 2003.

Virginia
The Washington Post, May 23 – 27, 2004
Assisted Living in Virginia

In a series of articles this week, The Washington Post reported that residents at the facilities have suffered thousands of incidents of harm, including death, abuse, neglect and serious injuries. The state is home to 627 facilities licensed to care for more than 34,000 residents who need supervision and care but who are not sick enough to qualify for a nursing home. The problems stem from several causes, including poor staff training, insufficient resources and relatively weak enforcement by state regulators, according to records and interviews.

Michigan

The Detroit News, May 5, 2004 Group home abuses escalate

The March 29 beating joins a growing number of complaints about abuse at Michigan group homes, where many of the state's most vulnerable citizens are cared for by employees with low wages and limited training. Last year, the state of Michigan fielded 1,898 complaints about adult group home conditions. That represents a sharp rise compared to 2002, when there were 1,300 total complaints statewide. An estimated 35,000 people live in more than 4,200 state-licensed adult foster care facilities in Michigan. In general, the staff members are paid fast-food wages and given about two weeks of training before they take over the care of the mentally ill and developmentally disabled adults in the homes.

Massachusetts

The Patriot Ledger, March 20 – 23, 2004 Special Report: Retarded at risk; System failures

When it comes to medical care, some of the state's most vulnerable residents, the 8,700 adults who live in group homes for persons with mental retardation, are treated as second-class citizens. Since 2002, three group home residents died because of medical neglect and nine other deaths are under investigation. Since 1999, more than 260 cases of physical abuse and medical error involving the disabled have been substantiated each year. Often, when something goes wrong, no one is held accountable.

Virginia

The Virginia Pilot, February 29, 2004 Special Report: Virginia's treatment of the mentally disabled

Was it truly their time to die, or could their deaths have been prevented? The answers are difficult to find, mostly because the state, which used to be the primary caregiver for the mentally disabled, has surrendered much of that role to a patchwork system of community-based programs, such as group homes. The homes, 106 of them in South Hampton Roads, operate with low-paid, minimally trained workers. They churn along with a steady stream of money from the state and federal government, but with little oversight from either. The state employs 12 inspectors to monitor 2,468 mental health, mental retardation and substance abuse service locations, including group homes. That's an average caseload of 206 locations per inspector. A single inspector has responsibility for all of South Hampton Roads, except Portsmouth. Accidents and injuries are supposed to be self-reported by the provider, but may go unreported. Deaths do not have to be reported to the medical examiner. State records that do exist show problems. Of 34 group home providers in South Hampton Roads, 18 have been cited for state licensing violations and 11 for client abuse or neglect in the past three years. The state has legal authority to fine violators but never has done so. Only one provider's license has been revoked in the past three years. [Internet Access: <http://www.hamptonroads.com/pilotonline/>]

Indiana

The Times Newspapers of Northwest Indiana/S. Chicago, January 25, 2004 Caring for our invisible citizens; Developmentally disabled caregivers often overworked, undertrained, unqualified

A severe shortage of direct care providers across the country has stemmed from a mass exodus of state

institutional care. The result is an annual turnover rate ranging from 50 to 75 percent due in part to low wages. Indiana had no state standards for direct care providers until late 2002. These standards, however, still allow the hiring of individuals regardless if they have employment experience or training of any kind. In addition, no required registry exists for these employees if they are fired from one agency for alleged neglect or abuse and then hired at another agency. Critics said the old threat of state-run institutionalized care has been replaced by a new danger - the big business of private care. That machine is fed by money from the Medicaid waiver program, a financing arrangement that relieves clients from traditionally strict care regulations. In 2003, Indiana's Family and Social Services Administration received 467 formal complaints against some of the approximately 850 approved private providers. Some complaints were minor, some more significant, resulting in corrective actions.

New Mexico

The Albuquerque Journal, November 18, 2003

State Probes Abuse of Disabled

Gov. Bill Richardson has ordered an independent inquiry to track down former residents of the now-closed Los Lunas Hospital and Training School. Richardson's order follows publication of news stories about three developmentally disabled women who were discharged from the Los Lunas facility more than 20 years ago and placed in the unlicensed home of a staff housekeeper and her husband. The goal of the investigation announced Monday is to find whether any more of the former residents may have "slipped through the cracks," receiving no state services and no monitoring. [Internet Access: <http://www.abqjournal.com>]

New Mexico

The Albuquerque Journal, November 3, 2003

Judge Won't Halt Disability Suit: State's Request for Stay Rejected

The Jackson class action lawsuit, filed in 1987, resulted in the closure of Los Lunas and Fort Stanton State Developmental Centers and the court-ordered transfer of residents into group homes and other community settings. In 1997, the parties reached an agreement intended to be a blueprint for ending the lawsuit once certain benchmarks were reached. Oversight has since ended in about two-thirds of the areas. The state's motion to dismiss the case, arguing that all requirements have been met, failed in light of evidence that there remained pronounced shortcomings in providing safety for New Mexicans with severe disabilities. Attorney for the plaintiffs, Peter Cubra, told the judge that there had been more than one death of class members per month over the past 20 months. The state lacks an effective system for dealing with neglect and abuse when it occurs and for preventing its recurrence, plaintiffs argued. Arc attorney Maureen Saunders cited instances where guardians for clients had learned of problems at group homes operated by contract providers and had informed both providers and the state about them. She said she received no response or one that was delayed for months.

Illinois

The Chicago Tribune, September 1, 2003

Report blasts group homes – Dirty, unsafe conditions cited

Developmentally disabled residents of six Chicago-area group homes endured filthy and unsafe living conditions, frequently going without toilet paper, while the homes' owners spent thousands of dollars of leased cars and other perks, a disability-rights watchdog group said in a new report. Surprise inspections at the homes, operated by These are God's People Too, found dark, "foul-smelling" homes, walls smeared with feces, bathrooms without toilet paper and "unkempt yards strewn with garbage," said the report by a non-profit group that the state has designated to "protect and advocate" for the disabled. The investigation, conducted from March 2002 to June 2003, also found safety hazards, such as blocked exits and easily accessible cleaning products, as well as staff members unfamiliar with proper techniques for restraining unruly residents, the report said.

National Policy Research Brief (University of Minnesota), September 2003 Medicaid Home and Community-Based Services: The first 20 years

HCBS and other community services for persons with mental retardation and developmental disabilities have grown at an extremely rapid rate during the past decade. This growth and the nature and flexibility of HCBS have brought enormous challenges in monitoring of service quality and protecting persons receiving them. States have not been able to expand quality assurance (QA) systems commensurate with this growth. But even if they had, they would have had to adjust to new expectations. What was considered “quality” in community services in 1982 or even in 1992 no longer satisfies contemporary values. Today, definitions of quality in human services require attention to dimensions of quality of life in addition to protection of health and safety. A few states have established systems for quality review that attend to the new concepts of quality (see Bradley & Kimmich, 2003; www.qualitymall.org) and over the past decade there have been persistent concerns about whether they attend sufficiently even to the basics of health and safety. A March 19, 1993, House hearing called by Rep. (now Senator) Wyden examined the quality of community services and concluded, “State public officials charged with their oversight had little or no knowledge of the conditions within their homes...or at best found out only after terrible events had occurred.” The Wyden hearing was followed by newspaper stories of the inadequate, life-threatening, sometimes life-ending quality in community services published in several major newspapers in the late 1990s and early 2000s (e.g., Washington Post, San Francisco Chronicle, Minnesota Star Tribune, Hartford Courant). They stimulated emotional reactions, defensive responses, and promises to do better. But, in June 2003 the General Accounting Office (GAO) issued a new report critical of QA in Medicaid HCBS. Although focused primarily on HCBS for elderly people, it recommended that the federal government: “1) establish more detailed criteria regarding necessary components of HCBS QA systems; 2) require states to submit more specific information about QA approaches prior to approval; 3) ensure that states provide sufficient and timely information in their annual reports on efforts to monitor quality; 4) develop guidance on the scope and methodology for federal reviews of state programs; 5) ensure allocation of sufficient resources for conducting thorough and timely reviews of quality in HCBS and hold regional offices accountable for such reviews” (GAO, 2003, p. 5). Clearly, addressing challenges of creating effective quality assurance systems will require leaders that believe that the safety, well-being and quality of life of people with mental retardation and developmental disabilities deserves public investment in a time when other substantial needs are competing for that investment.

Colorado

The Denver Post, August 11, 2003

State Medicaid program a mess, participants say; Oversight at issue in waiver care

Medicaid clients and advocates report failures by state officials to adequately monitor the care patients received through the state home and community-based waiver program. State regulators have known about holes in quality oversight since a scathing report two years ago, but say that policing home care is tough with the little power state legislators have given them. Complaints range from theft and negligence by in-home caregivers to allegations that aides forced patients to sign false time sheets and that caseworkers kept people from qualifying for service. Some clients say they’ve waited for years for the state to address complaints about shoddy service or forgotten care – with no response. A report issued by the Colorado state auditor in June 2001 found that investigators of Medicaid waiver-related complaints sometimes waited months to follow-up, spent far less time investigating complaints than other states did, kept inadequate records of investigations, and were far less likely than investigators elsewhere to cite health providers with deficiencies even after multiple complaints.

National

U.S. General Accounting Office, July 2003

Long-Term Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened (Report No. GAO-03-576)

Despite a growing number of home and community-based waiver beneficiaries (up to almost 700,000 as of 1999), State waiver applications and annual reports for waivers contain little or no information on state mechanisms for assuring quality in waivers, thus limiting the information available to the federal government.

GAO's analysis of available federal and state oversight reports for waivers serving beneficiaries identified oversight weaknesses and quality of care problems. More than 70% of the waivers that GAO reviewed documented one or more quality of care problems. The most common problems included failure to provide necessary services, weaknesses in plans of care, and inadequate case management. The full extent of such problems is unknown because many state waivers lacked a recent CMS review, as required, or the annual state waiver report lacked the relevant information. GAO recommends strengthened federal oversight.

Georgia

The Atlanta Journal-Constitution, February 24, 2003

Agency failed clients; Poor service may be linked to 6 deaths

Mismanagement by a state-funded community service board in northwest Georgia might have contributed to the deaths of six disabled people, according to a written state review. A scorching report on the performance of the Highland Rivers Community Service Board also found payments to employees who might not exist; long delays in serving mentally ill and mentally retarded patients; and high staff turnover. The state Department of Human Resources has given Highland Rivers until the end of February to come up with a plan for fixing 12 "critical" problems cited in the report. Highland Rivers has another month to address the other issues noted in the 30- page report.

Massachusetts

The Boston Globe, February 4, 2003 Audit

alleges misuse of \$1 million

Since 1997, the state Disabled Persons Protection Commission has investigated 19 complaints of client injury at Community Group, Inc., facilities and substantiated three cases involving neglect. Another six cases are pending. Officials said they were concerned about the well-being of many of the 85 clients the firm was caring for at 21 group homes in Eastern Massachusetts. The for-profit company was hired by the state to provide housing and job training for people with mental retardation. In addition to the accusations relating to poor care, a state audit recently found that the company had secretly raised more than \$1 million selling products made by its clients with disabilities and used the money for a Mercedes-Benz, country club membership, and other perks for company management. Community Group, Inc. of Wakefield also kept \$673,000 in profits from group homes and support services – three times the amount allowed by its approximately \$4 million contract with the state. The state Department of Mental Retardation fired the company last fall, accusing it of providing poor care, in addition to the alleged financial misdeeds.

Connecticut

The Hartford Courant, January 4, 2003 Study:

DMR Clients Died Needlessly

A legislative committee has concluded that some mentally retarded residents of group homes in Connecticut needlessly died "tragic" deaths, which were then not investigated properly because poor oversight by state agencies. In a voluminous report on group home deaths, the Program Review and Investigations Committee also found that the state Department of Mental Retardation created a conflict of interest by investigating deaths itself, and said it should transfer that responsibility to another state agency. The legislature late last year asked the committee to review deaths in DMR group homes after a Courant investigation found evidence of neglect, staff error or other questionable circumstances in one out of every 10 deaths over the past decade. As part of the lengthy report, the committee reviewed the 36 cases identified by The Courant and 177 others chosen randomly to see if there were any patterns of neglect. The committee report concluded: "Tragic things happened that but for a different set of circumstances might not have." It also pointed out that systems were in place to address the risks to DMR clients, but for one reason or another were not carried out.

Wisconsin

Milwaukee Journal Sentinel, December 13, 2002

Assisted living sites go without inspection; Audit finds citations rose 140% in 3 years

Nearly half of the 2,114 assisted living facilities that care for the elderly and people with disabilities went more than a year without a visit from a state regulator, an audit report revealed Friday. The lack of state scrutiny came at the same time that complaints and citations against such assisted living homes and apartments in the state were increasing, according to the report from the Legislative Audit Bureau. State legislators requested the review in October 2001, after a series detailed how residents in assisted living facilities had died or been injured because of inadequate care or supervision. The series also showed that the state's regulation had fallen behind the growing industry, which expanded from 1,824 facilities to 2,114 from 1998 to 2001. The capacity of the facilities grew even faster, jumping 35% over the three-year period. At the same time, the number of field inspectors assigned to scrutinize assisted living facilities by the state Bureau of Quality Assurance has decline from 23 from 26.

Ohio

Cincinnati Enquirer, September 2002 Ohio's Secret Shame

In two previous installments of Ohio's Secret Shame, the *Enquirer* revealed that the state mental retardation system is so chaotic that it routinely fails to prevent deaths, correct problems or enforce minimum standards of care. The well-being of 63,000 mentally retarded people depends on the system, which taxpayers fund with \$1.8 billion every year. Among the newspaper's findings thus far: 80 to 120 mentally retarded people die each year from choking, drowning, abuse, neglect or other avoidable causes. That's one of every seven deaths in the system; Reports of neglect, abuse, and other serious incidents have quadrupled in the past four years. Yet there's little public accounting; and Caregivers who abuse and neglect mentally retarded people rarely are punished.

Washington State

Seattle Post-Intelligencer, July 27, 2002 Audit blasts DSHS services for disabled

A \$250 million-a-year state program serving about 11,700 developmentally disabled Washingtonians is so poorly run that it jeopardizes the health and welfare of its client and violates federal law, a federal audit has found. The report concluded that Washington provided services through the federally subsidized program to more than 5,000 ineligible people over 4 ½ years — and the feds want millions of dollars back. The report also found that the state unfairly denies services and inappropriately handles appeals of service denials. The state further provides shoddy financial accountability. The review was conducted by the Centers of Medicare and Medicaid Services and looked at the Department of Social and Health Services' operation of the waiver program which is intended to offer community-based alternatives to institutionalization for people with mental retardation, cerebral palsy, epilepsy, autism and similar conditions.

Maryland

Baltimore Sun, July 21, 2002

Violence raises concerns over group homes

The killing of a caretaker this month at an Ownings Mills group home for the mentally ill — the latest in a series of violent incidents at assisted-living centers — has renewed concerns about the state's ability to regulate such facilities. In several incidents this year, a state review uncovered serious problems, including inadequate staff training and supervision. And although state officials acknowledge that as many as 1,000 unlicensed group homes may be in operation, there are no inspectors dedicated to finding them. In every case of violence, officials found problems. There were too few staff members supervising the group homes, not enough training for caretakers, and inadequate screening of residents and staff for histories of violent or criminal behavior. The number of hospital beds for the mentally ill has steadily declined as a result of recent cuts in state funding for mental health

and deinstitutionalization, a movement to transfer such patients from long-term institutions to community settings.

New Jersey

The Bergen Record, June 23, 2002 N.J. finds dangers in group homes

State inspectors uncovered violations that jeopardize the health and safety of disabled people in more than half of the 86 group homes in Bergen and Passaic counties. Inspection reports reviewed by The Record found dozens of instances where residents were given improper medication or failed to receive prescribed treatments. The 136 reports, which covered a four-year period, also cited homes for employing untrained staff and failing to keep complete records. An increasing number of people with autism, cerebral palsy, and other disabilities are living in group homes. In 1992, about 1,590 people lived in 260 group homes statewide. Today, 742 homes, run by 106 private agencies, house nearly 3,400 people. The agencies receive state funds to operate the homes.

Kentucky

State Audit Report, May 2002

Kentucky can better serve mentally retarded/developmentally disabled persons, State Auditor Ed Hatchett announced today that a performance audit of Kentucky's community-based services for people with mental retardation and developmental disabilities has raised questions about the failure to report abuse, the quality of care provided, and the number of persons served. The audit examined 210 incidents of alleged abuse, neglect, or exploitation and found that Kentucky's Cabinet for Families and Children (CFC) had reported only 19 to law enforcement. In addition, one of these cases were reported to the Attorney General's Office in spite of a contractual agreement obligating the Cabinet to refer all cases "which exhibit substantial potential for criminal prosecution . . ." The audit also revealed that SCL providers as well as the Cabinet for Health Services have frequently failed to inform the Cabinet for Families and Children of incidents of neglect and abuse.

Maryland

Washington Post, May 8, 2002 Md. concedes failings of group home system

Maryland health and child welfare officials acknowledged this week that they have not adequately monitored the patchwork of complaints that run more than 300 group homes for troubled youth, including a Wheaton home where a 14-year-old girl committed suicide. Last fall, mounting evidence that several group homes were leaving unstable children in the custody of untrained, poorly paid workers prompted Gov. Parris N. Glendening (D) to convene a task force to propose an overhaul. But months later, he rejected the key steps the pane had offered in an October report because the state could not afford the added \$3.8 million in costs, one of his aides said. In meetings with the task force last year, advocates complained that no central agency is monitoring complaints about group homes. Homes that were cited by the Department of Health and Mental Hygiene may still have clean records with the Department of Human Resources or the Department of Juvenile Justice.

New York

The New York Times, May 29, 2002 Here, life is squalor and chaos

Federal prosecutors in Brooklyn and Manhattan said yesterday that their offices were investigating adult homes for the mentally ill in New York City to determine whether poor conditions in the homes resulted from criminal conduct by their operators and health care providers. F.B.I. agents have begun interviewing current and former workers at the homes, and prosecutors said they would focus on whether the operators or health care providers had defrauded federal aid programs, siphoning off money that should have been spent on care for the residents. Their action came after a three-part series in The New York Times that laid out neglect and misconduct in private, profit-making homes, which are regulated by the state.

Ohio

Dayton Daily News, February 3, 2002 There are deaths that are preventable

As it stands on the brink of its most sweeping overhaul since deinstitutionalization began three decades ago, Ohio's \$1.85 billion system to protect 63,000 people with mental retardation is riddled with gaps that have deadly consequences. Since 1997, at least 30 people with mental retardation in Ohio have died from neglect while in the care of others. These people died from chokings, drownings, bowel obstructions, accidents, malnutrition or other causes that experts say are preventable or can be successfully treated. The system is so enshrouded in secrecy that fatal mistakes are often hidden from the public. But an 18-month Dayton Daily News examination, which included more than 200 interviews and a computer analysis of 400,000 Ohio death records from 1997 - 2000, found a pattern of neglect toward the state's most vulnerable citizens.

Ohio

Cincinnati Enquirer, February 2002 Ohio's Secret Shame

At least 12 Ohioans with mental retardation, and probably more, have died in questionable circumstances in the past four years. Deaths from all causes jumped 78 percent, and reports of neglect and other serious incidents quadrupled. Yet there's little public accounting. Some county caseworkers are supposed to watch over 125 people at once, five times the state's recommended number. Taxpayer support is so uneven that one Ohio county spends \$43,800 a year on each person with mental retardation, while another spends just \$2,800. Articles in the investigative series include, "Twelve who died," "Unequal System," "Who is accountable," "Slow reform," "Take control," and "Taft to review plight of retarded in response to report on questionable deaths."

Service Employees International Union (SEIU)

Widespread Problems in Quality of Care January 28, 2002

A new online service launched today provides important information for family members of people with mental retardation/developmental disabilities (MR/DD), advocates, state regulators and purchasers of MR/DD services. The service, <http://www.rescarewatch.org>, tracks issues regarding quality of care provided by ResCare, Inc., and its subsidiaries in the United States. The online service is not affiliated with ResCare, Inc. Copies of inspection and investigative reports for problem programs in California, Indiana and other states.

Wisconsin

Milwaukee Journal Sentinel, January 25, 2002 Charges allege care center abused patients

A North Carolina-based corporation was charged in a groundbreaking prosecution Friday with 10 criminal counts alleging physical and sexual abuse of developmentally disabled patients at its care center in Milwaukee. Personnel at the Jackson Center Nursing Home, where "use of alcohol and drugs by staff" is a "regular" occurrence, were responsible for "numerous acts of abuse," ranging from ear twisting to forced hot sauce feeding to sexual assault on an elevator, the criminal complaint filed by the state attorney general's office charges. Neglect led to an unattended patient falling out a third floor window and another nearly drowning in a whirlpool, the complaint says. Benchmark Healthcare of Wisconsin Inc., was charged in the complaint with six counts of intentional abuse of a patient, three counts of intentional neglect of a patient and one count of second-degree sexual assault. The charges carry fines totaling up to \$91,000. Assistant Attorney General William E. Hanrahan, who drafted the criminal complaint after an investigation by the Medicaid fraud control unit of the state Justice Department, said the unusual step of charging a corporation with crimes was taken because "the primary responsibility for the patients' care lies with the corporation." The facility in question is a

large community-based facility.

Connecticut

Hartford Courant, December 2-4, 2001

Fatal Errors, Secret Deaths

Despite a history of official insistence that untimely deaths are virtually nonexistent in Connecticut's 774 group homes for people with mental retardation, a *Hartford Courant* investigation of group homes found evidence of neglect, staff error and other questionable circumstances in one out of every 10 deaths over the past decade. The series spans five articles, including "The Toll: Suffocation, Drowning, Choking and Burns," "How did they die? The State Won't Say," and "Lawmakers Call for Inquiry into DMR."

Georgia

**Atlanta Journal-Constitution, December 2-4, 2001 Dying
in Darkness**

At least 163 of Georgia's most vulnerable residents have died under the state's watch in the last four years, in circumstances largely shrouded in secrecy. Some who died were malnourished, bruised, scalded, and dehydrated. *The Journal-Constitution's* investigation into deaths of people with mental retardation began as an assignment to see how former residents of the Brook Run retardation center were faring after the facility closed in 1997. Many of the 60 families interviewed expressed concerns over injuries and deaths of residents who had been moved into smaller residential settings around the state. The Journal found that "Group home deaths reveal ugly picture of state care." The series spans 7 articles.

National

**Children and Family Research Center, November, 2001 Abuse
of Developmentally-Disabled Children Bibliography**

This resource lists 72 peer reviewed studies about the abuse of children with developmental disabilities (8 pages). [Internet Access: <http://cfrcwww.social.uiuc.edu/respract/biblio.pdfs/abuseofdisabled.pdf>].

Minnesota

**Minneapolis Star Tribune, October 25-31, 2001 Voiceless
and Vulnerable**

Since 1995, at least 20 Minnesotans with mental retardation and other problems have died in cases in which maltreatment or questionable care was identified, a *Star Tribune* investigation found. The deaths involved neglect, starvation, physical restraint, medication overdose, drowning or other circumstances. At least 15 died in group homes where authorities or workers raised questions about proper training. The state's watchdog, the Office of the Ombudsman for Mental Health and Mental Retardation, has a backlog of about 500 deaths of mentally retarded and other vulnerable people that have yet to be reviewed. In addition, in 1994, the ombudsman stopped requiring intensive review of injuries, despite having broad authority to do so. More than 4,000 mentally retarded people have suffered serious injuries since then, the newspaper found. The injuries, which were reported to the ombudsman's office, ranged from serious head injuries to fractures to burns to frostbite. The number of serious-injury reports has increased each year since 1998, with 424 reported that fiscal year and 672 in fiscal year 2001. The *Star Tribune's* investigation provides the first public examination of deaths of mentally retarded people in Minnesota. Their files had been kept confidential by the ombudsman's office until the *Star Tribune* sued to have them opened. Three national experts reviewed death files for the *Star Tribune*. All three concur that Minnesota's system is broken, dangerous and operates with little accountability.

Pennsylvania Auditor General Audit, October 9, 2001

**Casey audit finds serious deficiencies in state's oversight of Personal Care Homes; Offers over
30 recommendations to better protect residents' health and safety**

The Pennsylvania Department of Public Welfare (DPW) was seriously deficient in its oversight of personal care homes, according to a performance audit released today by Auditor General Robert P. Casey, Jr. During the two-year period covered by Casey's audit, DPW renewed licenses without verifying that serious violations were corrected, licensed new homes without ensuring that administrators and staff were qualified, failed to impose fines and penalties as required by law, and investigated almost half of the complaints it received late. The commonwealth currently annually inspects about 1,900 personal care homes which, by definition, provide "safe, humane, comfortable and supportive residential settings" for older or disabled adults "who require assistance beyond the basic necessities of food and shelter but who do not need hospitalization or skilled or intermediate nursing care." In the two-year period covered by Casey's audit -- July 1, 1998, through June 30, 2000 -- bed capacity at Pennsylvania personal care homes increased 34 percent. During this time, however, DPW was not adequately staffed to oversee these homes. Casey's audit found that there were just 34 DPW employees monitoring more than 1,800 personal care homes with nearly 50,000 residents and a licensed capacity of nearly 75,000. [Internet Access: <http://www.auditorgen.state.pa.us/Department/Press/PCH-PR.html>]

Washington, D.C.

The Washington Post, September 9 - 12, 2001 The District's Lost Children

This four day investigative series (9 articles) reveals a decade of deadly mistakes that resulted in the deaths of 229 children from 1993 through 2000. One in five lost their lives after government workers failed to take key preventive action or placed children in unsafe homes or nursing homes. Seventeen of the deaths were homicides, most of them in homes. Many of these children were severely disabled. In the District, there are few long-term alternatives for severely disabled children whom nobody wants: some group homes, out-of-state institutions and foster homes.

Kansas

The Wichita Eagle, September 5, 2001 Malpractice verdict: \$4 million

The family of a developmentally disabled woman who died in a western Kansas rehabilitation center won one of the state's biggest malpractice awards Tuesday: \$4 million. The verdict included \$2.5 million in punitive damages against Golden West Skill Center of Goodland and its parent company, Res-Care Kansas Inc. It was the largest jury award in Kansas for medical malpractice in three years, culminating an eight-week trial before U.S. Magistrate Judge John Reid at the federal courthouse in Wichita. The case involved the treatment of Christine Zellner, 23, of Denver, who died 13 days after entering the Goodland facility in January 1996. An autopsy never determined the cause of death, but the woman was found face down with marks on her wrist indicating she'd been tied up.

Wisconsin

The Milwaukee Journal, August 25 - 30, 2001 Caring for the Elderly, Disabled: Overwhelmed and Broken Down

A six-month examination of long-term care in Wisconsin finds caregivers overwhelmed, families torn apart and businesses barely surviving. The elderly and disabled wait interminably for care, and at times, they are harmed by the care they finally receive. And the future looks bleak.

The Tennessean, August 2, 2001 Tennessee may lose disability funding

Tennessee has failed to protect the health and welfare of people with mental retardation who live in supervised homes, a federal report has concluded. The federal government placed a moratorium on moving any more residents of state-run developmental centers into the community until the state takes "corrective action." Findings

include, numerous medication errors; inappropriate medical care; many homes did not have adequate food supplies and/or the food in the homes was inappropriate for the clients' diets; staffers often have their children with them while on duty, even when clients' care plans indicate they should have (one-on-one) care; care plans are often outdated or not followed; and community agencies have refused to send records to family members, even when releases have been signed. The report also noted that substantiated cases of abuse and neglect have ranged from 25 incidents for every 100 individuals in homes in the community to 42 incidents per 100. In comparison, the rate for the state's developmental centers last year was 14 substantiated incidents of abuse or neglect for every 100 residents, according to a separate report released in January. The federal government began investigating last year after receiving complaints from family members that the state did not seem to be able to correct the problems.

Maryland

The Herald Mail, July 23, 2001

State reports cited agency for poor living conditions

The now defunct Hagerstown-based agency that served 25 developmentally disabled people last year received nearly 40 pages of citations from the state, some of which alleged poor living conditions, improperly trained staff and lack of medical supervision. The citations for Consumer Driven Services Inc. are listed in a 37-page May 2000 report put together by the state's Office of Health Care Quality. A 24-page follow-up report completed in December 2000 alleges that the agency did not fix many of the conditions for which it had been cited in the first report. The report states that many staff members of Consumer Driven Services were not properly trained in CPR, first aid and treatment for seizure disorders. An inspection of the group homes run by the agency turned up alleged safety and health hazards. An inspector of one of the homes wrote in the May report: "There is a strong smell of urine coming from one of the bedrooms that can be detected from the hallway. The bedroom bath has a very stained toilet and the shower door is broke. The cover is off the temperature control in the hallway. Curtains are off the window in one individual's bedroom and the dresser door swings open. A pot of stew, left over from the previous day, was found inside the oven." One of the visits by state officials in December found that the temperature in the living room and bedrooms in one of the homes was 55 degrees for several days. The reports also state that some of the group homes were understaffed, compromising the health and safety of the clients. Other pages of the reports detail instances in which one client had 12 to 15 teeth pulled by a dentist without first being told of the decision and another client was not being given doctor-ordered biweekly blood pressure checks. Consumer Driven Services had received state funding from the Western Region Developmental Disabilities Administration (DDA) until the local agency filed for bankruptcy on July 7. The DDA was the main funding source for the agency, contributing about \$1.2 million toward the agency's annual budget.

Illinois

The Arc of Illinois — Today, July 20, 2001 HCFA

Comes Back to Illinois

In 1998, the Health Care Financing Administration (HCFA; now called Center for Medicare and Medicaid Services (CMS)) audited the Illinois home and community-based waiver. At that time CMS stated: "The review team found that the State is not in compliance with the statutory and regulatory requirements set forth to protect the health and welfare of waiver individuals and to safeguard the integrity of Federal funds expended. Illinois Department of Public Aid has not fulfilled its responsibilities to oversee the integrity of the programmatic and financial aspects of the waiver program. It has not adequately overseen Illinois Department of Human Services functions and activities by failing to perform evaluations of the waiver's implementation including program and fiscal integrity and accountability for both Federal and State funds expended by Public Aid." As a result of these findings, a moratorium was placed on new waiver placements and adult foster care was withdrawn from the waiver program.

The 2001 CMS audit of the Illinois waiver program will not find the Illinois waiver in jeopardy and will be less dramatic in its findings. Nonetheless, there continue to be serious problems that require attention in the following areas: Implementation of Program Plans; Inappropriate Use of Psychotropic Medications; High Case Loads;

Ineffective Problem Resolution; Lack of Authority; Failure to Communicate with Co-Agencies; Lack of Freedom of Choice; and Placement in Restrictive Day Programs.

Virginia

Times-Dispatch, July 19, 2001

Mental care crisis looming? Psychiatric-beds shortage worsening

Hospitals and rescue squads were forced to use a regionwide emergency plan for the first time this week to find beds for acutely ill psychiatric patients in the Richmond area. The decision to use the emergency diversion plan Monday was the latest sign of the worsening shortage of hospital beds for psychiatric patients since the closing of Capitol Medical Center in Richmond this month. "I wouldn't say it's a crisis, but it's on the verge of being a crisis," said Jon R. Donnelly, executive director of Old Dominion Emergency Medical Services Alliance, which helps coordinate operations between hospitals and rescue squads. The emergency plan was put into effect early Monday and ended late that night, but the loss of Capitol's 62 psychiatric beds continues to be felt by local hospitals and mental health agencies. Hospital emergency departments are seeing more people with psychiatric problems and being forced to hold them longer until a bed becomes available.

California

The Center for Outcome Analysis, July 1, 2001

Eight Years Later: The Lives of People Who Moved From Institutions to Communities in California/Year 2001 Report of the Quality of Life Evaluation of People with Developmental Disabilities (The "Quality Tracking Project")

This report seeks to answer two questions, "Are the people who moved ("Movers") better off than they were when living in Developmental Centers?" and "Are the people who moved into community homes better off than they were last year? (do they continue to grow, learn and flourish year after year in the community?)."

The report finds that Movers are generally better off in 11 of the 21 "dimensions." The report notes that the Movers are somewhat worse off in the "number of close friends," the "staff perceptions of the quality of health care," the "frequency of dental care," and the opportunity for supportive and competitive employment. Researchers also found, however, that the average Mover lost ground in adaptive behavior in the past year in the community. The average Mover also lost ground in the challenging behavior area; that is, their challenging behavior increased. The researchers noted, "This is the first time in 22 years of constant research by this team that such an outcome has been observed. We have never before seen people in community service systems lose skills and increase challenging behavior. However, the monitoring process put into place through Welfare & Institutions Code 4418.1 has resulted in early detection of these problems. A concerted effort to identify the reasons for these outcomes can surely result in quick and decisive action to arrest further decline. Without the kind of quantitative monitoring mandated by the Legislature for the present project, no one would even know that the average Mover has now begun to lose ground behaviorally." Researchers attribute the decline, in part, to an underfunded community system.

Office of Inspector General, U.S. Department of Health and Human Services May 3, 2001

Reporting Abuses of Persons with Disabilities

Federal requirements for protecting persons with disabilities from abuse and neglect are directed at facility providers rather than State agencies. Some persons with disabilities reside in facilities that are subject to the Health Care Financing Administration's (HCFA) conditions of participation as well as State laws and regulations. However, we estimated that up to 90 percent of persons with disabilities reside in facilities, such as group homes, some residential schools, and supervised apartments, that do not receive HCFA funds or were not part of the Medicaid waiver program and rely solely on various levels of protections that are provided by State laws and regulations. In addition, Department of Health and Human Services (HHS) is at a disadvantage in identifying systemic problems since it receives incident information from a limited number of sources.

We recommend that HCFA, the Administration for Children and Families, the Substance and Mental Health Services Administration, and the Food and Drug Administration work cooperatively to provide information and technical assistance to States that would (1) improve the reporting of potential abuse or neglect of persons with disabilities; (2) strengthen investigative and resolution processes; (3) facilitate the analysis of incident data to identify trends indicative of systemic problems; and (4) identify the nature and cause of incidents to prevent future abuse. [Internet Access: <http://oig.hhs.gov/oas/reports/region1/10002502.htm>]

Missouri

Missouri Office of State Auditor, March 15, 2001

Missourians with developmental disabilities who rely on contractor-operated facilities are not well protected from acts of physical aggression by other clients or from medication errors. Inadequate monitoring by the states 11 regional centers over contractor-operated facilities, which provide day programs and residential environments to nearly 9,000 developmentally disabled, leave clients and staff at risk. The review included an analysis of incident and injury reports of eight contractors operating in five of the states regional centers.

Wisconsin

The Milwaukee Journal, February 21, 2001

Inspector falsified reports on care sites, officials say; Misconduct charges sought amid state report alleging 'pattern of lying'

A state inspector responsible for monitoring the care of frail elderly and disabled clients in more than 100 assisted living homes is accused of falsifying reports to show some homes were problem free when, in fact, he had not visited them for years. "There . . . were ample indications that the employee's performance had not been adequate for a significant period of time," Patrick W. Cooper, director of the state Office of Program Review and Audit, wrote in a cover letter to the report. "The employee wrote only 11 statements of deficiency over an almost four-year period, when a typical licensing specialist might have written between 150 and 200." "The employee's work was also subject to many complaints by external parties, yet these complaints were not acted on in a manner that would lead to uncovering the extensive misrepresentation of work activities. . . . We believe he showed a pattern of lying about having completed licensing and complaint investigation work that he, in fact, had not performed." [Internet Access: <http://www.jsonline.com/news/metro/feb01/inspect21022001a.asp>]

Texas

WFAA-TV (Dallas News 8), February 8, 2001 News 8 investigates ResCare Part II

[Transcript excerpts] "Thirty years ago, a process began in this country to stop warehousing people with mental retardation in state institutions and move them out into community-based group homes. The theory was that by deinstitutionalizing people with mental retardation, we would give them better, more normal lives. ResCare is the largest provider of group homes in Texas and the nation. In Texas, many people may know ResCare as EduCare, because the two firms merged about two years ago. Together they operate more than 170 group homes around the state. No one else comes close in sheer volume of clients or revenue. It's become a multi-billion dollar business, which has some asking why the company only allocates \$5 per day per person to feed their mentally retarded clients . . ."

"According to ResCare, the amount [\$5 per day] is an 'acceptable and widely used rule of thumb for a daily food budget' and 'falls within the official guidelines available from (USDA).' But a 1995 study which specifically compares 700 group homes in Texas shows that even six years ago, the average daily allotment for food was \$5.86 per person. The study was provided by ResCare's own paid consultant . . . Today, criticism of ResCare's treatment of their mentally retarded clients extends beyond just food and the borders of Texas. The company has come under fire in Florida, Indiana and New Mexico, where there is a moratorium on placing any new residents

in ResCare facilities because of serious health and safety issues . . . But what concerns advocates for the mentally retarded is that despite numerous warning signs over the years, state regulators have continued to let ResCare expand — to the point that even if regulators needed to close ResCare’s facilities, there wouldn’t be enough other group homes to take in their clients.”

Washington

Washington State Internal Audit, December 2000

An internal, simulated audit of the DSHS Division of Developmental Disabilities (DDD) Community Alternatives Program (CAP) Medicaid Home and Community-based Services (HCBS) Waiver was conducted to identify potential problems when the program receives its next formal audit by the Federal Health Care Financing Administration (HCFA). The audit of the \$200 million state program for the developmentally disabled found that the program is so "woefully inadequate" that it poses a threat to the very health and safety of the 10,000 people it serves. Federal officials "would likely conclude that the lack of sufficient personnel and resources creates a situation in which no one is fully aware of what is happening to the average developmentally disabled client," the report reads. "Case management oversight and monitoring of individuals is so limited as to pose high risks for the individuals being served."

Connecticut

The Connecticut Post, December 22, 2000 Group homes need uniform safety rules

Advocates for the disabled and the State Department of Mental Retardation want to know whether two drownings at Connecticut group homes for people with mental retardation, being similar and occurring close together, indicate a widespread problem. The Department of Mental Retardation will investigate whether the drownings were isolated incidents or part of a pattern of neglect.

Pennsylvania

The Post-Gazette, September 29, 2000

Retarded man drowns in group home; was moved from Western Center in May

The state Department of Public Welfare will launch an investigation into the death, said Jay Pagni, a spokesman. The parents' group that fought the closing of Western Center have tabulated that 23 mentally handicapped people have died from accidents in group homes since they were taken out of Western Center. In 1998, the state decided to close Western Center and move its remaining 380 residents to group homes. State Auditor General Bob Casey Jr. released a 162-page audit in May that criticized state welfare officials for being too lax, too slow, and too ineffective in ensuring the safety of mentally retarded individuals living in group homes.

Maine

Maine Sun Journal, July 23, 2000 Institution gets new lease on life

It is what was best about Pineland, an institution that closed in 1996, that captured the imagination of Owen Wells who heads the Libra Foundation. "I found [Pineland] had spectacular potential," he says. "How better to meet the needs of the disabled people, both physically and mentally, here in Maine?"

Wells pictures a multi-use complex that would draw tenants from all walks of life, including white- and blue-collar businesses, accommodating all handicaps. It would mix business, industry, recreation and education. His picture is set out in blueprints, approved by town and state officials. In December, he signed a purchase agreement for the property. The deal closed last month with Libra paying \$200,000 for the campus and \$540,000 more for an additional 617 acres abutting the former school. Estimates for the completed project top \$40 million.

Rather than running from its controversial past, Wells chose instead to embrace it. "I thought there's nothing to be ashamed of in terms of what Pineland was for many years. It was a wonderful farm operation and it was a wonderful facility," he says. He's even commissioned a book about Pineland's 88 years as an institution. "We set out very early not to abandon the history," Well says. "The history is good. We think it is a history that ought to be acknowledged."

Texas

Austin American-Statesman, May 31, 2000 Hard questions about their care

Between March 1999 and last April, Texas withheld Medicaid money from at least 104 group homes for health and safety violations. Unless there is a complaint, Texas conducts annual surprise inspections of its 11 state schools and 890 group homes with six or more residents. It surveys the providers of more than 200 smaller homes but doesn't inspect them. Most of the money was withheld from group homes because of minor infractions, but there also were about a dozen more serious cases of abuse and neglect. Texas will have to make a much bigger commitment than it's making to properly move to a community-based system. Compared to other states, Texas allocates little money for Medicaid, the joint state-federal program that pays for much of the care in any setting. In 1998, Texas was 41st in total spending. It was 40th in community-care spending and 29th in institutional spending. Texas' relative stinginess may have contributed to some of the health and safety violations in the state schools and group homes. Many of the incidents were related to a lack of supervision. With an entry-level, direct care job at Austin State School paying just \$7.26 an hour — about 50 cents more than the starting salary at McDonald's — state schools and group homes have trouble attracting and keeping staff.

The American Prospect, Volume 11, No 12, May 8, 2000 Neglect for Sale

Two decades ago, advocates fought to shut down abusive institutions that warehoused the mentally retarded. Today, people with developmental disabilities face a new threat: big business. The American Prospect offers an investigative report by Eyal Press and Jennifer Washburn which looks at ResCare, the nation's largest for-profit provider of services to people with developmental disabilities.

[Internet Access: <http://www.prospect.org> - link: Archives (search by author -- Eyal Press) [Direct Link: <http://www.prospect.org/print/V11/12/press-e.html>]

Pennsylvania

Pennsylvania Auditor General Audit, May 8, 2000

Audit finds serious deficiencies in Ridge administration's oversight of group homes; Casey offers nearly 50 recommendations to improve quality of care

A performance audit of the Commonwealth's oversight of group homes for the mentally retarded in western Pennsylvania has found serious deficiencies that threaten the health and safety of residents, including allegations of abuse and unexpected deaths that were not investigated promptly, direct care workers with criminal backgrounds, and inadequately trained caregivers. In addition to numerous audit findings, Pennsylvania Auditor General Robert P. Casey, Jr.'s audit report offers 47 recommendations to improve the Ridge administration's oversight of group homes and, ultimately, the quality of care provided to group home residents across Pennsylvania. Casey's audit, which examined the Pennsylvania Department of Public Welfare's (DPW) oversight of eight group homes in Allegheny, Beaver, Fayette, Washington, and Westmoreland counties from July 1, 1994, through June 30, 1999, focused on four areas: 1) unexpected deaths and incidents of abuse; 2) staffing issues that affect the health and welfare of group home residents; 3) the quality of service provided to residents; and 4) the physical condition of the group homes.

Pennsylvania

Post-Gazette, April 12, 2000

State closing home for mentally retarded amid continued appeals, protests

State officials said they would begin to shut down Western Center in Canonsburg today, an announcement that prompted last-minute court appeals, protests from parents and the near arrest of a mentally retarded resident after a confrontation with state police. As final preparations were made for the closing, the center operated more like a fortress than a home for the mentally retarded. State police set up a roadblock behind the administrative building yesterday so relatives could not visit residents until they were moved to other facilities.

New Mexico

Albuquerque Journal, April 9, 2000

Troubled Care: Assisted Living Provider Faces Lawsuit, Complaints, Moratorium on New Clients

On April 9, 2000, the *Albuquerque Journal* reported that ResCare New Mexico, which receives \$10 to \$12 million a year from the health department to serve its citizens with mental retardation and developmental disabilities, has been hit with a number of allegations of neglect and abuse over the past year. ResCare and its subsidiaries in New Mexico have the highest rate of abuse at about 18 cases of abuse per 100 clients; they are also one of the largest community-based providers. A lawsuit has been filed against ResCare alleging a pattern and practice of abuse and neglect; Arc of New Mexico, which serves as guardian for 153 people, will be moving all of its wards from ResCare homes; The Arc is threatening to file a lawsuit against ResCare; and there is a moratorium on new placements in ResCare programs. New Mexico closed its last state-operated developmental center in 1997, following a lawsuit by Protection and Advocacy.

Washington State

Seattle Times, March 24, 2000

Record verdict against state in abuse case

The state Department of Social and Health Services and two adult family-home operators were ordered by a jury to pay \$17.8 million - the largest judgment ever against the state - to three disabled men who say they were molested in the state-licensed facility. The size of the judgment from the Pierce County Superior Court jury shocked officials from the governor's office, DSHS and the Attorney General's Office, the agency that defended the state in the suit. The case has major implications for the future: At least a half-dozen other defendants abused or neglected in long-term care claim they could have been saved from suffering if the state had acted properly. These and other cases were highlighted in a Seattle Times investigation last year that concluded the state did little or nothing to stop abuse or neglect of people in state-licensed care, nor did it often prosecute their abusers.

Oregon

Oregon Statesman Journal, March 12 - March 15, 2000 Fairview's

Legacy

- (1) Sunday, March 12, 2000: Day 1: Success and Failure
 - (a) Safety of disabled in doubt after deaths
 - (b) Inquiries find neglect a key factor
 - (c) Fairview history: Dignity wins out over time
 - (d) High turnover, heavy caseload plague system
 - (e) Homes that work: Group Home (Shangri-La) rebounds from bleak times
 - (f) Salem group home fell into dysfunction

- (2) Monday, March 13, 2000: Day 2: Comparing Services
 - (a) 4,000 disabled wait for state aid

- (b) Waiting list can seem endless
- (c) Fairview's end won't shorten list
- (d) Past residents: Change can be difficult
- (e) Other states face lawsuits
- (f) Views on group homes varied:
 - Group home gets praise from mother
 - Father hopes to see end to group homes
 - Leaving Fairview a mistake: Brothers go without therapy

(g) Individual choice is the main advantage

(3) Tuesday, March 14, 2000: Day 3: Market Shifts

- (a) Caregivers fight to remain solvent
- (b) Group home boom: Turnover, funding still worrisome
- (c) Workers face high demands
- (d) Rising costs hit care provider
- (e) Experiences of area facilities show challenges facing industry
- (f) Low pay fuels staff turnover
- (g) Group homes draw complaints
- (h) Following Fairview's former employees: Many still caregivers; some rebuild careers

(4) Wednesday, March 15, 2000: Day 4: Looking Ahead

- (a) Costs likely to delay developing campus
- (b) Plot offers great variety of options
- (c) Saving old sites possible
- (d) Officials, residents plan for Fairview's future
- (e) Fairview land use complicated issue
- (f) Mothballing costs remain uncertain
- (g) Buildings hard to save or sell
- (h) Industry likely to replace farm

Oregon

The Oregonian, January 7, 2000

State inquiry finds neglect of former Fairview resident

A longtime Fairview Training Center resident who died less than two months after moving into a group home in Salem was neglected by his new caregivers, and public officials who learned of the neglect failed to act, according to a state investigation released Thursday. The report from the Office of Client Rights concluded that neglect led to dehydration and malnourishment in the weeks before his death and that a number of public officials and Salem Hospital failed to report his condition or investigate as required by law. Gary Avery's death has heightened concern about how Fairview's former residents are faring in a community system plagued by high turnover of workers and relatively low wages. To make sure no similar problems exist, the state's Development Disability Services Division is reviewing the cases of 260 other former residents who have been moved into the community since May 1998. Fairview is scheduled to close in late-February.

Washington, D.C.

Washington Post, December 1999 - January 2000 Invisible Deaths: The Fatal Neglect of D.C.'s Retarded

- (1) System Loses Lives and Trust, December 5, 1999
- (2) D.C. Vows Review of Deaths in Homes, December 6, 1999
- (3) City to Investigate Deaths, Williams Promises Accountability, December 7, 1999
- (4) D.C. Official Suspended in Probe of Homes, Records of Deaths Allegedly Shredded December 9, 1999
- (5) Files on Retarded Out of Reach, Advocates Frustrated by Lack of Cooperation from D.C. Superior Court, December 15, 1999
- (6) Group Home Administrator Named, December 20, 1999
- (7) Group Home Deaths, Washington Post Editorial, January 10, 2000

Note: There has been significant follow-up since the investigative series by *The Washington Post* (see e.g., “Progress Reported On Care of Retarded,” September 26, 2000; “Group Homes’ Dept to D.C.: \$6.8 Million,” October 27, 2000; and “District Settles Claims for Retarded, Agreement Includes \$29 Million Fund,” January 23, 2001).

Pennsylvania

A disabled boy, a family in crisis: Mounting pressures may have led a couple to abandon their child, December 1999

Extensive national news media coverage has been available about the crisis facing Dawn and Richard Kelso. The couple has been charged with “abandoning” Steven, their 10-year old son with severe developmental disabilities, at the hospital that had previously served Steven’s extensive health care needs. In December, 1999 Mrs. Kelso retired as a member of the Pennsylvania DD Council; Mr. Kelso is the CEO of a Fortune 500 company.

Washington, D.C.

Washington Post, March - May, 1999

Invisible Lives: D.C.’s Troubled System for the Retarded

- (1) Forest Haven is Gone, But the Agony Remains, March 14, 1999
- (2) Olympic Achievements Out of Reach, March 14, 1999
- (3) Elaborate Structure of Care, March 14, 1999
- (4) Residents Languish, Profiteers Flourish, March 15, 1999
- (5) Nonprofits Struggle in Current of Greed, March 15, 1999
- (6) Death Among the Mentally Retarded, March 15, 1999
- (7) U.S. Probes D.C. Group Homes, May 4, 1999

[Internet Access: <http://washingtonpost.com/invisible>]

Georgia

The Atlanta Constitution Journal, February 20, 1999

In February 1999, three former employees of the Northeast Georgia Community Service Board, which provides social services in a 10-county area, were charged with insurance fraud, theft by deception and conspiracy to commit theft by deception. The three were among nine employees fired on April 1, 1998, after an investigation into allegations of insurance fraud, abuse and neglect involving people with mental retardation. The former employees allegedly sold life insurance policies to the individuals with mental retardation and listed themselves as beneficiaries. Health care officials have said the situation represents one of the worst cases of systemic abuse of clients in Georgia in years. Investigators painted a picture of a community care network apparently operating with almost no oversight. An audit into nine of the 28 community service boards in Georgia was ordered. A preliminary draft reveals a system that lacks oversight and financial accountability and one in which officials manipulate treatment and billing practices to increase Medicaid payments (Source: *The Atlanta Journal Constitution*, February 20, 1999).

California

San Francisco Chronicle, February, 1997 - August, 1998

Fifty-six (56) articles were released detailing the abuse, neglect and death that plagued California's system of community-based care for people with mental retardation following the aggressive deinstitutionalization of over 2,000 people. The articles include reference to University peer-reviewed research that finds risk of mortality to be higher in California community-based programs than in the state institutions serving people with mental retardation.

The California mortality studies can be accessed on the Internet at <http://www.LifeExpectancy.com>, link: articles (comparative mortality studies).

Pennsylvania

The Philadelphia Inquirer, November 1997

Lawsuit without an End

- (1) Serving the Retarded: Some are more equal: Those who once endured a notorious institution get a cornucopia of care in Philadelphia. But others, in the arms of their families struggle. And wait. November 2, 1997.
- (2) Case studies tell a tale of disparity: Two men from Pennhurst exemplify the strides taken on their behalf. And then there's Denise Carruth. November 3, 1997.
- (3) Lawsuit aids some retarded at all costs: The rights of Pennhurst's alumni have been well guarded for years. But amid bounty, some feel forsaken. November 4, 1997.