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 2018 - 2019

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

Georgia
Report: Deaths, Lack of Housing Plague Georgia System for Disabled, Mentally Ill
The Augusta Chronicle - August 26, 2019

An independent reviewer found that despite Georgia's claims of compliance, a state health care system for the developmentally disabled and mentally ill is still inadequate.

Georgia claims it is in compliance with a settlement with the federal government to improve the care of those with developmental disabilities and mental illness, but an independent source found their death rate is climbing and that the state still failing to meet its responsibility to house thousands suffering from these disorders.

Earlier this year, the state twice asked the Justice Department to find it had complied with and should be released from a 2010 settlement over its treatment of the developmentally disabled and mentally ill in its care. But in her report to the U.S. District Court filed last week, independent reviewer Elizabeth Jones found a number of areas where the state was lacking and in fact doing worse than in previous years, particularly with the deaths of developmentally disabled patients in community care.

An Augusta Chronicle investigation in 2015 found nearly 1,000 deaths among those patients in community care in both 2013 and 2014, and the state has twice halted moving them from state hospitals into community care over the lack of adequate care among those providers. In its last Annual Mortality Review that covered fiscal year 2017, Jones noted that the death rate has continued to climb each year, from 12.5 per 1,000 in fiscal year 2015 to 16.4 per 1,000 in 2017.

"Perhaps most significantly," Jones notes, the death rate for those the state has already identified as high risk is anywhere from twice to four times as high.

https://www.augustachronicle.com/news/20190826/report-deaths-lack-of-housing-plague-georgia-system-for-disabled-mentally-ill

National (Administration for Community Living)
Government Report Finds Living Centers For People With Disabilities Have Not Conducted Inspections In Years
Forbes - August 14, 2019

The U.S. Department of Health and Human Services (HHS) of the Office of Inspector General (OIG) released a report that reveals that the Administration for Community Living (ACL) has not conducted its required oversight of independent living programs for the last five years.

Americans with disabilities often face severe obstacles in life, such as getting a job, finding adequate transportation methods and living independently at home. Therefore, these independent living service programs play an integral role in bridging the gap between the inaccessibility of society and the livelihoods of people with disabilities. If the systems that are supposed to support them do not do their due diligence, then this already disadvantaged population is left even more vulnerable.

Since July 2014, the ACL has been regulating two separate independent living programs: the Centers for Independent Living and Independent Living Services. These programs aim to support the independence of people with disabilities nationwide by providing tools, resources and support for integrating the disability population fully into their communities. Services rendered by these programs include providing discretionary grants to nonprofit organizations and improving nursing homes and other assisted-living institutions.

Under section 706(c)(1) of the Rehabilitation Act of 1973, which governs both programs, the ACL must conduct onsite compliance reviews of at least 15% of the Centers for Independent Living programs that receive funds under this law. Without these congressionally mandated site reviews, program funds are vulnerable to fraud, waste and abuse.

Upon receiving a hotline complaint in June 2017 alleging that the ACL was not conducting required oversights, the HHS of the OIG conducted an audit of 284 Centers for Independent Living and two Independent Living Service programs that receive federal grants from the ACL. The department was not aware that the onsite inspections were not being conducted until the receipt of the hotline complaint.

The ACL was appropriated $156.6 million for independent living program services during the audit period of October 1, 2015, through September 30, 2017. Although the ACL awarded $151.5 million to grantees for independent living program services, it did not allocate sufficient funds from the remaining $5.1 million to support onsite compliance reviews.

https://www.forbes.com/sites/sarahkim/2019/08/14/government-report-finds-living-centers-for-people-with-disabilities-have-not-conducted-inspections-in-years/#6444fa9912bd

Oregon
$4.5 million lawsuit alleges abuse of developmentally disabled man at state-licensed group home
The Oregonian - August 11, 2019

In September 2014, Margaret Lamb dropped off her 21-year-old son at a green, one-story house in Gresham with mixed feelings.

She knew her son required more care than she could provide as a working single mother. She hoped the state-licensed group home for developmentally disabled adults would provide Matthew Lamb with the specialized attention he needed.

But she didn't realize she would spend the next four years trying to get him out.

She's now suing the company that operated her son's group home as well as Multnomah County and the state of Oregon, alleging they failed to care for Matthew Lamb, protect him or properly investigate her complaints about his treatment. The suit seeks up to $4.5 million in economic and noneconomic damages.

https://www.oregonlive.com/pacific-northwest-news/2019/08/45-million-lawsuit-alleges-abuse-of-developmentally-disabled-man-at-state-licensed-group-home.html

Indiana
13 Investigates uncovers pattern of abuse, neglect in group homes for the disabled
WTHR-TV13 - July 29, 2019

Indiana's most vulnerable residents are often cared for in group homes with round the clock staff. No one disputes it can be a tough job, but when you have an industry with high turn over rates and improperly trained workers, group homes can become places of extreme abuse.

13 Investigates' Sandra Chapman uncovered troubling issues for a provider with a network of group homes across the state and the country. One of these group homes is in a house located on Atwood Court in Fishers. The home is operated by ResCare, one of Indiana's largest residential care providers, and is where Indiana's most vulnerable are supposed to be protected.

Records show that protection wasn't extended to Anthony Harris who lived at the ResCare group home in Fishers. Harris has cerebral palsy and is completely disabled and non-verbal.

A caregiver admitted to viciously beating Harris in 2017.

Emergency workers found Harris bloodied, beaten and, according to his attorney, tortured inside his room. He suffered all of the injuries at the hands of Michael Anderson, the man ResCare hired to care for him.

Emergency room nurses from Community Hospital were the first to alert police.

In a 911 call obtained by 13 Investigates, a nurse tells the dispatcher: "His face is all bruised up. His eye is swollen and the CAT scan, it seems like he might have been abused in the group home or somewhere. And there's another patient that came from the same group home, same situation. His face is all bruised up," she said, referring to Harris' roommate who was also attacked.

"There was blood everywhere. It had been splattered. It was a horrific scene," said Scott Benkie, the Harris family attorney.

https://www.wthr.com/article/13-investigates-uncovers-pattern-abuse-neglect-group-homes-disabled

Missouri
Missouri reaches more than $1 million settlement in disabled man's death
KSHB-TV41 - July 26, 2019

After the death of a developmentally disabled man in Missouri's care, the state has paid more than $1 million to settle a federal lawsuit. Carl DeBrodie's badly decomposed body was found in a garbage can encased in concrete in a Fulton, Missouri, storage locker in April 2017. DeBrodie, 31, had been staying at Second Chance Homes, a Fulton facility contracted by the Missouri Department of Mental Health's Division of Developmental Disabilities.

"They went through that provider enrollment process, and then they were basically out there and could start making themselves available for families and guardians to select as a provider," said Valerie Huhn, director of the Division of Developmental Disabilities. The money to pay for providers such as Second Chance Homes comes from both federal and state tax dollars.

According to the now-settled federal lawsuit and ongoing criminal cases, Second Chance Manager Sherry Paulo and her husband, Anthony Flores, had DeBrodie fight another client for their amusement.

Those court records also say that in the fall of 2016, DeBrodie had a seizure from his injuries in those fights.

Flores and a client placed DeBrodie in a bathtub and turned on the shower in an effort to get him to snap out of it, according to court records.

"And there was never any type of outside medical care requested or attempted to be given," said Rudy Veit, Summers' attorney in the federal lawsuit.

DeBrodie died in the bathtub.

"He stayed in that tub for a length of time until they moved him to a different location, which was a trash can," Veit said.

https://www.kshb.com/news/local-news/investigations/missouri-pays-more-than-1-million-settlement-for-disabled-mans-death?fbclid=IwAR37Z9JJx_5_KHSnkC9DkZH77y4l-RY2Vg_Ex5mPgillH5DoWH_PE9z8-1E

New York
Why New York says parents weren't told of incidents at group homes
Albany Democrat & Chronicle - July 23, 2019

The state's Office of Mental Health failed to properly notify parents of incidents of abuse at several facilities despite a law requiring timely notifications, according to a new audit from the state's Comptroller's Office.

New York adopted "Jonathan's Law" in 2007 to expand the access to information regarding allegations of neglect and physical, sexual and psychological abuse at state-operated or licensed facilities to parents, guardians and other qualified persons.

The law was named after Jonathan Carey, a 13-year-old non-verbal and developmentally disabled child from the Albany area who died while in state care in 2007. His parents made several attempts to obtain information regarding several injuries he sustained during his time at the facility to no avail.

A review of 210 incidents across eight facilities between April 2015 and Jan. 9, 2018, found 42 incidents with no evidence to support a telephone communication was ever made within the required 24-hour window, the audit from Comptroller Thomas DiNapoli found.

Some facilities also failed to provide requested information to a qualified person within the required timeframe, the audit said.

https://www.democratandchronicle.com/story/news/politics/albany/2019/07/23/why-new-york-says-parents-werent-told-incidents-group-homes/1796379001

Maryland
Service Provider Sued Over Alleged 'Dickensian' Conditions
The Baltimore Sun - July 10, 2019

A residential and educational facility for students with disabilities operated under "Dickensian" conditions, failing to provide children with required medication or appropriate supervision and attempting to cover up assaults, according to a lawsuit filed this month by the Maryland Attorney General's office.

AdvoServ Inc. ran a program for people and students with disabilities in Delaware. Dozens of Maryland children with cognitive disabilities and mental illnesses were sent to their facilities for treatment and education after the state determined their needs couldn't be met at home or in their local schools.

But even though the state paid AdvoServ more than $230,000 a year to care for each child, the lawsuit alleges their facilities failed to "provide even minimally adequate care to the children under their protection."

Maryland ended its contract with AdvoServ in 2016. The state planned to sever ties with the company by October of that year but still hadn't removed the 31 Maryland children in their care when a 15-year-old girl died at the Bear, Del., facility that fall.

The company — whose facilities across the country have a long and troubled history — has since changed its name to Bellwether Behavioral Trade. Representatives did not immediately return calls seeking comment.

The attorney general's office said the state paid AdvoServ more than $13 million to care for children between June 2015 and October 2016, and is seeking to recover unspecified damages and penalties from the company.

https://www.baltimoresun.com/education/bs-md-frosh-disability-services-lawsuit-20190710-sxymb6pigncrrhcincacknsfci-story.html

South Carolina
SC Mental Health patient suffocated by hospital staffers who failed to follow training
The Charlotte Observer - July 14, 2019

A state Department of Mental Health patient suffocated to death earlier this year at the bottom of a dogpile of agency employees who failed to follow the department's training on physically restraining patients.

At least three of the employees involved in the death of 35-year-old William Avant had not been trained properly, according to an ongoing probe by state health regulators reviewed by The State as part of the newspaper's weeks-long investigation into Avant's death.

Avant, a Georgetown, S.C., native who had been in Mental Health's inpatient care for more a dozen years, was killed on Jan. 22 when Mental Health staffers improperly pinned him face down on a Columbia hospital floor and lay atop his back for four minutes, preventing his diaphragm from expanding to deliver oxygen to vital organs. Hospital staffers failed to check Avant's breathing as he died beneath them, records show.

Their actions were explicitly prohibited — in red, all-capital letters — in the department's training manual, raising questions about the agency's management of employees, including training, and how well Mental Health cares for its 100,000 patients, including 1,500 inpatients who are some of the state's most vulnerable residents.

https://www.charlotteobserver.com/news/state/south-carolina/article232536702.html?fbclid=IwAR0xOIZmxFJg6oVbRVcFKcECrg4BFZoTttP9hwiq0av-d67EIc4ZQ5f9gJQ

New York
Judge Orders Expanded Oversight for Mentally Ill New Yorkers In Supported Housing
ProPublica - July 12, 2019 (Follow up to story appearing December 6, 2018)

Not enough people are covered by an oversight system meant to safeguard residents of a New York housing program for people with mental illness, a federal judge found this week, after reviewing a report commissioned in response to a ProPublica and Frontline investigation.

Since January 2014, more than 750 people with severe mental illness have moved out of troubled New York City adult group homes and into subsidized apartments under a federal court order. The idea was to give them a chance to live outside institutions, with services coming to them as needed through a program called supported housing.

But last December, ProPublica and Frontline revealed that more than two dozen people who had moved out struggled to live safely on their own. Many had been repeatedly hospitalized. One went missing; another was in jail. At least six had died under suspicious circumstances, and the state had only recently developed a system to track such incidents.

The story prompted U.S. District Judge Nicholas Garaufis to order a report from Clarence Sundram, the independent court monitor assigned to oversee the transition. Garaufis asked Sundram to gauge the effectiveness of the incident reporting system implemented in the summer of 2018.

https://www.propublica.org/article/judge-orders-expanded-oversight-for-mentally-ill-new-yorkers-in-supported-housing#

New York
Residents Cowered While Workers at a Group Home Smacked and Pushed Them
The New York Times - June 9, 2019

Some of society's most vulnerable people have long been preyed upon by abusive workers in group homes. New York vowed reforms, but they didn't happen.

The people who worked at the brick building that housed 24 developmentally disabled residents called it the "Bronx Zoo."

One worker regularly hit a resident while he ate, making him cower in fear at mealtimes. Another worker would repeatedly “smack, punch and push” a female resident, sometimes when she tried to watch staff members cook. A female worker sat in the lap of a male resident who used a wheelchair, placing his hands on her breasts and moving provocatively while other employees laughed and cheered, according to records and depositions.

The abuse first came to light five years ago, leading to a public outcry and an investigation by the state, which runs the facility, called the Union Avenue I.R.A., in the Bronx. But in a new review of the case, The New York Times found that when officials tried to fire 13 employees for abuse or neglect at the home, they failed each time. The workers were shielded by the state arbitration process, whose shortcomings often return abusive employees to the job.

The Bronx case is emblematic of a larger problem across New York. Hundreds of pages of disciplinary records from 2015 to 2017, obtained by The Times under the state open-records law, show that more than one-third of the employees statewide found to have committed abuse-related offenses at group homes and other facilities were put back on the job, often after arbitration with the worker’s union.

The residents in the state’s far-flung network of more than 1,000 group homes are particularly dependent on their caregivers. In many cases, they are unable to communicate and live in group homes almost their entire lives. Some are also immobile, while others have been all but abandoned by their families.

Recycling abusive employees has long been an endemic problem. Eight years ago, The Times reviewed thousands of pages of disciplinary files for 233 workers. In a quarter of substantiated abuse cases, employees were transferred to other homes rather than fired, including in cases involving sexual assaults. The newly obtained disciplinary records involved 120 employees. They show that while the transfers appear to have decreased, the state still keeps problematic workers at their jobs.

The findings are the latest sign that attempts to change the oversight of care for the developmentally disabled by Gov. Andrew M. Cuomo’s administration has stumbled.

https://www.nytimes.com/2019/06/09/nyregion/new-york-group-home-abuse.html

New Jersey
Bellwether's license to operate group homes in New Jersey revoked
North Jersey Online - May 22, 2019

New Jersey will shut down the state’s largest for profit provider of residential and day programs for individuals with developmental disabilities for operational violations and failure to make needed improvements.

Following an investigation by an independent monitor, a moratorium on admissions and a period of enhanced oversight triggered by reports of alleged operational violations at facilities statewide, Bellwether Behavioral Health will lose its licenses to operate in New Jersey, according to the state’s Division of Developmental Disabilities.

Bellwether did act to address state officials’ concerns, and “has not been able to demonstrate the systemic improvement needed to continue operations in our state,” said Jonathan Seifried, the division's assistant commissioner.

The state report on the independent monitor’s findings released Wednesday found 12 of Bellwether’s 14 group homes operating on provisional licenses in New Jersey were deficient in cleanliness. Half smelled of urine, five had rotten or expired food in the refrigerator and one was found to have mixed up residents’ medications, according to the report.

Some homes had as many as 60 deficiencies, the report states.

https://www.northjersey.com/story/news/new-jersey/2019/05/22/bellwether-nj-license-operate-group-homes-new-jersey-revoked/3768714002/?fbclid=IwAR1cOoVsPKIcvDDF8Sip801ZuxLhoWqbj82tvVlQrYL6S6iW65Z-G62pmf8

Washington
DSHS to pay $8M after neighbors' pleas to help vulnerable Seattle man brought no action
The Seattle Times - May 20, 2018

Vernon Gray was living with rats when a social worker showed up to his Central District home, where a layer of garbage coated the floor and a squalid odor caused people to gag when they stepped onto the property.

That was in 2009, when the state's Adult Protective Services received its first report about him. Gray, who has a developmental disability, had been living in the house alone since his mother died in 2000. Neighbors begged the state to intervene, explaining he was unable to take care of himself. They continued after Gray became homeless in 2013.

Adult Protective Services (APS) investigated Gray's situation three times since 2009, but each time, he was left on his own. The agency, which is within the Department of Social and Health Services (DSHS), investigates reports of vulnerable adults who have been abused, abandoned or neglected. Attorney David Moody argued in a tort claim that the state failed to protect Gray, now 64.

On Thursday, the department agreed to an $8 million settlement, which Moody said is the largest paid by the state in an adult protective services case. The state agreed to settle the case before a lawsuit on Gray's behalf was filed.

This is the latest in a series of troubling and costly incidents at DSHS, which oversees a state mental-health system that has been stung by damaging federal and state court rulings and federal decertification of its main psychiatric hospital.

https://www.seattletimes.com/seattle-news/sorry-for-what-happened-to-mr-gray-says-dshs-about-to-pay-8m-after-neighbors-pleas-to-help-vulnerable-seattle-man-brought-none

California
Cases of abuse, neglect of California disabled clients going unchecked: whistleblower
KTVU-TV2 - April 25, 2019

Cases involving starvation, neglect and sexual abuse targeting developmentally disabled clients in California are not being addressed thoroughly or going unchecked altogether, according to a former North Bay care employee who worked with patients.

Roberto Franco, an ex-employee of the North Bay Regional Center in Napa, said he is blowing the whistle on the multi billion dollar care industry that he believes is overwhelmed with cases and allowing serious incidents to fall through the cracks. "It's crazy because I've been trying to tell people about these things I've seen," he told 2 Investigates.

By law, the California Department of Developmental Services (DDS) is responsible for ensuring more than 330,000 people with developmental disabilities receive services and support. Every year, the department allocates billions of taxpayer dollars to 21 different regional centers statewide to carry out its responsibility. Those regional centers hire and pay service providers to directly house and care for clients whose disabilities include autism, epilepsy, intellectual disabilities and cerebral palsy.

Franco was fired from the North Bay Regional Center (NBRC) in January 2018 for being "unprofessional and insubordinate," according to his termination letter. But he believes regional center management penalized him for being persistently outspoken about client issues. As a service coordinator, it was his job to monitor client care and report problems.

All caretakers, providers and agencies are legally required to report incidents where a client is hurt or could be hurt. These reports are processed by regional centers and DDS.

http://www.ktvu.com/news/2-investigates/cases-of-abuse-neglect-of-california-disabled-clients-going-unchecked-whistleblower

Oregon
US Senate Launches Investigation Of Group Home Provider
The Oregonian - April 3, 2019

The U.S. Senate has launched an investigation into a national corporation's homes for people with disabilities in response to a report about substantiated abuse at one of the company's facilities.

The Oregonian reported in January that Oregon regulators shuttered a Mentor Network home in Curry County following extensive evidence that a client with a disability had been severely neglected. State regulators found that managers repeatedly ignored caregivers' concerns about the person's festering pressure wound, including that it smelled of "rotting flesh."

"When vulnerable Americans are abused or even killed in the care of a taxpayer-funded care provider, that organization must be held accountable," Sen. Ron Wyden, D-Ore., said in a statement this week.

The Senate Committee on Finance, chaired by Sen. Chuck Grassley, R-Iowa, sent letters Tuesday to the Oregon and Iowa branches of the The Mentor Network, demanding copies of a raft of compliance records by month's end. The company operates in 36 states, serving about 13,000 people in group homes and 19,000 in non-residential settings.

The Senate investigation comes on the heels of renewed oversight by state regulators in Oregon who have been closely monitoring Mentor Oregon since finding problems in Curry County in late 2017. This marks the second attempt by the state Department of Human Services to force Mentor Oregon to make its facilities safer for residents.

https://www.oregonlive.com/pacific-northwest-news/2019/04/us-senate-launches-investigation-of-oregon-homes-for-people-with-disabilities.html

Virginia
A caregiver raped two intellectually disabled women, police say. Both gave birth to children.
The Washington Post - March 2, 2019

The mission of the center in Fairfax County is to "employ and support" people with disabilities, but a prosecutor said a worker sexually assaulted a 29-year-old woman with Down syndrome in its offices.

Police began an investigation in October 2017 after a doctor made a disturbing discovery: The woman was five months pregnant, authorities said. She later gave birth.

The pattern played out again nearly a year later. Police say another client at the MVLE Community Center, a 33-year-old woman with intellectual disabilities, was raped. The case was reported to police in August 2018 after her doctor discovered she was pregnant. She also gave birth.

Last month, Bernard Betts-King, 60, a behavioral specialist at MVLE, was charged with sexually assaulting both women. DNA tests showed he was likely the father of the second woman's child, court papers say. DNA results are pending in the other case.

Advocates say the case underscores a problem that has received less attention in the #MeToo era: the sex assault of the intellectually disabled. Numbers produced by the federal Bureau of Justice Statistics for an NPR investigation last year found those with intellectual disabilities are sexually assaulted at seven times the rate of people without disabilities.

https://www.washingtonpost.com/local/public-safety/a-caregiver-raped-two-intellectually-disabled-women-police-say-both-gave-birth-to-children/2019/03/02/06146a2c-36ba-11e9-854a-7a14d7fec96a_story.html

Note: Betts-King pleaded guilty in July:
https://www.nbcwashington.com/news/local/Virginia-Therapist-Bernard-Betts-King-Pleads-Guilty-to-Raping-Impregnating-2-Clients-With-Disabilities-513086811.html

California
El Dorado Hills school where special-needs student died will close
The Los Angeles Times - January 22, 2019

An El Dorado Hills school at the center of an investigation over the death of a 13-year-old autistic student announced this week that it plans to close its doors permanently on Friday.

Guiding Hands School, a private school that has served students with disabilities since 1993, made headlines when a student, identified as Max Benson, died after being placed in a face-down restraint by school staff in November. The California Department of Education said the boy was held down for an hour and 45 minutes, according to Sacramento Superior Court records.

https://www.latimes.com/local/lanow/la-me-ln-guiding-hands-school-closure-20190122-story.html

New Jersey
Missing developmentally disabled man found dead
Atlantic City News (BreakingAC) - December 28, 2018

A developmentally disabled man who disappeared from a day program in Vineland more than two weeks ago was found dead Wednesday, police said
.
While the death is being investigated, the group manager of the Mays Landing home where Robert Nicholson IV lived blames negligence.

Nicholson, 28, left the facility Dec. 10. A landscaper found his body Wednesday, near a retention pond at 3001 E. Chestnut Ave., across from Vineland's high schools.

It was only Nicholson's second day at the facility, where he was supposed to be a "line of sight" patient, meaning he is to be supervised at all times, said Heather Grosso, his house manager.

https://www.breakingac.com/2018/12/missing-developmentally-disabled-man-found-dead/?fbclid=IwAR2BGzyANRTulbN3N1ZaFtk0nKhqZRK4roinka3wpUOZrHD00JNC1D5TQAs

California
Is California Failing Its Most Vulnerable Adults?
Type Investigations - December 11, 2018

A joint investigation by The Investigative Fund at The Nation Institute and FiveThirtyEight has found that from 2013 to 2017, there were at least 2,400 reported allegations of abuse and neglect in the more than 4,500 day programs like Jackie's in California.

The goal of adult day care programs is to help clients build their capacities by doing activities in their communities, rather than by being sequestered in live-in institutions. But our findings, along with a series of industry association reports that found funding gaps have affected the quality of care at day programs, suggest that the state's adult day care system has its own problems. This summer, 51-year-old Timothy Cortinas was found dead in a car in West Covina, California; a lawsuit alleges that he was left alone in the vehicle for hours by a day care staff member as temperatures inside the car climbed to over 100 degrees.

https://www.typeinvestigations.org/investigation/2018/12/11/california-developmental-disabilities-services

New York
Living Apart, Coming Undone: Report from ProPublica & Frontline
ProPublica - December 6, 2018

Abraham Clemente, who is 69 and has schizophrenia, kept the shower and sink running for the "oxygen." He blamed a kitchen fire on a doll nailed to a cabinet. He believed he could crush and smoke his antipsychotic medication to achieve its intended effect.

Yet the state of New York determined Clemente was capable of living on his own.

He is one of hundreds of severely mentally ill New York City residents who have been moved out of institutions into private apartments over the past four years under a landmark 2014 settlement. The approach is meant to be a national model for the rights of the mentally ill to live independently.

It begins with the assumption that most people in adult homes — group facilities that often house hundreds of residents — can live on their own with the right help. Adult home residents are given a subsidized apartment, called scattered site supported housing, and assigned a team of social workers and others to help navigate bureaucracies, housing problems and everyday tasks.

But more than 200 interviews and thousands of pages of medical, social work and housing records reviewed by ProPublica and the PBS series Frontline, in collaboration with The New York Times, show that for some residents, the sudden shift from an institution to independence has proved perilous, and even deadly.

https://features.propublica.org/supported-housing/new-york-mentally-ill-housing-group-homes

Follow up report published July12, 2019:
https://www.propublica.org/article/judge-orders-expanded-oversight-for-mentally-ill-new-yorkers-in-supported-housing#

New York
Sex Offenders Placed in Homes for Seniors and the Disabled
WRGB-CBSTV6 - October 29, 2018

From nursing homes to state-operated homes for the disabled, violent sex offenders have local group homes listed as their home address, and residents have no idea.

The New York Sex Offender Registry indicates a 58-year-old sex offender, who served his time after he was convicted of sexually abusing a 9-year-old girl, is now living at a Clifton Park group home on Lapp Road operated by the NYS Office for People with Developmental Disabilities.

“It's a predator’s dream, they can pray on the most vulnerable, and then you have a system that's all about hiding what's happening from the general public and the families,” Michael Carey said.

Michael Carey oversees the Jonathan Carey Foundation, an advocacy group for the disabled. The foundation is named after his developmentally disabled son who was killed by a care worker in 2007. His team has spent weeks examining the sex offender registry. Far from done, they've already found 80 sex offenders who list a group home as their primary residence. He says mixing sex offenders in with disabled patients is a recipe for sexual assault.

“Many of them can absolutely never tell their parents because they're non-verbal. This is an emergency situation, this is something the governor should be immediately putting a stop to. It’s beyond outrageous, it's unconscionable and it's also illegal,” Carey said.

Carey believes knowingly placing a sex offender in the same home as a disabled patient is a violation of the state law, Endangering the welfare of a disabled person, and also puts care staff at risk.

“There are no cameras, and the staff aren't properly trained,” Carey said.

https://cbs6albany.com/news/local/cbs-6-investigates-sex-offenders-placed-in-homes-for-seniors-and-the-disabled

Related Links:

https://www.adirondackdailyenterprise.com/news/local-news/2018/09/sex-offenders-in-group-homes-for-disabled-isnt-new-in-tupper-lake/

https://www.lohud.com/story/opinion/perspective/2018/09/27/new-york-must-safely-house-developmentally-disabled-sex-offenders/1430061002

Wisconsin
Office of the Inspector General, Department of Health and Human Services:
Wisconsin Did Not Comply With Federal Waiver and State Requirements at all 20 Adult Day Care Centers Reviewed
Department of Health and Human Services, Office of the Inspector General – October, 2018

Wisconsin did not comply with Federal waiver and State requirements in overseeing centers that serve vulnerable adults who receive services through the Family Care program (the program). All 20 of the centers we reviewed did not comply with State certification requirements. In total, we found 208 instances of noncompliance with health and safety and administrative requirements.

https://oig.hhs.gov/oas/reports/region5/51700030.pdf

Florida
Autistic man abandoned at Naples hospital has no place to go
Naples Daily News - August 27, 2018

A public guardian and a state agency thought they had a solution for a severely autistic young man whose mother abandoned him more than a year ago at a Naples hospital.

Placement in a local group home lasted four days before the 22-year-old — referred to as "John Doe" in court records — was back at NCH Downtown Baker Hospital, said Patrick Weber, the public guardian in Collier County.

Doe's care requires intensive services in a 24-hour setting, and no group home in Collier is equipped for that, experts say.

https://www.naplesnews.com/story/news/health/2018/08/27/nch-still-caring-autistic-man-who-has-no-discharge-options-locally/1067492002

Indiana
Group home owner, 4 workers, charged in beating of resident, prosecutors say
The Indy Star - August 15, 2018

The owner of an Indianapolis group home for adults with intellectual and developmental disabilities and four workers have been charged in the beating of a resident that was caught on video, prosecutors say.

Safe Journey LLC owner Amelia Hagedorn, 50, has been charged with criminal confinement with bodily injury and battery resulting in bodily injury to a disabled person, the office of Marion County Prosecutor Terry Curry said Tuesday night in a news release.

Three Safe Journey employees face the same charges. A fourth was charged with failing to report the incident.

https://www.indystar.com/story/news/crime/2018/08/14/owner-indianapolis-based-safe-journey-charged-hurting-resident/994327002/

New Jersey
Murphy Administration Demands Action from Major Group Home Operator after Safety Problems Revealed
NJcom - August 9, 2018

Gov. Phil Murphy's administration has halted new admissions at New Jersey's largest group home operator for people with developmental disabilities and demanded "immediate correction of all concerns" involving safety and staffing shortages uncovered in 18 months of inspections. The state Department of Human Services intends to appoint an independent monitor and to continue random

unannounced inspections at all 62 properties operated by for-profit Bellwether Behavioral Health, state Department of Human Services spokesman Tom Hester said.

According to the report, Bellwether homes in Branchburg in Somerset County drew 156 rescue squad calls over two years, including seven involving employees accused of assaulting residents. Police are routinely called several times a day to intervene when staffing is low, the report said.

In addition to having the largest capacity of any group home provider in New Jersey, at 494 beds, Bellwether has also recorded the largest number of allegations of abuse and neglect. According to state data from March 2017 to March 2018, the state investigated 71 complaints, and substantiated 33. Six residents were repeatedly victimized, the data said.

https://www.nj.com/healthfit/index.ssf/2018/08/group_home_operator_for_disabled_will_get_no_new_a.html

Illinois
Audit rips Illinois' oversight of group homes for adults with disabilities
The Chicago Tribune - July 19, 2018

A damning state auditor general report released Thursday found systemic failures in Illinois' licensing and oversight of thousands of taxpayer-funded group homes for adults with disabilities, problems first exposed in a 2016 Tribune investigation that documented substandard conditions and widespread harm.

The nearly 230-page report also questioned whether the state did enough in recent years to ensure the safe transition of more than 400 vulnerable adults from large developmental centers into the smaller group homes. And auditors found the state used "questionable procurement strategies" when it awarded multimillion-dollar contracts to the company managing that transition.

The audit focuses on the state's oversight of more than 3,000 group homes — one-third of which are in Cook County — that serve about 10,000 adults with developmental and intellectual disabilities. It covers a four-year period ending June 30, 2016.

The auditors cited findings by the Tribune's investigative series "Suffering in Secret," which in late 2016 detailed deaths and mistreatment that occurred inside the group homes and day programs and found the public often was unaware of the tragedies because of secrecy and inaccurate reporting. Tribune reporters identified 1,311 cases of documented harm dating back to summer 2011 — hundreds more cases than the state had publicly reported. In response, state officials retracted erroneous reports and promised widespread reforms.

http://www.chicagotribune.com/news/watchdog/ct-met-illinois-group-home-audit-20180719-story.html#

The Auditor General's Report is available online: https://www.auditor.illinois.gov/Audit-Reports/Performance-Special-Multi/Performance-Audits/2018_Releases/18-CILA-Perf-Full.pdf

California
Temecula caregiver shot 3 developmentally disabled men before setting home on fire, coroner records show
Orange County Register - June 22, 2018

A drunken James Steven Jennex sent a text message to a friend apologizing in advance for his actions and then fired a bullet into the heads of each of three developmentally disabled men in his care before setting his Temecula-area home ablaze and killing himself with a .357 revolver blast to the head.

The fire, on Aug. 29, 2016, at the Renee Jennex Small Family Home, killed a fourth developmentally disabled man and burned all five people beyond recognition. Investigators pulled a gas can from the rubble.

Those facts, never before revealed by the Riverside County Sheriff's Department, were included in autopsy reports obtained from the Coroner's Office by this news organization through a Public Records Act request.

https://www.ocregister.com/2018/06/22/coroner-records-temecula-caregiver-apologized-before-killing-4-

developmentally-disabled-men-himself/

Missouri
Lawsuit Claims Caregivers forced developmentally disabled Missouri man to fight to the death June 1, 2018

A developmentally disabled Missouri man was forced to fight another man for the "amusement" of people who ran the private care home where he lived and was left to die in a bathtub from injuries he suffered in the clash, his mother has alleged in a lawsuit.

Carl DeBrodie in a photo from a missing person's flyer. The body of the developmentally disabled Missouri man was found in a concrete-encased container in the Fulton area on April 24, 2017.

Carolyn Summers, the mother of Carl DeBrodie, 31, also alleges in the lawsuit filed Tuesday that government agencies responsible for her son didn't provide required care and didn't check on DeBrodie for months. DeBrodie's body was found in April 2017 encased in concrete in a container inside a storage area, months after he went missing.

https://www.stltoday.com/news/local/crime-and-courts/caregivers-forced-developmentally-disabled-missouri-man-to-fight-to-the/article_c2da602d-c3d1-5437-83bc-dbb8642f6ee6.html

January, 2018:

JOINT REPORT from U.S. Department of Health and Human Services' Office of Inspector General (OIG), Administration for Community Living (ACL), and Office for Civil Rights (OCR):

"Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight"

This report, released by three agencies operated by the U.S. Department of Health and Human Services, acknowledged the systemic shortcomings in protecting residents of HCBS waiver group homes from incidents of abuse and neglect. OIG found that **up to 99 percent of these critical incidents were not reported to the appropriate law enforcement or state agencies as required**. The report stated, "Group Home beneficiaries are at risk of serious harm. OIG found that health and safety policies and procedures were not being followed. Failure to comply with these policies and procedures left group home beneficiaries at risk of serious harm. These are not isolated incidents but a systemic problem – 49 States had media reports of health and safety problems in group homes.**"**

OIG highlighted the lack of reporting critical incidents of abuse and neglect in privately operated group homes, including "deaths, physical and sexual assaults, suicide attempts, unplanned hospitalizations, near drowning, missing persons, and serious injuries. Critical incidents requiring a minor level of review generally include suspected verbal or emotional abuse, theft, and property damage. For critical incidents that involve suspected abuse or neglect, the HCBS waiver and State regulations also require mandated reporting." It found that in the states under study, "the State agencies did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities."

For more information on the Joint Report go to the ACL website at:
https://www.acl.gov/aging-and-disability-in-america/joint-report-ensuring-beneficiary-health-and-safety-group-homes
The report is available for download at:
https://oig.hhs.gov/reports-and-publications/featured-topics/group-homes/group-homes-joint-report.pdf
or:
https://www.vor.net/images/stories/2017-2018/ACL-group-homes-joint-report.pdf

Connecticut
Autistic Man's Abandonment In Hospital Emergency Room Is Tip Of Deepening Problem
The Hartford Courant - January 1, 2018

A young man with autism and an intellectual disability was abandoned by his family in July and has languished at Manchester Hospital, with no medical diagnosis, for five months as the state's disabilities agency maintained that there were legal barriers to taking him into state care.

The 21-year-old has behavior problems, and he has shuttled between a hospital room, the busy emergency room, and an area normally reserved for psychiatric patients, according to an advocacy group that has taken up his cause at the behest of a hospital staff deeply concerned that they are not equipped to care for him. After the first article was published, the man was placed into a group home. A week later, he was sent back to Manchester Hospital. The group home was not capable of dealing with his behavioral problems.

His presence in the emergency room is indicative of a statewide quandary, as hospitals have become the dumping ground for a growing number of profoundly disabled children and young adults. "Virtually every Connecticut hospital has recently dealt with or is presently dealing with one or more patients like this," said Carl Schiessl of the Connecticut Hospital Association.

A series of four articles illustrate the problems encountered:

December 22, 2017:
http://www.courant.com/news/connecticut/hc-ct-news-disabled-man-languishes-manchester-hospital-1223-story.html

December 26, 2017:
http://www.courant.com/news/connecticut/hc-news-disabled-man-languishes-manchester-hospital-folo-20171226-story.html

December 27, 2017:
http://www.courant.com/news/connecticut/hc-news-manchester-autistic-man-back-emergency-room-1228-story.html

January 1, 2018:
http://www.courant.com/news/connecticut/hc-news-autistic-man-abandonment-statewide-crisis-1229-story.html