



Rose Mary Center Report

March 10, 2014



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Rose Mary Center Report

Executive Summary

In response to a complaint about the care and treatment of youth who live at Rose Mary Center in Cuyahoga County, Disability Rights Ohio conducted an on-site investigation and reviewed extensive records. Rose Mary Center is a 42-bed Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) with residents aged 9 to 26, operated by Catholic Charities Diocese of Cleveland.

Disability Rights Ohio's investigation found that the facility's physical environment is inadequate and poorly maintained, including a strong bad smell throughout the facility and bathrooms missing toilet paper, toilet paper holders, towels, and soap. We have concerns about the quality of care provided to youth and whether they receive necessary supervision, which creates serious risks to the health and safety of youth at the facility. The facility's programming and care plans for the youth are insufficient, and sometimes not followed by staff. Equipment and toys are in disrepair and not readily accessible to the youth. Incident reports reflect concerning physical injuries and allegations against staff that are not appropriately addressed by the facility or outside investigators.

These findings are consistent with recent citations by the Ohio Department of Developmental Disabilities and the Ohio Department of Health. Although Rose Mary Center has received notice of these problems, the facility continues to receive citations for the same or similar deficiencies. Disability Rights Ohio recommends that the state agencies that license or certify Rose Mary Center conduct thorough reviews of the facility and take decisive action against the facility. We also recommend that incident reports be more thoroughly investigated with the purpose of protecting the youth, not the staff who are the subjects of the reports.

Youth should not live in institutions, especially institutions like this. Disability Rights Ohio recommends that each of the youth at Rose Mary Center be assessed to determine how their needs could be better met in their own homes and communities.



Complaint and Investigation

Disability Rights Ohio received a complaint regarding the care and treatment provided to the youth residing at Rose Mary Center, an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) located at 19350 Euclid Avenue, Euclid, Ohio 44117 in Cuyahoga County.

In response to this complaint, Disability Rights Ohio completed an investigation that consisted of two unannounced on-site visits, touring the facility, photographing the physical environment, meeting with youth, observing the services provided by Rose Mary Center staff, and reviewing program and medical records, including medication administration records, nursing notes, Human Rights Committee minutes, incident reports, Major Unusual Incident (MUI) reports, and Behavior Support Plans.

Summary of Facility

Rose Mary Center is currently licensed for 42 individuals. Two of the beds are used as respite beds, which are housed separately from the other units. Youth living at Rose Mary Center are 9 to 26 years of age.¹ There are four living units, each housing ten youth. Each unit has five bedrooms (ranging from one bed to three beds), one congregate bathroom, one half bathroom (toilet and sink only), a kitchen, a dining area, and a play room. Currently, the facility is operating on a one year license from the Ohio Department of Developmental Disabilities that expires on June 30, 2014.² The Ohio Department of Health has certified the facility to provide Medicaid services.

Summary of Findings

Disability Rights Ohio's investigation identified serious concerns in the following areas:

- Physical environment
- Safety, supervision, and quality of care
- Programming and staff interactions
- Availability of equipment and other items
- Incident reviews

These findings are consistent with repeated citations by the Ohio Department of Developmental Disabilities and the Ohio Department of Health. For these reasons, Disability Rights Ohio recommends that these state agencies act quickly to conduct thorough surveys of the facility and take appropriate remedial action, including termination of licensure or certification. We notified the Ohio Department of Developmental Disabilities and the Ohio Department of Health of our

¹ 42 C.F.R. § 483.470(a)(1) prohibits the housing of clients of grossly different ages, developmental levels, and social needs in close physical proximity unless the housing is planned to promote the growth and development of all those housed together. Citations to regulations in this report are not intended to indicate a finding of a violation, but rather to indicate recommended areas of focus for future reviews.

² The facility's one year license—as opposed to a two or three year license—signifies that it passed only eight or nine out of eleven standards and/or had eight to fifteen deficiencies in its most recent survey by the Ohio Department of Developmental Disabilities. See Ohio Admin. Code § 5123:2-3-03(D).



initial concerns about the facility while this report was pending. We also recommend that incident reports be more thoroughly investigated, and that youth at the facility be assessed to determine how they could receive services in their homes and communities instead of in an institution.

Physical Environment

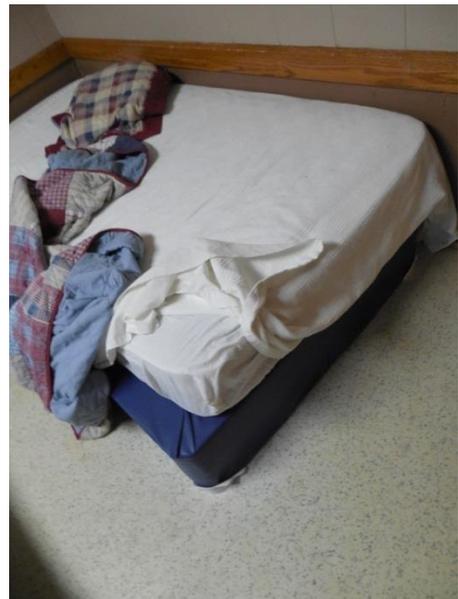
During our on-site visits, we identified concerns with the physical environment, including furnishings and cleanliness. Federal regulations require facilities to have adequate space, furniture, linens, and storage areas. Our observations raise concerns about whether the facility is meeting these requirements.



The four living units (A North, A South, B West and B East) are connected by long, cold corridors that are locked via a latch at the top of the door. The latches present a safety concern, as they are inaccessible to the youth, and unnecessarily lock the youth into the facility. Yet they do not provide any safety precaution against adults who should not enter the facility as they are accessible to any adult who is walking through the facility, and the doors are not alarmed to provide notice of any individuals entering or leaving the units.



The units were drab, small, and lacked the comforts expected in a home where youth live and play. There was a strong malodor throughout the facility, as noted in recent surveys by the Ohio



Department of Developmental Disabilities. The facility was very dirty and unsanitary. We observed black mold in the bathrooms. Doorframes were rusted and portions were missing. Urine and dried fecal matter was observed on the floors of the facility. Dirty linens were placed in two large trash cans in the hallway.³

The bedrooms were sparsely furnished (generally only a bed and dresser),⁴ and those containing three beds were

³ 42 C.F.R. § 483.470(g)(3) requires adequate dirty linen storage areas.

⁴ 42 C.F.R. § 483.470(b)(4)(iv) requires functional furniture and individual closet space in bedrooms.



crowded.⁵ Three mattresses in the facility were placed directly on the floor with no frame.⁶



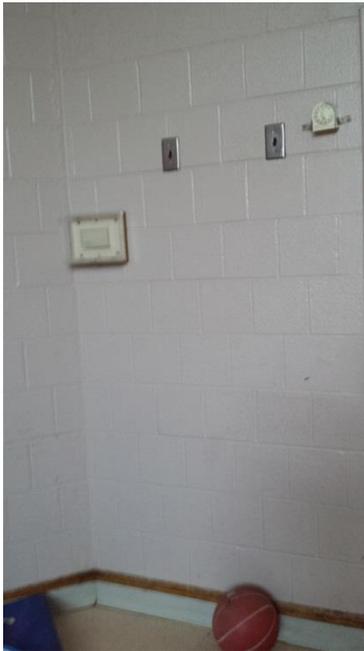
The bedding typically consisted of two thin sheets and a thin blanket. On the majority of the beds there was either no fitted sheet or the elastic on the fitted sheet was so stretched and worn that it did not conform to the mattress.⁷

Typically, the youth's personal possessions in their bedrooms were stored too high for the youth to access them.⁸ The room with the two respite beds is separate from the four housing

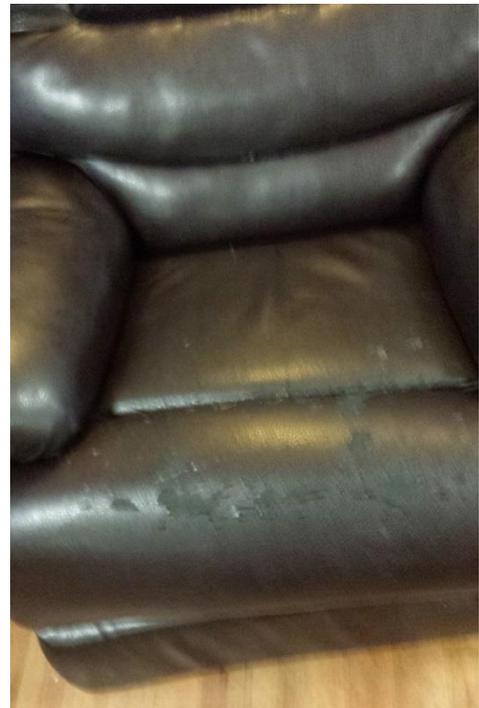
units. It was sparsely furnished, with two beds and a portable toilet.

The furniture in all areas was sparse, old, and several pieces were stained.⁹ The dining areas contained old and worn furniture. Throughout the facility, furniture was torn,

missing pieces of fabric, and stained. The televisions were behind Plexiglas that was so worn or scratched that it was difficult to see the screen.



Light switches at the facility were approximately 5'6" in height, making it impossible for the majority of the youth (if not all) to turn on or off the lights. Timers were mounted on the walls throughout the facility, raising concerns that they are used to time seclusion or "time-out" of youth. Although the facility claimed not to use the timers for seclusion or any other purpose, the timers are still on the



⁵ 42 C.F.R. § 483.470(b)(iv) requires 60 square feet per client in multiple client bedrooms.

⁶ 42 C.F.R. § 483.470(b)(4)(i) requires beds of proper size and height for the convenience of the client.

⁷ 42 C.F.R. § 483.470(b)(4)(iii) requires bedding appropriate to the weather and climate.

⁸ 42 C.F.R. § 483.470(c)(2) requires suitable storage space, accessible to clients, for personal possessions, such as TVs, radios, prosthetic equipment, and clothing.

⁹ 42 C.F.R. § 483.470(g)(1) requires sufficient space and equipment for services.



walls.

Several bathrooms were missing supplies. On B East the playroom bathroom did not have toilet paper or a wastepaper basket. On A North, the playroom bathroom had a broken toilet paper dispenser, no paper towels, an opened box of latex gloves, and no toilet paper. On A South, there were no paper towels in the playroom bathroom. Large men's belts were hanging in each of the bathrooms, which raises concerns that they are used for restraints or even physical abuse, especially when considering reports of injuries that are consistent with youth being hit with belts (discussed below).

Safety, Supervision, and Quality of Care

Through our on-site observations and record reviews, we identified concerns with whether the facility is providing adequate treatment and supervision to the youth. Several youth's plans indicate that they engage in pica (ingesting inedible items), yet opened, unsecured boxes of latex gloves were found throughout the facility. This is a clear hazard, as youth could easily access and ingest the gloves.



Documentation of R.C.'s¹⁰ head-banging recorded over 1200 incidents of this behavior from July to October 2013, according to the Human Rights Committee's minutes. Although the numbers decreased over the months, this concerning rate of self-injurious behavior indicates a need for consultation from an outside specialist. No such consultation appeared in the records reviewed.

On November 23, 2012, M.R. was diagnosed with pneumonia at Rainbow Babies and Children's Hospital after having an elevated temperature for two weeks. The records reviewed by Disability Rights Ohio do not indicate what treatment, if any, the facility provided to M.R. during this two week period, but it is concerning that she could have developed pneumonia while receiving care in the facility.

Two youth lost or broke teeth, and it is not clear whether they received appropriate supervision or prompt dental treatment.¹¹ On April 23, 2013, L.S. bit a staff member and then began engaging in self-injurious behavior (head-banging) and lost her front tooth, which was previously loose. It was initially thought that she had lost only part of the tooth, but upon further examination, remains of the tooth were not visible. During L.S.'s team meeting on May 7, 2013, L.S.'s Children Services case worker requested that the tooth be replaced "depending on funding," and Nursing staff indicated that they would explore options for tooth replacement. On

¹⁰ Throughout this report, we refer to youth by their initials.

¹¹ 42 C.F.R. § 483.460(e)(1) requires the provision of comprehensive diagnostic and dental treatment services.



July 17, 2013, another youth, R.C., was seen in the dental clinic and approvals were obtained for a tooth extraction and treatment of two broken teeth under anesthesia. The records do not indicate how long R.C.'s teeth were broken or what caused the teeth to break.

R.C.'s behavior support plan requires 1:1 staff supervision immediately next to him from before food is presented until all clients are finished eating and the leftover food has been removed and placed in the kitchen. Yet we identified two MUIs from 2013 and one already from 2014 in which R.C. choked on food, indicating a lack of appropriate supervision. This is a life-threatening concern.



Programming and Staff Interactions

Staff rarely were observed interacting with youth, even though our visits occurred on days when the residents were all at home (one Saturday and one day that school had been cancelled). There were no posted activity schedules on the units. Federal regulations require the facility to provide “active treatment” to residents in accordance with their individualized plans.¹²

On January 24, 2014, on B West, we observed J.S., unsupervised, eating unknown objects and substances out of the vent in the playroom. Other youth appeared to be wandering around the living units without guidance or interaction from staff.

According to M.M.'s Case Summary Report dated February 14, 2013, staff are to encourage M.M. to sign, verbalize and point to photos to indicate his wants and needs. During our visits, this did not occur. M.M. repeatedly came to the staff/nurse's station located between the residential units and attempted to communicate with staff. Staff did not encourage M.M.'s communication using the aforementioned measures.

Documentation was incomplete for J.P.'s meal completion. There was no documentation for breakfast for February 5 or 6, 2014, and there was no documentation for lunch for February 4, 5, and 6, 2014.

J.P.'s money program instructs him to match a penny to a penny to increase his familiarity with money. J.P.'s program binder contained a pouch of fake, plastic money that had “copy” prominently stamped on both sides. Management staff confirmed that these were the “coins” that were used for J.P.'s program. The effectiveness of this program is questionable because of the abstract reasoning required to associate the “copy” penny with a real penny, as well as the limited utility of pennies in daily living.

¹² 42 C.F.R. § 483.440 governs the development, implementation, and documentation of active treatment.



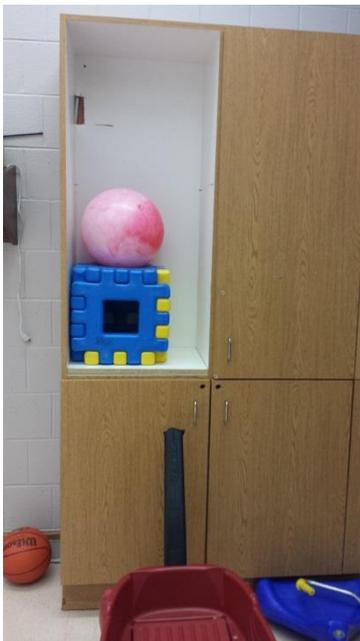
J.P. had an additional program on the same documentation sheet that instructed staff to assist J.P. with making vending machine purchases. Documentation for February 1, 2, 3, 4, 5, 6, and 7, 2014 were marked no. This program did not appear relevant to the penny matching program. Management staff stated that the vending machine program was a reward and for tracking purposes only. We did not observe a vending machine on any of the units, although the facility's 2011 survey by the Ohio Department of Developmental Disabilities indicates that the facility has vending machines.

Availability of Equipment and Other Items

Several toys and program equipment necessary for the implementation of behavior, communication, and treatment plans for youth were in poor condition, broken, or completely inaccessible to the youth. On B East, a large banana swing was in the center of the playroom and did not contain a sling. When questioned, the facility stated that the swing was broken but they planned to move it to unit A. Staff did not indicate an intent or timeline to repair the swing.



Each unit appeared to have two Big Mac communication switches mounted on walls. These switches assist the youth in communicating through the use of pre-recorded messages. One switch on B West was not working. A switch on B East was working, but the sound was turned off, making it non-functional for the youth.



R.W.'s Individual Behavior Plan includes several aversive measures. Among the aversives is a direction for staff to complete a two-person transport using a wheelchair or wagon when R.W. is in a dangerous situation. Wagons observed by Disability Rights Ohio were broken and in disrepair. We did not observe extra available wheelchairs that could be used as an alternative device in these situations.

During J.C.'s annual review on July 17, 2013, the team discussed the use of his communication device at the facility. His device was only at school, and his mother expressed a desire to use it or a similar communication system at the facility. It is concerning that the facility would not have ensured the consistency of his communication program between school and home.

Many sensory or play items, such as toys and books, were stored in the facility, but not accessible to the youth. The few books that we observed were old and torn. Although several youths' plans list listening to music as a preventative measure, music was not readily accessible on the units.



According to K.F.’s case summary report dated August 8, 2013, staff are to encourage K.F. to sniff a scent bottle if he engages in urine play. During our visit, a scent bottle was not observed or readily accessible to K.F.

R.K.’s case summary states that staff should encourage him to participate in sensory enrichment activities such as deep pressure, object manipulation, tickling, book reading, listening to his favorite music, singing, massages, olfactory stimulation, being sandwiched between mats or wrapped in a weighted blanket, being held by staff, lying in a donut mat, or engaging in his favorite sensory activities (blinking lights, moving glitters, beads, musical instruments, bumble ball, electric back massagers). We did not observe staff engaging R.K. in any of these activities or items during our visits.

Incident Reviews

Unusual Incident Reports

Disability Rights Ohio reviewed the facility’s Unusual Incident Reports (UIRs) for the past six months, a total of over 375 reports including over 250 with physical injury to the youth. Those reports depict a concerning pattern of alleged staff abuse—both physical and verbal—as well as numerous physical injuries of “unknown origin.”

Although UIRs, MUIs, Case Summaries and other records describe significant injuries and concerning wounds, Rose Mary Center does not take pictures of the injuries. UIRs are often also missing details of the extent of the injury (such as the size, shape, and color). This documentation failure raises the concern that staff minimize the youth’s injuries to prevent a thorough review.¹³

The following 14 UIRs were notable for their allegations of physical or verbal abuse by staff.¹⁴ Many of the allegations were made by other facility staff members.

UIR Date and Time	Details
07-30-2013, 7:24pm	R.W. suffered 4 welts on her left leg and 2 welts on her right leg. Staff stated that R.W. was playing with a belt and smacked herself on her legs.
08-08-2013, 7:30am	Staff witnessed another staff hit K.A. across the buttock area with a belt.
08-10-2013, 8:00am	L.C. sustained a black eye. When asked how the injury occurred, he stated that the injury was caused by staff.
08-16-2013, 1:00pm	C (no last name provided) was slapped by staff for asking for pop and balls. It was reported that C is “always hit.” Another incident is

¹³ 42 C.F.R. § 483.420(d)(3) requires the thorough investigation of alleged violations, and prevention of potential abuse during an investigation.

¹⁴ 42 C.F.R. § 483.420(a)(5) requires the facility to ensure that residents are not subject to any form of abuse or punishment.



	referenced for 08-11-2013 but does not have a separate UIR.
08-16-2013, 1:00pm	Staff witnessed two other staff lock K.A. in her room. This was accomplished by putting a towel in the door, causing the door to jam. ¹⁵ K.A. was secluded in her room for approximately 45 minutes after the door was jammed, but the amount of time that K.A. was secluded in her room before the door jammed is unknown.
08-16-2013, 1:00pm	Staff witnessed L.S. being dragged to her room by another staff.
08-16-2013, 1:00pm	Staff reported that “the DSPs (staff) on A-South for 2nd shift is abusive physically and verbally to the children.”
08-16-2013, 5:00pm	B.G. was verbally abused by staff who stated that B.G. “needs her ass kicked for playing in spit.” Another incident is referenced for 07-28-2013 but does not have a separate UIR.
08-16-2013, 5:00pm	Staff witnessed another staff kick youth R.W. on the ground in the hips and legs.
08-29-2013, 5:15am	Staff reported that another staff had positioned their chair in front of K.A.’s door. The report noted concern about the chair being a fire hazard and a possible client rights issue.
09-16-2013, 8:20am	Staff reported that another staff directed staff to “beat her (L.S.’s) ass.” This statement was made in the context of L.S. having a “behavior” and being “assisted” by staff back to her room.
10-24-2013, 12:00pm	New staff stated that other staff members were “pushing, yanking, and yelling” at S.A. The new staff asked the other staff members why they were so “rough” with S.A. and the response was, “it’s part of her (S.A.’s) plan.” The new staff stated that the “abusive” interaction lasted approximately two hours.
10-31-2013, 4:45pm	Staff reported that another staff clapped her hands on both sides of R.W.’s head. It was stated that “clapping” R.W.’s head was “the only way to get her up”.
12-16-2013, 1:50pm	Staff reported observing a note written on the white board in the B West common area/nursing area stating, “Dear (K.F.), sit your ass down now. You walk/run (rest not legible-I think it said, climb way too much, but not sure).”

¹⁵ 42 C.F.R. § 483.450(c) governs time-out rooms, including the requirement that the door be held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.



The incident involving R.W. on 7-30-2013 requires special attention. R.W. has a Behavior Support Plan that lists her target behaviors, but hitting herself with a belt or other object is not included in this list. Given no other evidence of such behavior, it is reasonable to conclude that these injuries were actually caused by staff, and the conclusions in the report were an attempt by staff to avoid consequences, including possible criminal charges for abuse.



Additionally, despite this conclusion, multiple belts were observed hanging throughout the congregate areas in the facility. Every bathroom we observed had an adult-sized belt hanging from either the towel rack or the hook on the bathroom stall. If self-harm were a concern for R.W. or any other youth, then the facility should ensure that belts and other dangerous objects are not readily available.

Other UIRs documented concerning restraints, some resulting in physical injuries. The facility appears to rely on face shields and other aversive measures that other providers have discontinued. The following 3 UIRs were concerning for restraints.¹⁶

UIR Date and Time	Details
10-12-2013, 6:30pm	L.C. was head banging in his room and sustained a 4 inch scratch to his upper left chest, and redness and swelling to his left eye. Staff states “witnessed resident, had to grab him by the shirt, removed him, and calmed down.” Injury was cited in the report as being unknown. It is also stated in the report, “resident was aggressive toward staff 30 minutes prior to injury being noticed.”
10-16-2013, 8:00pm	Staff noticed multiple welt like marks on H.W.’s back, shoulder, and chest areas, determined to be caused by the straps of H.W.’s transportation harness.
12-04-2013, 1:46pm	L.S. was placed in a 4 point supine restraint with a face shield helmet and arm immobilizers/splints. Per L.S.’s plan, “if L.S. is not cooperative when placing her helmet and arm immobilizers, staff may use the 4 point 3 person supine restraint during application. Staff should

¹⁶ 42 C.F.R. § 483.420(6) requires the facility to ensure that residents are not subject to unnecessary physical restraints.



	<p>apply helmet at first signs of aggressive, then start supine and after resident is in 4 point supine hold, apply arm splints. Resident should not be in supine for more than five minutes after equipment is applied.” The UIR shows L.S. having her face shield helmet applied from 1:46pm until 2:00pm. The face shield helmet is checked at 2:03pm. The face shield helmet continues to be utilized until 2:22pm. The arm immobilizers/splints are applied at 1:46pm until 2:00pm. The arm immobilizers/splints continue to be utilized from 2:05 until 2:20pm. The 4 point supine begins at 1:46pm and ends at 2:00pm. Another 4 point supine begins at 2:05pm and ends at 2:20pm.</p>
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The incident involving L.S. on 12-04-2013 requires further comment. Contrary to L.S.’s plan, the supine restraint continued much longer than five minutes after her helmet and splints were applied. The documentation of this incident is also questionable because it indicates that the splints and restraint were discontinued for five minutes (from 2:00pm to 2:05pm) and then reapplied. It is more likely that the helmet, splints, and restraint actually occurred for the entire thirty-four minute period from 1:46pm to 2:20pm.

The UIRs also reflect a disturbing trend of injuries of “unknown origin.” In light of the pattern of physical injuries caused by staff noted above, these reports are concerning because the youth have very limited communication skills (many are non-verbal) and thus are unable to report whether the cause of their injuries is physical abuse. We acknowledge that some of the youth engage in self-injurious behavior and that some UIRs document minor injuries that commonly result from normal youthful activity (such as scraped or bruised elbows, knees, or shins). However, a facility serving such high-need youth would be expected to provide appropriate supervision levels that would either prevent many injuries from occurring or at least provide an explanation for the cause of the injuries. The following 31 UIRs raised particular concerns due to the description of the injury and/or its location.

UIR Date and Time	Youth	Reported Injury of Unknown Origin
07-10-2013, 7:20am	B.D.	bruise on her left hip and back of her right arm
07-24-2013, 8:00am	H.W.	small circular bruise on right shoulder
07-25-2013, 9:00pm	R.L.	2 bruises on upper left thigh
07-27-2013, 10:20pm	R.C.	bruise and swelling on left buttock
08-02-2013, 7:10am	K.F.	2 inch scrape on the left side of his mid back
08-02-2013, 8:45pm	B.D.	bruise on the right upper leg, above the knee



08-03-2013, 8:00pm	R.L.	bruise on upper right thigh (report conflict on whether the injury was sustained on either the right or left thigh)
08-03-2013, 8:00pm	R.K.	bruise on his left shoulder
08-08-2013, 8:45pm	A.B.	bruise on his right buttock
08-09-2013, 5:30pm	L.C.	swelling and purple bruising to right eye
08-10-2013, 9:30pm	K.A.	¼ inch scrape on her back
08-14-2013, 8:30pm	A.M.	2 small bruises on right chest
08-16-2013, 8:00am	R.C.	3 purple bruises on his upper left thigh that were 2x2 inches
08-26-2013, 8:00pm	S.A.	4 to 5 purple bruises to right lateral thigh
09-15-2013, 1:00pm	T.R.	redness on back of right upper thigh, below buttocks
09-26-2013 (no time provided)	L.S.	4 pink raised irregular shaped areas to left flank, and 2 raised pink irregular shaped areas to left upper/inner arm
10-10-2013, 4:30am	S.A.	brown bruise on upper eyelid and below left eye
10-10-2013, 6:00pm	B.D.	2 blisters on lower left leg, both 2.5 x .5 inches
10-12-2013, 7:00pm	O.M.	bruise on his upper back
10-15-2013, 8:00am	M.R.	bruise on inner left thigh
10-18-2013, 8:00am	T.M.	blue/purple bruised outer aspect of left eye
10-21-2013, 7:30pm	A.B.	4 bruises on his left leg
10-26-2013, 8:00pm	R.L.	bruise on upper right arm
10-28-2013, 4:38pm	L.S.	bruise on her left arm
11-05-2013, 8:00pm	K.F.	bruises on left arm
11-06-2013, 7:20am	B.D.	3 small bruises on upper right arm, underneath armpit
12-04-2013, 8:00pm	R.L.	red bruise on the left side of her back, above buttocks
12-13-2013, 8:30pm	C.D.	¼ cm round open sore underneath the foreskin of youth's penis
12-16-2013, 7:45pm	A.C.	bruise on her right buttock
12-17-2013, 3:30pm	L.S.	bruise on her chest
12-20-2013, 4:35pm	A.M.	swollen foot and heel

Major Unusual Incidents



Disability Rights Ohio reviewed the facility’s Major Unusual Incidents (MUIs) for the past six month. The investigations of several MUIs raised concerns about whether youth are adequately protected from abuse and neglect because MUIs were closed as “unsubstantiated due to insufficient evidence” despite reports by staff witnesses that the incidents had occurred. Many of the youth involved in the incidents were not interviewed as part of the investigations because of their communication deficits. Some of the investigations even concluded that the incidents had occurred, but still closed the MUI as “unsubstantiated” because there was no evidence of direct harm to the youth. These investigations by either the Cuyahoga County Board of Developmental Disabilities or the Ohio Department of Developmental Disabilities need to more seriously consider the standard of proof when staff report egregious conduct by other staff.

Many other MUIs are concerning because of delays between the date of the incident and the date of the report.¹⁷ In some MUIs, it appears that the reporting staff was terminated for delaying his/her report, but no adverse action was taken against the staff who allegedly abused the youth. This result provides a strong disincentive to reporting, and empowers potential abusers.

The following 12 MUIs were especially concerning due to the allegations of physical abuse and/or the result of the investigation. Some of the MUIs may overlap with UIRs listed above.

MUI #2013-018-1072	Physical Abuse	Inc. 07-28-2013	Disc. 08-16-2013
Staff reported observing other staff, Anthony Webb, ¹⁸ drag L.S. to the bathroom by L.S.’s arms. Reporting Staff and Anthony Webb were placed on administrative leave. The staff member who alleged the physical abuse was terminated for failure to report. The Investigative Agent stated that “it is believed that the staff made up the allegations out of spite of her co-workers. Staff [name withheld] ¹⁹ stated that she could no longer work at Rose Mary Center, as the children were not being treated right.” The Physical Abuse allegation was unsubstantiated due to insufficient evidence.			
MUI #2013-018-1069	Physical Abuse	Inc. 07-28-2013	Disc. 08-16-2013
Staff reported that two other staff had been involved in repeated systematic abuse of four youth. Reportedly, Anthony Webb slaps C.N. on the back of the head every time he asks for a pop. C.N. has communication deficits and was unable to be questioned. The Physical Abuse allegation was unsubstantiated based upon insufficient evidence, due to the fact that there were no marks or injuries noted.			
MUI #2013-018-1031	Physical Abuse	Inc. 08-08-2013	Disc. 08-08-2013
Supervisor witnessed Nell Brown grab K.A. by the arm and hold her while hitting her buttocks with a belt. Other staff reported that he overheard Supervisor state, “Are you really going to hit K.A. with a belt?” Staff stated that he saw Nell Brown had a belt in her hand. Supervisor stated			

¹⁷ 42 C.F.R. § 483.420(d)(2) requires immediate reporting of allegations of mistreatment, abuse, neglect, and injuries of unknown origin.

¹⁸ Staff names throughout this report are pseudonyms.

¹⁹ Disability Rights Ohio is withholding the name of this staff person to preserve the confidentiality of the reporter.



that she observed Nell Brown lift K.A.'s arms up over her head, turn K.A., and hit her with the belt on the buttocks. The Physical Abuse allegation was unsubstantiated due to insufficient evidence.			
MUI #2013-018-1039	Physical Abuse	Inc. 08-10-2013	Disc. 08-12-2013
Staff stated that L.C. had bruising around his eye. When L.C. was questioned about his injury, he stated that Ashley Douglas was responsible for the injury. Ashley Douglas did not complete an incident report. The Physical Abuse allegation was unsubstantiated due to insufficient evidence.			
MUI #2013-018-1071	Unapproved Behavior Support	Inc. 08-11-2013	Disc. 08-16-2013
Staff reported that she saw a washcloth in the door of A.K.'s room, preventing A.K. from opening the door. Per the IA, a maintenance request was completed to repair the door after it was confirmed that the door knob came off and the door would jam. Anthony Webb stated that youth K.A.'s door was jammed, and that stated that other staff was inside the room with K.A. for about 15 minutes before the door could be opened due to the knob falling off. Reporting Staff was terminated for failure to report, staff assigned to K.A. was terminated, and other staff were retrained.			
MUI #2013-018-1070	Verbal Abuse	Inc. 08-11-2013	Disc. 08-16-2013
Staff reported on 08-11-2013 (MUI reports two conflicting dates) that Anthony Webb told B.C. that if B.C. continued to play with her spit that Anthony Webb was "going to kick her ass." Despite the report by staff, the MUI investigation concluded that there was "no witness to the incident." The Verbal Abuse allegation was unsubstantiated due to insufficient evidence.			
MUI #2013-018-1074	Failure to Report	Inc. 08-13-2013	Disc. 08-16-2013
Staff reported that Debbie Wilson told R.W. to get up and then used her right foot to kick youth R.W. on her side one time. Debbie Wilson was terminated on 08-22-2013 for a different incident. Reporting Staff was terminated on 08-23-2013 for failing to report the incident immediately. The Failure to Report allegation was substantiated.			
MUI #2013-018-1223	Verbal Abuse	Inc. 09-16-2013	Disc. 09-17-2013
Administrative staff heard Susan Thomas say to other staff who were intervening in a behavioral incident for L.S., "When you get her back there, beat her ass." L.S. had bruises and abrasions, which were found to be consistent with previous self-injuries. L.S. was not interviewed due to her functional and communication deficits. Because there was no evidence that L.S. heard the statement or felt threatened, coerced, intimidated, harassed or humiliated by the statement, the Verbal Abuse allegation was unsubstantiated due to insufficient evidence even though Susan Thomas admitted to "making a statement in response to the invention taking place."			
MUI #2013-018-1481	Physical Abuse	Inc. 10-31-2013	Disc. 10-31-2013
Staff reported hearing a loud clapping sound; Carol Davis stated that it was the "only way staff could get R.W. to move quickly and demonstrated clapping her hands on the side of R.W.'s face." Carol Davis stated that she had used the technique several times, and that other staff had			



witnessed it. She claimed that the technique did not hurt R.W., and that there is no type of force to hurt R.W. but “just a sound wave which R.W. responds to.” The MUI investigation found insufficient evidence for Physical Abuse because there was no evidence that R.W. was hit or slapped. The prevention plan states, “the team will meet to discuss the technique of light ear/facial tapping and if it should be included into the consumer’s plan or not.”

MUI #2013-018-1493	Physical Abuse	Inc. 11-03-2013	Disc. 11-03-2013
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Staff saw Stacey Williams pinch T.M. in the arm while T.M. was self-injuring (biting/scratching his arms. The witness stated that the pinching caused T.M.’s self-injurious behavior to “increase and intensify.” The Physical Abuse allegation was unsubstantiated due to insufficient evidence.

MUI #2013-018-1628	Unapproved Behavior Support	Inc. 11-30-2013	Disc. 12-02-2013
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Staff reported that during a visit with his mother, K.F. began hitting his head and screaming. Multiple staff picked up K.F. and carried him, which was not in his plan. He was placed in a supine restraint by 7 staff for 30 minutes, even though his plan only includes a 3 person restraint. As a result of this incident, K.F.’s behavior plan was revised.

MUI #2013-018-1665	Physical Abuse	Inc. 12-04-2013	Disc. 12-06-2013
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Staff had reported that T.M. fell on his face as he was running, and he was treated with ice. During a visit two days later, his family was concerned that the injuries they observed—a black eye with a golf ball sized lump—could not have occurred during a fall. The family alleged that the injury was due to physical abuse. T.M. was not interviewed as part of the investigation. The Physical Abuse allegation was unsubstantiated due to insufficient evidence.

We are also concerned about the following MUI from 2012, which did not appear as a citation in the Ohio Department of Developmental Disabilities survey of the facility. This staff member is not on the Abuser Registry, even though the prone restraint occurred over twenty months ago.

MUI #2012-018-0597	Physical Abuse	Inc. 05-09-2012	Disc. 05-10-2012
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Four staff witnessed Robert Porter place T.M. in a “full nelson” and take him to the ground, face down, and kneel on him. Staff reported Robert Porter placed his arms underneath T.M.’s arms and his hands behind T.M.’s head, smacked T.M. on the head and took him down on the floor, and knelt on T.M.’s back. Robert Porter was ordered to get off of T.M.’s back four times before he complied. T.M. had redness on the bridge of his nose, forehead, both kneecaps, sternal notch and the back of his left shoulder. The Physical Abuse allegation and prone restraint was substantiated.

Two concerning MUIs were still under investigation at the time of our review. We recommend that the following MUIs receive careful review by all involved investigators.



MUI # 2014-018-0048	Unapproved Behavior Support	Inc. 01-07-2014	Disc. 01-08-2014
M.T. was placed in a supine restraint for 30 minutes in response to agitation and physical aggression.			
MUI #2014-018-0301	Neglect	Inc. 02-20-2014	Disc. 02-20-2014
T.C. was discovered unsupervised in a bathtub filled with water. Staff was in another wing of the building, talking to other staff.			
MUI #2014-018-0323	Physical Abuse	Inc. 02-23-2014	Disc. 02-24-2014
Staff flicked T.M. in the head and told him to “Hurry up, let’s go.”			

State Agency Surveys

The findings of Disability Rights Ohio’s investigation are consistent with recent surveys by the Ohio Department of Developmental Disabilities and the Ohio Department of Health. The consistency of these findings, and the length of time over which they have persisted and increased indicates that the facility has not made sufficient efforts to improve its environment and services.

The Ohio Department of Developmental Disabilities completed surveys in March 2009, March 2011, March 2012, September 2012, and March 2013. In March 2009, the department cited seven deficiencies, including failure to complete timely incident reports, unapproved locked doors, habilitation staffing, holes in bathroom wall, lack of soap, behavior plan consent, and implementation of plans. The facility received a two year license instead of a three year license due to these deficiencies.

In March 2011, the Ohio Department of Developmental Disabilities cited ten deficiencies, including failure to: implement plans as written (youth drank bleach due to lack of supervision, youth’s money management plan documented zero times in two months), follow treatment orders, maintain the building in a clean and sanitary manner (pervasive urine odor), maintain appropriate equipment, ensure appropriate staff interactions, log all UIRs, timely notify the county board of MUIs, provide a plan of prevention for MUIs/UIRs, ensure safety of time-out room (using bedroom for time-out), and check restraints every 30 minutes. The facility received only a one year license for these deficiencies.

In March 2012, the Ohio Department of Developmental Disabilities cited eleven deficiencies including failure to: complete self-medication assessments, include a service recipient on the Human Rights Committee or document why this is not feasible, document the length of time a restraint is used, follow behavior plan as written, follow treatment orders, implement individual plan, timely notify county board of MUIs, timely report all incidents, properly classify incidents as UIRs or MUIs, maintain the facility in a clean and sanitary manner, and revise plan based on



individual's needs/wants. The facility again received only a one year license for these deficiencies, and the department conducted a follow-up survey in September 2012. During that survey, the department cited the facility for failure to maintain the building a clean and sanitary manner, ensure the equipment (refrigerator seal) was in good repair, and maintain supplies (toilet paper).

In March 2013, the Ohio Department of Developmental Disabilities cited thirteen deficiencies, including failure to: ensure plan addressed behavior support, fire safety, and emergency response needs; obtain informed consent, including for aversive measures; revise plan based on individual's needs/wants; obtain Human Rights Committee approval for behavior plan; ensure proper documentation of restraints; update property inventory; follow treatment orders; implement plan as written; timely notify the county board of MUIs; and document notice of MUIs to Children Services. The facility received a one year license.

The Ohio Department of Health completed a fire safety survey and a fundamental annual survey in January 2014. The fire safety survey cited the facility for failure to: provide smoke detectors in appropriate locations, have the fire alarm function as a single system, and install fire alarm pulls at accessible heights. The fundamental annual survey cited the facility for failure to: ensure staff were appropriately trained to prevent choking incidents, include a vocational evaluation as part of three individuals' comprehensive functional assessments, design programs with measureable data (all eight sampled individuals), and provide comprehensive dental treatment (delayed assessment for lost tooth).

These citations are consistent with Disability Rights Ohio's findings in this report. Although our visits were unannounced, the facility is aware of the general timing and substance of the state agencies' surveys because they occur on a specified cycle and cover the same aspects of the facility each time. It is especially concerning that the facility's citations in surveys by the Ohio Department of Developmental Disabilities continue to increase despite this advance notice and the application of the department's standard survey tool. The persistence of these citations suggests that the facility is either unwilling or unable to comply with the standards for continued operation.



Recommendations

The agencies involved in licensing, certifying, monitoring, and investigating Rose Mary Center must take swift, decisive action to prevent this facility from continuing to provide substandard care for youth with developmental disabilities. The facility has continued to operate despite numerous, significant deficiencies in its physical environment and services.

Recommendation #1: The Ohio Department of Developmental Disabilities upcoming licensure survey should thoroughly inquire into each standard, with close attention to areas of continuing deficiencies. If the facility's deficiencies continue, the department should impose sanctions in accordance with Ohio Admin. Code § 5123:2-3-02(Q), including suspension of admissions, placement of a monitor at the facility, non-renewal of the license, and/or license revocation.

Recommendation #2: The Ohio Department of Health should conduct a full (not fundamental) survey of the facility in concert with the Ohio Department of Developmental Disabilities and take appropriate remedial action—including action to terminate the facility's participation in Medicaid/Medicare. As this report was being finalized, we became aware that the department was conducting a complaint-based survey of the facility. That complaint-based survey is not an adequate substitute for a full survey of the facility.

Recommendation #3: Rose Mary Center should immediately begin documenting physical injuries more thoroughly, including taking pictures of all injuries. Documentation should include the size, shape, and color of all physical injuries observed by staff, as well as any potential causes of the injuries. Staff should also document any incident that does not result in a visible physical injury, but could lead to bruising or other injuries at a later date.

Recommendation #4: Investigative Agents of the Cuyahoga County Board of Developmental Disabilities and/or the Ohio Department of Developmental Disabilities should thoroughly investigate all MUIs and apply the standard of proof in a way that reasonably accounts for the availability of evidence, especially staff witnesses who report misconduct by co-workers, and the inherent harmfulness of being subject to abuse or other forms of mistreatment.

Recommendation #5: The Ohio Department of Developmental Disabilities should review all UIRs and MUIs from the facility for the past year and ensure that appropriate referrals to Children Services and/or law enforcement are completed.

Recommendation #6: ICF/IIDs are not appropriate homes for youth. The Ohio Department of Developmental Disabilities should assess all of the facility's residents and facilitate their enrollment in Home and Community-Based Services (including Medicaid waivers) to meet their needs in a non-institutional environment.



Image Appendix

Rose Mary Center for Children



Appendix Part 1: Facility Exterior



Facility Exterior



Facility Exterior



Appendix Part 2: Furniture



Vacant and Inaccessible Entertainment Center

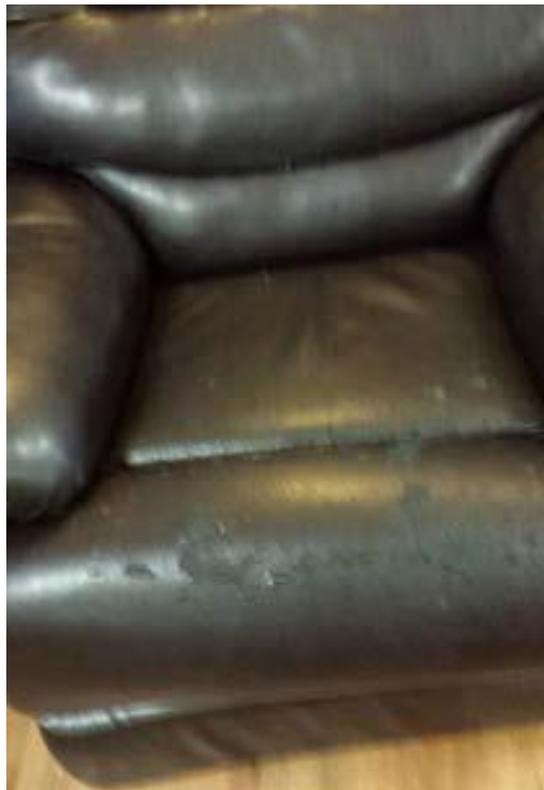


Inaccessible Shelving Placed Over 5 feet 6 inches





Inaccessible Items on Top of Dresser



Worn Furniture





Inaccessible Items; Worn and Damaged Furniture



Inaccessible Objects, TV without Remote Controls, Worn Wardrobes



Appendix 3: Bedding



There are Three Beds Per Room



Inadequate Bedding





Ripped Bedding with Holes in Mattress Pad



Inadequate Bedding



Appendix Part 4: Adaptive Equipment



Broken Sensory Item



Frayed Shower Chair





Sparse and Broken Toys



Worn Chair with Duct Tape





Broken Cabinet Door



Dated Sensory Items (Rotary Dial Phone)





Broken Banana Swing with Missing Seat



Broken Hula Hoop Toys in Playroom



Appendix Part 5: Belts



Belt in Bathroom



Two Belts in Bathroom





Belt in Shower Stall



Belt on Shower Stall Door





Belt on Towel Rack



Belt in Bathroom by Dirty Mop



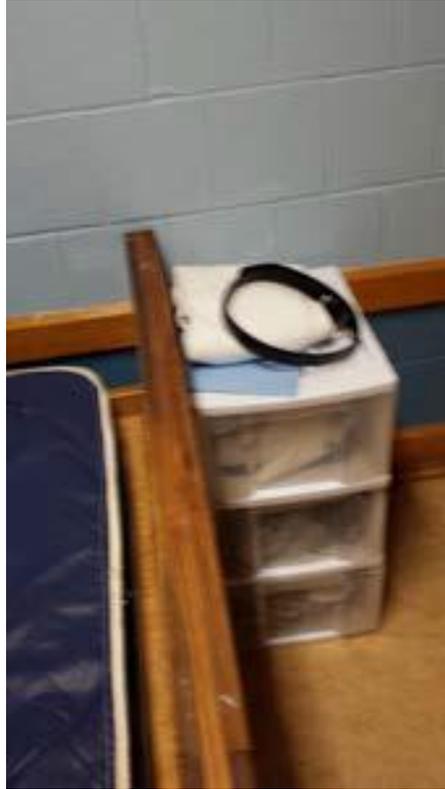


Belt in Bathroom Stall



Multiple Belts in Bathroom





Belt in Bedroom Next to Bed



Two Belts Hanging in Bathroom Next to Sink



Appendix Part 6: Health, Safety and Maintenance Issues



Stain on Wall



Fecal Matter on Floor





Fecal Matter on the Floor



Fecal Matter on Floor

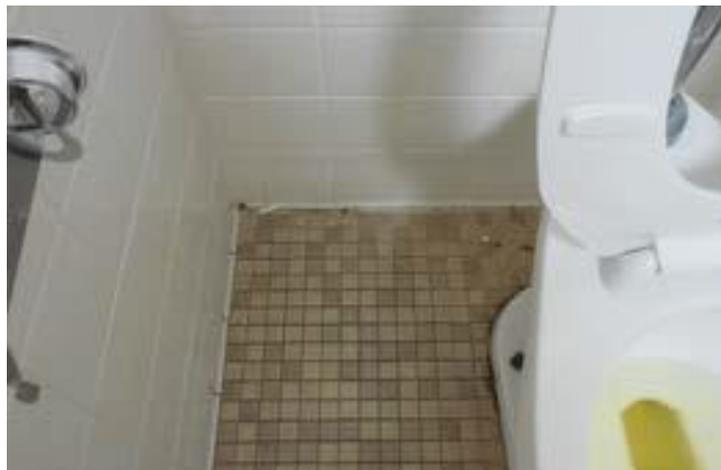




Hole in the Floor



Black Mold and Dirt on Bathroom Floor



Black mold, Missing Tiles, No Toilet Paper





Black Mold, Broken Tiles, No Toilet Paper



Rusted Adaptive Equipment in Bathroom





Obscured Fire Extinguisher



Cracked Flooring





Broken Wagon with Missing Handle, Jagged Plastic



Damaged Doorway





Damaged Ceiling Tile



Hole in Floor





Damaged Doorway



Damaged Doorway





Damaged and Rusty Doorway



Damaged and Rusty Doorway





Stained and Scratched Doorway



Damaged and Rusty Doorway





Holes in Floor



Stained and Damaged Doorway





Warped Ceiling Tiles



Warped Ceiling Tiles



Damaged Ceiling Tiles





Dirty Ceiling Tile, Ceiling Tiles are Missing



Damaged Flooring





Broken Shower Curtain on Floor; Mold



Holes in Wall



Holes in Ceiling





Broken Bathroom Floor Tiles



Damaged Rusty Doorway, Black Mold on Floor,
Warped Flooring



Damaged Bathroom Floor Tile





Black Mold



Timer On Wall Near Playroom





Inaccessible Light Switch at Approx
5 feet six inches



Black Mold in Bathroom





Dirty, Rusted Doorway with Black Mold



Inaccessible Light Switch and Mounted
Timer in Play Room





Broken Cabinet



Missing Floor Board and Black Mold





Damaged Floor Board and Black Mold



Holes in Flooring



Broken Ceiling Tile





Damaged Ceiling Tile



Leaking Windows



Holes in flooring





Missing molding and black mold



Holes in Floor



Holes in door frame, rust in door frame, black mold in flooring tiles





Dining Cart is Dirty and Stained



Damaged Door





Dirty and Damaged Windowsill



Trash Cans Used for Dirty Linens Kept in Hallways and Belts Hanging in the Bathroom



Cluttered Hallway





Full Mop Bucket with Dirty Water With Mop Unattended in Hallway



Worn Towels; Unsecured Latex Gloves in Bathroom

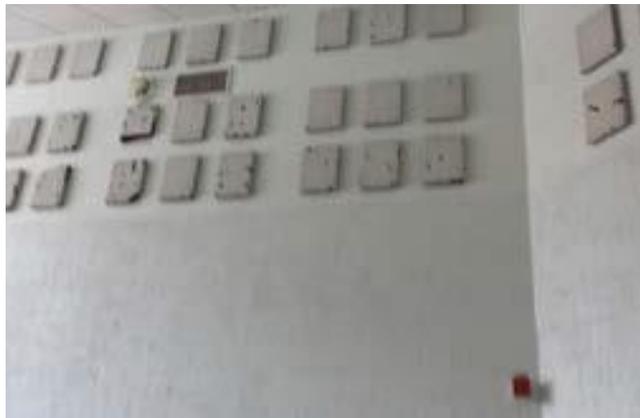




Chipped Wall



Tape and Molding Coming Off of Wall



Material Falling Off of Wall





Inaccessible Items



Rusted and Stained Doorway

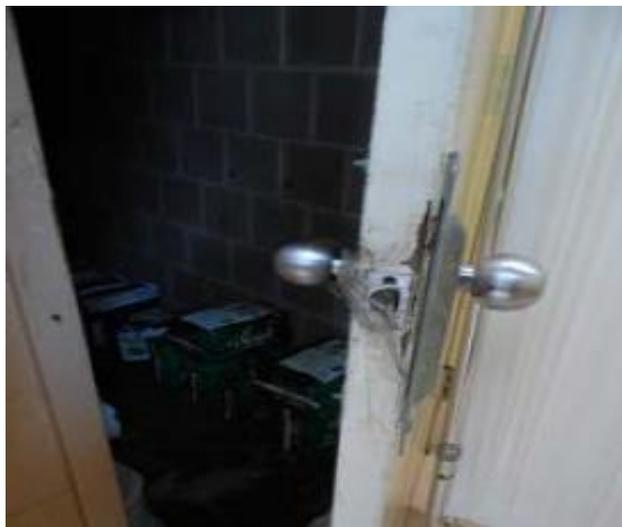




Stained Floor



Stained Floor



Taped Door in Playroom Bathroom





Stained Floor



Broken and Dirty Vent





Open and Accessible Latex Gloves (Safety Concern -
and Possible Choking Hazard)

