

Government Watchdog Warns Of Group Home Dangers

by Michelle Diamant | January 18, 2018

Injuries, serious medical conditions and even deaths of those with developmental disabilities living in group homes often are not looked into and go unreported, federal investigators say.

An audit of three states found that officials routinely failed to follow up on incidents ranging from head lacerations to loss of life in violation of federal and state policy. The issues are believed to be systemic affecting people with developmental disabilities residing in group homes across the country.

That's according to a joint report issued Wednesday from the U.S. Department of Health and Human Services Office of Inspector General, Administration on Community Living and Office for Civil Rights, which is recommending policy changes.

The report stems from a 2013 request by U.S. Sen. Chris Murphy, D-Conn., who was alarmed by newspaper reports of widespread abuse and neglect of group home residents in his state. After the inspector general's office found serious problems in its review of Connecticut, the office conducted similar audits of Massachusetts and Maine.

In each state, investigators identified emergency room visits from group home residents, then determined if the incidents were reported to the state and, if so, what action the state took.

The inspector general's office found that group homes often failed to report incidents to state officials. But even when states knew, up to 99 percent went unreported to law enforcement or other authorities for investigation.

"Each state was somewhat unique, but what was similar across the states was that there were gaps in policies and procedures so that when an incident occurred, they could make sure that it was identified, investigated, corrected and reported," said

Megan Tinker, senior advisor for legal review at the Office of Inspector General and an author of the report.

Aside from the three states that were audited, investigators said that recent media reports from 49 states citing health and safety problems in group homes suggest the issues are pervasive. The Office of Inspector General has additional audits underway or planned in another six states, Tinker said.

Citing the “magnitude of the danger for beneficiaries,” the Office of Inspector General worked with the Administration for Community Living and the HHS Office for Civil Rights and other federal entities to develop recommendations for the Centers for Medicare and Medicaid Services and states to address the holes in existing policies and procedures.

The report released this week is a culmination of that work and includes model practices for states to develop better oversight. In addition, the Centers for Medicare and Medicaid Services should take steps to help states address problems by forming a “SWAT” team and taking action when problems are identified in order to ensure the safety of group home residents, the recommendations indicate.

“CMS is working directly with the three states specifically examined by the OIG, and is working with department partners to distribute tools, information and any other necessary assistance to all states to ensure that quality care is being provided to all Medicaid beneficiaries,” the Centers for Medicare and Medicaid Services said in a statement to Disability Scoop. “The suggestions found in this report are being carefully examined for further action by the agency.”

Despite the problems identified, Tinker said many group homes are great places.

“If people are looking at a group home for their loved ones, we think it’s important to spend time at the group home and to ask questions and make sure it has the right policies and procedures in place,” she said. “What do they do if something goes wrong?”

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