VOR
A Voice Of Reason
Speaking out for people with
Intellectual & Developmental Disabilities

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Widespread Abuse, Neglect and Death in Small Settings Serving People with Intellectual Disabilities 1997 - 2002

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

NOTE: LINKS IN SOME OLDER ARTICLES MAY NO LONGER BE ACTIVE

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 stte 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 state's 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 . . ."
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> "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 41rst 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 their 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.