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 2010 - 2012

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

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 KillsThree

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 bedsore 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 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 at 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. Res-Care 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.