



Speaking out for people
with intellectual disabilities

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1. Monitoring Care for the Disabled

New York Times Editorial * May 7, 2012

The stories of abuse, suffering and unexplained deaths among those sent to homes for the disabled in New York State are horrifying. A worker sits on an autistic boy and crushes him to death. Another [worker sexually abuses a 54-year-old disabled woman](#). A quadriplegic drowns as an aide leaves him in a tub of water.

As reported by Danny Hakim and Russ Buettner in The Times over the last year, there have been numerous cases of abuse and at least [1,200 deaths attributed to unnatural or unknown causes](#) in publicly financed homes for the disabled in the last decade. Many cases have barely been investigated, with incompetent workers often being moved to a different facility, without being prosecuted.

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Governor Cuomo Announces First in the Nation Reforms to Protect People with Special Needs and Disabilities; Proposes New Justice Center to Prevent, Investigate and Prosecute Abuse and Neglect of Vulnerable New Yorkers, May 7, 2012

Governor Andrew M. Cuomo today unveiled new legislation to establish the strongest standards and practices in the nation for protecting people with special needs and disabilities. Governor Cuomo's legislation will create a new Justice Center for the Protection of People with Special Needs, an initiative that will transform how the state protects over one million New Yorkers in State operated, certified or licensed facilities and programs. The Justice Center will have a Special Prosecutor and Inspector General for the Protection of People with Special Needs who will investigate reports of abuse and neglect and prosecute allegations that rise to the level of criminal offenses. It will also include a 24/7 hotline run by trained professionals, a comprehensive statewide database that will track all reports of abuse and neglect and a statewide register of workers who have committed serious acts of abuse who will be prohibited from ever working with people with disabilities or special needs. Governor Cuomo's proposed Justice Center for the Protection of People with Special Needs will have primary responsibility for tracking, investigating and pursuing serious abuse and neglect complaints for facilities and provider agencies that are operated, certified, or licensed by the following six agencies: The Department of Health (DOH), the Office of Mental Health (OMH), the Office for People With Developmental Disabilities (OPWDD), the Office of Children and Family Services (OCFS), the Office of Alcoholism and Substance Abuse Services (OASAS), and the State Education Department (SED). The Justice Center will also absorb all functions and responsibilities of the Commission on Quality of Care and Advocacy for Persons with Disabilities, with the exception of the Federal Protection and Advocacy and Client Assistance Programs which will be designated to a qualified non-profit.

[Governor's Press Release](#)

2. Virginia: Martinsville adult group home owner found guilty of abuse

WBDJ.com (Channel 7; Martinsville, VA) * May 7, 2012

Virginia's Attorney General Ken Cuccinelli announced that Richard C. Wagoner, Jr., was found guilty of abuse and neglect of an incapacitated adult that resulted in death. A jury recommended that Wagoner be sentenced to five years'

incarceration. Wagoner will be officially sentenced on October 18, 2012.

The case was investigated by the Martinsville Police Department and the attorney general's Health Care Fraud and Elder Abuse Section. The Elder Abuse section specializes in investigating allegations of abuse and neglect of incapacitated adults, employing both nurse investigators and criminal investigators to assist localities in determining the root cause of injuries and holding responsible persons accountable for their crimes.

On February 8, 2011, after Mr. Tuggle suffered an episode of incontinence, direct care givers placed him in a bathtub while they cleaned the affected area of the house. Mr. Tuggle was placed under a faucet running scalding water and suffered second- and third-degree burns on his legs, face, buttocks, and arm. Ten days later, Mr. Tuggle was found dead in his bed with scabbed burns. The medical examiner determined that Tuggle died from sepsis and pneumonia secondary to thermal injury. His death was ruled as a direct result of the injuries he sustained on February 8, 2011.

According to court testimony, Mr. Tuggle's care givers failed to call 911 or the victim's physician, instead claiming to have called the local hospital's emergency room. The care givers claimed to have received instructions to treat the burns with First Aid ointment. However, hospital policy does not allow personnel to give treatment information over the phone.

An investigation by the attorney general's Health Care Fraud and Elder Abuse section revealed that, following the burn incident, Tuggle's care givers had placed him in a van to transport him to the hospital. However, Wagoner ordered the van to return to the group home. Wagoner then examined Mr. Tuggle's injuries and decided to keep him at the group home instead of providing him with emergency medical treatment.

[Read More](#)

[Read Attorney General Ken Cuccinelli's Press Release](#)

3. Massachusetts: DPPC faults care plan in group home resident's death

COFAR Blog * May 4, 2012 (excerpts)

A state investigative agency (the Disabled Persons Protection Commission) has concluded that a Tyngsborough group home resident died last year as a result of having ingested an inedible object, and that there was sufficient evidence to conclude that his death was due to a lack of adequate supervision by caregivers. The 50-year-old man, who had formerly lived at the Fernald Developmental Center, had reportedly ingested a plastic

bag.

The July 6 death of the resident is one of three cases of death involving former developmental center residents, all men in their 50s. In both of the sudden death incidents, the men had been transferred to state-operated group homes operated by Northeast Residential Services, a division of the Department of Developmental Services. DDS has refused to discuss or provide any information about these deaths, citing confidentiality and privacy regulations.

In a third case, a 51-year-old resident of a Northeast Residential Services home died on February 7, 2012 after having been sent back to his residence twice by Lowell General Hospital. That man had formerly lived at the Fernald Center as well.

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4. Texas: Group homes need city standards in Dallas (Editorial)

***The Dallas Morning News* * May 4, 2012 (excerpts)**

Oak Cliff Councilman Scott Grigg's passionate tone reflected the importance of this debate: City Hall either can keep ignoring the plight of group home residents, usually people with mental disabilities and addictions, or the city can finally move beyond the status quo of just regulating zoning and building code violations and do something to ensure that these vulnerable citizens have a decent place to live.

So did council member Dwaine Caraway, who explained how poorly run group homes are one of the worst problems in his district. He noted that some operators in southern Dallas are in "the business of housing," that is, caring more about making money off needy residents than in providing services.

Other council members and Mayor Mike Rawlings also seem to understand that the city can no longer ignore the mediocre care, crowded sleeping quarters and shoddy facilities that characterize some of the 300-plus group homes in Dallas. City staffers, however, appear to be resisting the ordinance.

As things stand, too many group home residents here lack access to decent services, live in facilities where operators take their money and give them little to live on, and confront drugs or violence in their quarters. These residents are the ones who too often are wandering the streets, panhandling and sometimes becoming a menace to themselves and others.

Is that really how our city wants these fragile citizens treated?

[Read More](#)

5. Illinois: Verdict in Group Home Death Leaves Questions

Associated Press * May 5, 2012

The violent death of Paul McCann led to improvements in how Illinois intends to protect the mentally disabled in group homes, but the trial of the first man accused of killing him suggests to some that justice and equality are still a challenge for them.

Jurors trying the case of caretaker Keyun Newble, 26, charged with killing McCann at an eastern Illinois group home, heard about the brutal injuries the 42-year-old suffered. He had 13 broken ribs and lungs filled with fluid, part of what a doctor called "massive internal injuries" suffered as apparent punishment for stealing cookies.

Newble was charged with murder, which would have sent him to prison for at least 20 years. But the judge allowed the option of a lesser charge, involuntary manslaughter, and the jurors took it, making him eligible for a sentence as short as three years.

For advocates of the disabled, the April 27 verdict was insulting. McCann's family reacted with confusion. Both are trying to make sense of the verdict's message just as officials are trying to better safeguard the lives of disabled people who need care from the state.

Gov. Pat Quinn has made it a priority to close institutions for disabled people like McCann and transfer them into situations closer to their families, such as in group homes. But the effort has drawn criticism from unions and some affected families. State legislation in the wake of McCann's death, called Paul's Law, led to changes that could broadly impact the thousands of people who now live in group homes and similar settings in Illinois. That population currently is 9,500 people, according to the state Department of Human Services.

The new law requires background checks of group home employees and a hard look by state regulators at any facility where an abuse claim has been filed. The law also requires a state repository of group home records readily accessible to residents' families.

[Read More](#)

6. Connecticut: DDS group home licensure reports are heavily redacted

Southbury Training School Association Blog * May 8, 2012

Citing privacy concerns, the Department of Developmental Services appears to routinely withhold critical information from public disclosure about the quality and conditions in group homes in Connecticut for people with intellectual disabilities.

Our family-based Southbury Training School Home & School Association was advised by DDS that we would have to file

Freedom of Information Act requests for any detailed information about licensing deficiencies found in specific group homes. However, when we did so for two selected group homes, we received documents from DDS that were either missing pages relating to what appeared to be potentially serious deficiency citations or were so heavily redacted that little or no information could be gleaned from them.

In particular, information in DDS documents relating to citations for “Ongoing health and injury” in the selected group homes were heavily redacted or missing entirely.

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7. New Jersey: Senate panel discusses 'Tara's Law,' calling for tighter rules for adult foster homes

The Star-Ledger * May 18, 2012

Nearly four years after 28-year-old Tara O’Leary died from starvation and neglect, a bill bearing her name was the focus of a Senate committee hearing Thursday that called for tighter regulations of state-licensed foster homes for adults with developmental disabilities.

[Read More](#)

8. Oregon Lawsuit - Sheltered Workshops May Violate Disabilities Act

[Disability Scoop](#) * May 1, 2012

The U.S. Department of Justice has come out in support of a group of adults with developmental disabilities who say they’re being relegated to sheltered workshops even though they’re capable of working in the community. Attorneys for the Justice Department filed a statement of interest in late April in a class action lawsuit pitting some 2,300 people with developmental disabilities against the state of Oregon.

In the suit filed in federal court in January, residents with disabilities alleged that the state is violating the Americans with Disabilities Act by failing to provide supported employment services, which allow people with disabilities to work in the community.

Now, the Justice Department is weighing in saying that limiting people with disabilities to sheltered workshops is no different than segregating them in institutions.

Individuals with disabilities who are named in the suit have experience working in the community at McDonald’s, Safeway and other companies. Nonetheless, without supports they have no choice but to work at sheltered workshops where they earn less than the state minimum wage of \$8.80 per hour, according

to the initial complaint filed in January.

Oregon has no public ICFs/Mr.

9. California: Near Melrose, a national healthcare predicament plays out; NIMBY

[LA Times](#) * May 7,2012

Residents of a Hollywood neighborhood, some with mixed feelings, fight a developer's attempts to build an 11-bed board and care facility for dementia patients.

When news spread on a tranquil block of Sierra Bonita Avenue that a developer wanted to tear down a modest 1920s duplex and build an 11-bed board and care facility for people with dementia, the outcry began.

Neighbors were already concerned about the growing number of group homes for the elderly and recovering addicts in the area, many of them for profit.

Some neighbors on Sierra Bonita worry that another care home will mean more parking headaches, more ambulance sirens and increased downward pressure on property values that have tumbled about 25% in six years.

10. Maine Lawsuit: Disability lawsuit settled by state

[Portland Press Herald \(Maine\)](#) * May 4, 2012

The state Department of Health and Human Services has reached a settlement with plaintiffs in a class-action lawsuit over services to help people with certain disabilities live more independently.

The lawsuit was filed in 2009 by three non-elderly men with cerebral palsy. Jacob Van Meter, Adam Fletcher and Eric Reeves alleged that they were being confined to nursing homes even though they were capable of going to school, working and participating in community activities.

The men, in their 20s and 30s, argued that the state failed to provide services that would allow them to be more integrated into their communities, in violation of the Americans with Disabilities Act and laws regarding Medicaid, nursing homes and civil rights.

As part of the settlement, the DHHS has committed to offering home- and community-based services to people who are living in nursing homes or are at risk of having to move into nursing homes. The department has agreed to offer services to at least 75 people over five years.

Maine has no public ICFs/MR.

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