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 2013 - 2014

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

Oklahoma
17 Deaths Raise Questions About Care Of Oklahoma Developmentally Disabled
Adwatch November 1, 2014

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

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

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

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

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

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

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

New York
Sex offenders in group homes, July 31, 2014
WHEC News (NBC)

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

(The link to this article is no longer active, but there is a related article in 2019)

Georgia
Mentally disabled suffer in moves from Georgia institutions: State unlikely to meet deadline from federal settlement, June 21, 2014
By Alan Judd, Atlanta Journal-Constitution

482 people have been deinstitutionalized since 2010. About three-fourths of the facilities have been cited for violating standards of care or investigated over patient deaths or abuse and neglect reports since 2010. Officials documented 76 reports of physical or psychological abuse, 48 of neglect, and 60
accidental injuries. In 93 other cases, group home residents allegedly assaulted one another, their caregivers or others. Forty people died after moving into group homes. At least 30 of those deaths had not been expected.
http://alanjudd.wordpress.com/2014/07/10/mentally-disabled-suffer-in-moves-from-georgia-institutions/

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

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

Two residents did die.

Chuck died 3 days after his transfer after falling down the steps while strapped and seated in his wheelchair. The DHS investigated but not fine was issued. Theo only penalty for Chuck's death was to install a lock. See, https://www.forwardhealth.wi.gov/prod/kw/dqa/CMTX11POCS.PDF.

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

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

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

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

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

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

Tennessee
The Tennessean, February 27, 2014

State Fights back against abuse of disabled adults (State Fights back against abuse of disabled adults ("Broken Trust" series)by his caretaker, captured in disturbing cellphone video footage obtained by The Tennessean, is a rare occurrence, "something so egregious and so horrendous it bothers every one of us to know it's occurred," the Department of Intellectual and Developmental Disabilities' chief attorney said Wednesday. Yet, problems have increased significantly among former residents of Tennessee's developmental centers.

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

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

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

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

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

Tennessee
The Tennessean, February 10, 2014
When people with intellectual disabilities leave facilities, results can fall short ("Broken Trust" series)

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

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

Outcomes due to Settlement implementation, which requires the downsizing and closure of facilities for people with intellectual and developmental disabilities and mental illness, are troubling. According to the Georgia Department of Behavioral Health & Developmental Disabilities' "Annual Quality Management Report," January 2013 - December 2013, there have been 1,200 hospitalizations of individuals (mental health and developmental disabilities) residing in community residential programs; 344 individuals requiring treatment

beyond first aid; 318 incidents requiring law enforcement services; 305 individuals who were expectantly absent from a community residential or day program; and 210 alleged physical abuse of an individual. A total of **82 unexpected deaths of individuals** with mental illness and developmental disabilities were reviewed during 2013.

National

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

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

http://www.motherjones.com/politics/2013/04/timeline-mental-health-america
http://www.motherjones.com/politics/2013/04/map-states-cut-treatment-for-mentally-ill

California

The Press Democrat, February 22, 2014
Police: Embezzlement from disabled went on for years

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

California

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

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

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

California

Los Angeles Times, February 18, 2014

L.A. Suit Accuses Unlicensed Care Facilities of Abuse

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

Some residents slept in bunk beds crowded into small rooms with 1-inch pads instead of mattresses. One resident lived in a "storage room" and others in an attic.

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

Ohio

NewsChannel5 (Cleveland), November 8, 2013
Neglect and abuse of Ohio's disabled slips under the radar

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

- **PART I: Ohio Department of Developmental Disabilities often fails to act, leaving disabled at risk**
  The Ohio agency that oversees those with developmental disabilities often fails to act despite serious health and safety violations by service providers. More than 2,000 people with disabilities were victims of abuse last year - ranging from physical and sexual assaults to neglect – across Ohio. Among the findings were 76 cases involving sexual abuse, 373 involving physical abuse and 1,072 cases of neglect. All were found to be substantiated by the Ohio Department of Developmental Disabilities. Even so, service providers are rarely put out of business.
- **PART II: Hundreds of Ohio service providers for disabled repeatedly ignore health, safety regulations**
  Hundreds of Ohio service providers for disabled repeatedly ignore health, safety regulations. Of 1,587 compliance reviews of service providers performed by the Ohio Department of Developmental Disabilities, 600 failed to follow state regulations.
- **PART III: Sexual abuse, neglect triggers increased scrutiny of service providers for Ohio's disabled**
  As a result of the NewsChannel5 investigation, Ohio State Senator Mike Skindell is proposing new legislation that would require the Ohio Department of Developmental Disabilities to post inspection and compliance reports online.

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

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

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

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

Illinois

WJBD News, October 1, 2013

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

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

New Jersey

The Record, September 25, 2013

Arrest of disabled New Milford man sheds light on police dilemma

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

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

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

Services for developmentally and intellectually impaired adults over age 21 “are definitely in short supply,” said Rocco Mazza, communications director for Bergen County Human Services. “The state needs to take a look at how they can address that.”
http://cached.newslookup.com/cached.php?ref_id=218&siteid=2178&id=3223552&t=1380166893

California

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

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

The Investigative Unit uncovers thousands of California residential care facilities are not required to have certain protections that fire officials say save lives in emergencies. Residents have died in such fires.

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

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

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

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

South Carolina

The Post and Courier, April 10, 2013
Study shows S.C. residential care facilities 'unsafe and deplorable'

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

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

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

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

Connecticut

Hartford Courant, March 3 – 5, 2013
Tracking Abuse Among A Vulnerable Population Is A Difficult Task; Courant Investigates Deaths Of Disabled In State Care

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

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

disabled-man

Connecticut

Hartford Courant, March 4, 2013

Senator Urges Federal Probe Into Abuse, Neglect Of Developmentally Disabled

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

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

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

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

National

Modern Healthcare Magazine, January 12, 2013

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

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

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

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

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

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

National

Modern Healthcare Magazine, January 15, 2013

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

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

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

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