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 2015 - 2017

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

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

The Maine Department of Health and Human Services failed to investigate the deaths of all 133 people with developmental disabilities who died between January 2013 and June 2015 while under the care of community-based providers across the state, and, as a result, failed to report suspicious deaths to law enforcement agencies to determine if crimes had been committed, according to a federal audit released Thursday, August 10, 2017.

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

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

Oklahoma
Company that Operates Oklahoma Group Homes for Children and Disabled Has History of Problems News OK June 18, 2017

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

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

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

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

reported to have been smoking marijuana and socializing with one staff member's boyfriend at the time they should have been supervising the residents."

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

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

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

Following three deaths, a U.S. Department of Justice investigation is underway into the decision to transfer Central Virginia Training Center residents to another state facility, according to Secretary of Health and Human Resources William A. Hazel Jr.

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

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

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

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

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

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

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

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

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

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

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

In a follow up story, the Tribune reported that state lawmakers have proposed six new laws that would strengthen licensing requirements and oversight for thousands of group homes for adults with disabilities. The legislative measures, state

officials said, are part of a continuing overhaul of the state's sprawling and fragmented group home system, which shelters more than 12,000 adults with intellectual and developmental disabilities.

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

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

2. http://www.chicagotribune.com/news/watchdog/grouphomes/ct-group-homes-new-legislation-met-20170130-story.html

Massachusetts

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

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

July, 2016

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

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

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

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

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

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

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

Connecticut

Department of Health and Human Services, Office of the Inspector General's Report:
Connecticut Did Not Comply with Federal and State Requirement for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries
May, 2016

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

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

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

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

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

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

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

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

New Hampshire
History of Abuse causes closing of Lakeview Neurorehabilitation Center

Corruption runs in the family at American Neurorehab Centers
Reveal News Organization, November 4, 2015

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

State inspectors already knew a lot about Lakeview's problems. Since the mid-1990s, they had been warned about fraud, abused clients, falsified records, medical negligence and aggressive marketing to vulnerable parents. They even knew about the suspicious death of one Lakeview client in 2012. But they did not crack down until a disability rights watchdog group published the details of that death in a 2014 report, which also detailed the systemic abuse of other clients.

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

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

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

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

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

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

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

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

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

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

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

Georgia

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

On October 29, 2010, the State of Georgia and the Department of Justice (DOJ) entered a settlement agreement

calling for the closure of all facilities serving people with developmental disabilities (ICFs/IID) and the deinstitutionalization of 9,000 people with mental illness. Since then, two DD facilities have closed; two remain open.

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

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

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

Georgia
Girl's death among 500 in one year in community care
By Tom Corwin and Sandy Hodson, The Augusta Chronicle, March 21, 2015

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

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

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

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

Georgia
A look at 'unexpected' deaths in community care homes
By Sandy Hodson, The Augusta Chronicle, March 21, 2015

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

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

Texas

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[1] http://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/document/2014%20Interim%20QM%20Report%20Final.pdf
(Pages 18-20)

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

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

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

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

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

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

The Modern Asylum

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

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

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

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

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

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

https://www.nytimes.com/2015/02/18/opinion/the-modern-asylum.html