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DJ 168-35-5

FEB 19 1982

CERTIFIED MAIL
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The Honorable Harry R. Hughes
Governor of the State of Maryland
State House
Annapolis, Maryland 21404

Re: Rosewood Center
Owings Mills, Maryland

Dear Governor Hughes:

As you will recall from former Assistant Attorney General Days' letter of November 7, 1980, the Department of Justice initiated an investigation of conditions at Rosewood Center, Owings Mills, Maryland, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. 1997. This letter is to apprise you of the major findings of our investigation to date, as required by the statute. We wish to express our thanks for the assistance and cooperation that we have received from the staff of Rosewood Center, the Mental Retardation and Developmental Disabilities Administration ("MRDDA") and the Office of the Attorney General. This cooperation has enabled the investigation to proceed smoothly.

Our investigation thus far has consisted of tours of Rosewood Center by an expert consultant and Civil Rights Division personnel; interviews of MRDDA officials and Rosewood staff, community service providers and advocates, and family members of some Rosewood clients; evaluation of information contained in a number of Rosewood and MRDDA documents provided to us, including Maryland's five-year plans for mental retardation services dating from 1977; and analysis of various surveys, inspections, and critiques of Rosewood Center conducted by federal, state, and local authorities, including Medicaid surveys and reports of Maryland's Humane Practices Commission. The information available to us at present reflects the existence of a pattern or practice of egregious or flagrant conditions causing the approximately 1135 Rosewood Center residents grievous harm in at least the following respects: lack of minimally adequate programming and related services; insufficient numbers of

adequately trained professional and direct care staff; abuse and neglect of residents; environmental conditions that are not minimally adequate; and inappropriateness of residential placement. Each of these areas is discussed in turn below. The supporting facts giving rise to these conditions are derived from the sources identified in this paragraph. To the best of our knowledge, these conditions have existed for some time, and at least since 1974.

I. Conditions at Rosewood

1. Lack of minimally adequate programming and related services.

Rosewood Center provides an inadequate number of habilitative programs of sufficient quality to meet its residents' identified needs. Rosewood officials admit, and state documents confirm, that on the average only 42% of each resident's individual program plan is implemented (excluding recommendations for community placement). Over 900 of the 1125 residents receive less than 50% of the services called for in their program plans. Hundreds of residents are in need of vocational and pre-vocational training programs. There are many residents, often those in greatest need of programs because of their developmental needs and years of prior neglect, who sit idle during prime programming hours. Some residents receive no programs at all. Both parents and staff described instances where Rosewood residents had gone years without receiving programs and had lost skills they formerly possessed. State law emphasizes Maryland's policy of providing each Rosewood resident with an individualized plan of care designed to foster his/her growth and development. Md. Ann. Code, Art. 59A, §§ 2, 8A.

Lack of staff, and insufficient training of available staff, have resulted in inadequate implementation of those programs for which residents are scheduled. Programs are often not carried out for one reason or another. On some units, especially those housing multiply disabled individuals, staff report (and outside surveyors have confirmed) that residents receive little more than custodial care. Even where programs are available, they tend to be offered in a congregate manner. The amount of individualized attention residents receive is minimal. According to the Rosewood Individualized Program Plan Survey for Fiscal Year 1980, the mean time for 1:1 staff:resident contact per day was only one hour.

Evaluations in a number of areas appear to be inadequate and based on availability of services rather than resident needs.

Waiting lists for services such as occupational therapy, physical therapy, and speech and hearing therapy are extremely long. Rosewood has identified 777 persons in need of and not receiving occupational therapy services. 143 residents are in need of and not receiving various speech and hearing therapy services. The waiting list for available physical therapy services is 48, which does not include the many residents that need those physical therapy services which are not currently provided because of staff shortages. Recreation services are also inadequate.

2. Insufficient numbers of adequately trained professional and direct care staff.

Rosewood lacks sufficient numbers of trained staff in a variety of positions that are crucial to the provision of minimally adequate habilitation. The long waiting lists for services noted above reflect the need for additional physical therapists, occupational therapists, and speech and hearing therapists. Rosewood also needs additional psychologists, especially those with training in behavior management techniques. Outside surveyors have identified the need for additional dietitians, and Rosewood has recognized the need for more registered nurses and licensed practical nurses. A psychiatrist is needed to provide services for behaviorally difficult clients. This need will increase with the anticipated transfer of some of the "Sachs population" from mental health facilities. Rosewood requires 146 additional adult activity staff - including teachers, activity therapists and aides, and instructors - to implement fully residents' individualized program plans.

Both state officials and outside surveyors have stressed the need for many more direct care staff at Rosewood. Even on units where the number of assigned staff approaches adequacy, the high level of staff absenteeism causes de facto shortages and temporary transfers of staff to unfamiliar units. Direct care staff, moreover, are in need of additional training and supervision. These staff often do not carry out necessary programs, and in a number of areas the quality of staff-resident interaction and supervision was observed to be deficient. Direct care and professional staff shortages have been exacerbated by the hiring freeze in effect for the first half of 1991. The staff shortages at Rosewood deny needed habilitative services to residents, causing them to regress and lose skills.

3. Abuse and neglect.

Staff shortages and lack of training contribute to another serious problem at Rosewood: the abuse and neglect of some Rosewood

residents. Incident reports compiled by Rosewood reveal that numerous clients have sustained injuries due to violent outbursts by other clients during low staffing periods. Parents have described the serious and usually unexplained injuries suffered by their children during periods of inadequate supervision. These sources also report instances of staff mistreatment and neglect of residents.

On December 5, 1980, six severely handicapped female residents of Johns Cottage were allegedly raped by an outside intruder. There was only one staff person on duty to supervise the 32 residents of Johns Cottage - and only one security officer on duty to cover the entire Rosewood facility. While the inability of the residents to communicate apparently prevented state officials from confirming the rapes or positively identifying the rapist (the staff person thought the intruder was a recently discharged Rosewood employee), it is undisputed that several of the residents had positive tests for gonorrhea of the throat right after the incident; that there was an unauthorized person in Johns Cottage; and that the mother of one of the affected residents was not informed of the incident until four days later. Nor is this incident the only instance of alleged sexual contact involving Rosewood residents. The charts of several male residents show the presence of venereal disease. Rosewood incident reports show that in June 1980, an employee of Gundry Building took a Rosewood resident off grounds without permission and sexually abused him. In March 1980, nonconsensual sexual contact occurred between one resident and at least one and possibly three residents of the Stump Building. This incident occurred while the direct care staff person on the unit was sleeping.

At least two deaths in 1980 were due in part to inadequate supervision by Rosewood staff. As you probably know, Attorney General Sachs has reported on one of these deaths to the Maryland Humane Practices Commission. In February 1980, William Tillman managed to obtain a set of keys from a direct care staff person and escape from Rosewood; he was found near Rosewood by some passersby nine days later, dead from exposure to the cold. Two staff scheduled to be on duty the evening of Tillman's escape were not present. Robert Haynie, who was profoundly retarded, died on September 5, 1980, when a staff person left him unattended in a bath. While the staff person was away, the resident had a severe seizure and drowned. As you state in your November 3, 1980 letter to Monroe Karasik, president of the Maryland Association for Retarded Citizens, Robert Haynie's tragic death was due to the staff's "lapse in judgment." Moreover, we have recently learned of the death of a resident of Benzinger Cottage. The resident apparently

died as a result of being pushed down a flight of stairs. In our judgment, residents are exposed to serious harm at Rosewood.

4. Inadequate environmental conditions.

The vast majority of Rosewood clients reside in inadequate, deteriorating buildings. These residences are sterile, crowded, noisy places which fail to provide even a modicum of privacy. There is no privacy in many bathroom areas. The stench of urine is prevalent in a number of buildings. In many buildings, residents sleep in large dormitories with beds lined up row after row. In some buildings, the "dayroom" area is the same as the dormitory area. In others, the dayrooms are large, unfurnished rooms with bare, terrazzo floors where residents are idle much of the time. Lack of funding has apparently prevented the purchase of furniture for some buildings, such as the Richards building. In other buildings, necessary furniture or special beds are available only through parent contributions. Medicaid surveyors have criticized the lack of furniture in some resident areas. Many residents do not have access to their clothes and personal possessions, which are stored in locked rooms. Residents must ask staff for toilet paper.

Within the past year, numerous problems have developed which underscore both the decaying physical plant at Rosewood and the lack of maintainence services. Plumbing problems in several buildings went unrepaired for days. In the Pembroke building, residents, many of whom have ambulation problems, were expected to cross over the puddles created by overflowing toilets to reach the few working toilets. Necessary repairs were delayed by the lack of plumbers on Rosewood's staff; several vacancies could not be filled because of the job freeze. Severe heating problems in the Richards building forced clients to sleep in their overcoats. During the recent cold wave, residents in Gundry, Richards, and Pembroke buildings were subjected to sub-freezing temperatures in the buildings themselves. Other buildings are uncomfortable in the summer because of a lack of air conditioning. For many Rosewood residents, their environment not only fails to provide a homelike atmosphere, it jeopardizes their health and safety. For example, the sixty-five severely physically handicapped (and mostly wheelchair-bound) residents of the second floor of the Wyse building would have great difficulty evacuating the building in the event of a fire. Indeed, a fire did occur in Wyse last winter.

We are aware, of course, that several Rosewood buildings have been renovated so that no more than four residents sleep in one bedroom. At present, there are only approximately 160 fully

Medicaid-certified beds at Rosewood out of a total of approximately 1250 beds. (There are nineteen non-certified buildings at Rosewood.) We are also cognizant of plans to renovate additional buildings. Such plans, however, have existed for some time. As far back as 1976, Rosewood planned to renovate 22 buildings over a five-year period ending in Fiscal Year 1982. To date, only five buildings have been renovated; the first three buildings were not completed until 1980. Plans for renovation of some buildings extend to 1990. For example, the Finesinger Building was originally scheduled to be renovated by 1980; current plans call for renovation in 1986. Dates for renovation of other buildings have been postponed as well. There is thus no assurance that the current renovation schedule will be followed. Even if it is, residents would continue to be housed in inadequate buildings for many years to come.

5. Inappropriate placement.

State documents and our outside consultant agree that large numbers of residents are inappropriately confined in Rosewood. For example, MRDDA's Master Facility Plan for Fiscal Years 1981-1990 states that only 9% of Rosewood's population, or 119 residents, require institutional placement. The Humane Practices Commission report of November 1980, relying on figures supplied by Rosewood staff, reported that only 94 residents require continued placement in Rosewood. MRDDA five year plans from 1976 to the present contain similar analyses. For example, the 1983-1985 Unit Plan states that 322 Rosewood residents require community placements, while 909 should be placed in slightly larger "alternative" settings.

As reflected in its planning documents, Maryland has adopted a clear policy in favor of promoting normalization and appropriate community placement. Such a policy is, of course, mandated by state law. Md. Ann. Code, Art. 59A, §§ 2, 10. But by the state's own admission, community programs have not been developed sufficiently to promote these goals. Thus, plans to reduce the size of Rosewood have had to be postponed. The result is the continued inappropriate institutionalization of Rosewood residents, institutionalization that limits these residents' growth and development. Moreover, to the extent community placement lags behind the state's plans, Rosewood residents will either be forced to remain in clearly inadequate buildings at Rosewood or the state's capital renovation program will have to be expanded still further. Community providers in Maryland have indicated a desire to serve Rosewood residents if sufficient financial support from the state is forthcoming. Our review of some

of these community programs indicates that they could easily be expanded to serve many of the clients now at Rosewood.

6. Other areas of concern.

While we have not examined in depth the quality of medical care services at Rosewood, we have received complaints concerning the failure of staff to identify residents' medical problems. In a number of instances, parents have complained that they have found their children with unexplained physical ailments and other medical problems that are either ignored or not observed by direct care staff. Some of these parents have themselves had to arrange for medical care for their children. A number of Rosewood residents have low body weights and receive laxatives, suggesting nutritional deficiencies. Rosewood's infectious disease reports reflect periodic outbreaks of various contagious diseases, such as hepatitis, pinworm, and gonorrhea. For some residents, psychotropic medications appear to be used in lieu of programming. Outside evaluations have found that physician orders do not state the rationale for prescribing the medication in question; in other cases, medication has been ineffective in reducing problem behaviors, yet other means of intervention have not been tried.

II. Minimum measures to remedy these deficiencies

We recognize that since 1976 Rosewood has made progress in improving the quality of services available to its residents. Nevertheless, the serious deficiencies outlined in this letter must be remedied in order for Rosewood residents to receive minimally adequate care and habilitation. In general, the minimum measures we believe to be necessary are the following:

1. Rosewood must take steps to provide for full implementation of residents' individualized program plans. Residents must be properly evaluated and provided with programming services deemed necessary. An intensive effort must be made to reduce substantially the extensive waiting lists for occupational therapy, physical therapy, speech and hearing, and vocational services. Rosewood must increase the amount of time its residents spend in meaningful, productive activity.

2. Needed professional and direct care staff must be hired, trained, and deployed. Rosewood must focus particularly on hiring additional direct care staff and ensuring that such staff receive adequate training in implementing programs, observing residents for medical problems, and learning how to interact appropriately with Rosewood residents.

3. Rosewood must reduce the level of abuse and neglect in the institution. Additional security staff must be hired. All staff must receive training in preventing abuse and must be encouraged to report instances of alleged abuse to institutional authorities. Staff found to have abused or neglected residents must be removed from contact with residents. Staff must improve methods of supervising residents in order to decrease resident to resident abuse.

4. The institution must devise a preventive maintenance plan to deal with the deficiencies of the various buildings at Rosewood. In unrenovated buildings, efforts must be made to increase the amount of privacy available to residents (through the use of curtains or partitions, for example). Residents should have easier access to their personal possessions and clothing and to items such as toilet paper. Bathroom areas should be modified to provide privacy to residents. Needed furniture should be obtained.

5. Rosewood must systematically evaluate residents for their need for community placement, and must, in conjunction with MRDDA and other appropriate state agencies, take concerted steps towards placing residents in accordance with those evaluations. MRDDA plans that identify numbers of residents who are inappropriately at Rosewood, and that recommend community placement for these individuals, must be implemented.

We are available and willing to discuss these issues with you in greater detail at your convenience. It is our hope that we can resolve these matters amicably. Once again, thank you for the cooperation we have received in conducting our investigation.

Sincerely,

Wm. Bradford Reynolds
Assistant Attorney General
Civil Rights Division

cc: Stephen Sachs, Esq.
Mr. Charles Leight
U.S. Attorney J. Fredrick Motz