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 2006 - 2009

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

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.ocregister.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-classbankheadcourt-council-didnt-see-unfavorable-informationspan/ab14b9f1-6f8e-4805-ba0c-e1bc0ab1ddf3/

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.