

# **Rosewood Center: A Demand for Closure**

*A Public Report by Maryland Disability Law Center  
February 1, 2007*



# Introduction

For years, MDLC has been raising concerns about unsafe conditions at Rosewood Center (Rosewood) and calling for closure of this flawed, outmoded institution. State oversight officials recently found conditions at Rosewood, Maryland's largest institution for people with developmental disabilities, pose immediate jeopardy to the health and safety of residents.

In 2001, MDLC informed the state that Rosewood failed to identify incidents involving abuse and neglect of its residents. In 2002, MDLC issued a public report detailing how a Rosewood resident died during an inappropriate restraint.<sup>i</sup> MDLC continued to document and report patterns of illegal use of restraints and other failures of care.

In April 2006, MDLC reported to state officials that residents at Rosewood were subjected to inhumane and illegal conditions, specifically citing the use of prolonged seclusion.

In September 2006<sup>ii</sup> and again in January 2007,<sup>iii</sup> the Maryland State Office of Health Care Quality (OHCQ) found that the facility fails to protect individuals from physical abuse and self-injury, fails to investigate incidents of abuse and neglect, and has not provided treatment interventions to meet the resident's needs.

On January 23, 2007, OHCQ imposed a 30-day ban on admissions so Rosewood could address its "full attention to corrective action and the needs of its existing residents."<sup>iv</sup>

These findings and others detailed in this report demand leadership from state officials to finally bring an end to segregating individuals into this large, expensive congregate setting. Our call to close

## Organizations Calling for Closure of Rosewood

- The Arc of Maryland
- Baltimore County Commission on Disabilities
- Cross-Disability Rights Coalition
- The Freedom Center
- Helping Hands
- Independence Now
- Making Choices for Independent Living
- Maryland ADAPT
- Maryland Association of Community Services for Persons with Developmental Disabilities
- Maryland Coalition for the Civil Rights of Persons with Disabilities
- Maryland Developmental Disabilities Council
- Maryland Disabilities Forum
- Maryland Disability Law Center
- Maryland Statewide Independent Living Council
- People First
- People on the Go of Maryland

Rosewood joins the demands from others across the state, with at least 16 advocacy groups taking a stand on closure.<sup>v</sup>

Four years ago, Governor Ehrlich's New Freedom Initiative proclaimed, "It is time to develop a concrete plan to start closing state institutions that warehouse people, rob them of their freedom, and waste state taxpayer dollars."<sup>vi</sup> Three years ago, the Department of Health and Mental Hygiene (DHMH)<sup>vii</sup> recommended closing Rosewood in keeping with both Maryland policy and the U.S. Supreme Court's *Olmstead* decision. The Court advised states to comply with the Americans with Disabilities Act (ADA) by moving people out of institutions at a reasonable pace.<sup>viii</sup> The Maryland Department of Disabilities 2007 State Disability Plan recommends dramatically increasing the number of persons discharged from state institutions for people with developmental disabilities.

Yet today, 200 people still remain trapped at Rosewood.

To understand what freedom means, meet Crystal and Daniel who recently moved into our communities after living at Rosewood for decades:

*Crystal* "Crystal" was institutionalized at age 13. Now 57, she has only recently been given the opportunity to move from Rosewood to a home in the community. Crystal has a profound intellectual disability and relies on a walker for support, but she has a zest for life, enjoys having her nails done, wearing make-up and carrying pocketbooks. In her new life in the community, Crystal takes advantage of opportunities to indulge her passion for music and dance, including a daily music class.

*Daniel* "Daniel," who has a severe intellectual disability, began living at Rosewood just before his 15<sup>th</sup> birthday in 1972 and did not move to the community until 33 years later. Daniel always wanted to live in a big house where he could watch football and baseball on T.V. Now, exclaiming his joy to be free from Rosewood, Daniel lives in a house, watches sports with his housemates, and is learning to cook, do laundry and other life chores for himself.

To help individuals like Crystal and Daniel gain freedom from the walls of institutions, in January 2007 the federal government announced that Maryland was awarded up to \$67 million in exchange for Maryland's promise to use the funding to move its citizens out of institutions. While the state is a beneficiary of an influx of funds to support community placement, it is simultaneously at risk of losing federal funding for the troubled Rosewood institution. OHCQ warned the facility of its intention to terminate its licensure

as a Medicaid provider if Rosewood did not address serious program violations. The continued commitment of state resources into Rosewood, the largest, most troubled and most expensive of our state institutions for persons with intellectual disabilities, must end. Those resources must be re-directed to serve some of the 16,000 people with developmental disabilities, many with critical needs, who are on the state waiting list to receive services as soon as funding is available.

**This paper is a call to advance the civil rights of people living in institutions, and in so doing, enrich the communities in which we all reside.** It will address the following issues:

Violations of Rights and Inadequate Treatment

- Inadequate Treatment
- Illegal Use of Restraint and Seclusion
- Failure to Support Community and Family Connections
- Failure to Protect the Right to Education
- Failure to Protect from Harm
- Illegal Segregation of Persons with Disabilities

Failed Mission within the Forensic Program

Unjustifiable Institutional Costs

Closure and Other Recommendations

*Congress finds that -*

(1) disability is a natural part of the human experience that does not diminish the right of people with developmental disabilities to live independently, to exert control and choice over their own lives, and to fully participate in and contribute to their communities through full integration and inclusion in the economic, political, social, cultural, and educational mainstream of United States society...

*- Developmental Disabilities Assistance and Bill of Rights Act of 2000*

# Inadequate Treatment

Individuals at Rosewood have constitutionally protected interests in conditions at the institution. Care, safety and training should be established according to reasonable professional standards and individuals with developmental disabilities should not be unreasonably restricted, according to the U.S. Supreme Court.<sup>ix</sup>

*Jason* “Jason” arrived at Rosewood at age 5 and has lived there ever since. With people he likes, he shows off any new clothes or accessories and especially loves belt buckles. Jason enjoys action movies. Using evocative facial expressions and energetic signs, he conveys animated descriptions of the movies he watches.

Jason is deaf and has intellectual disabilities. Although Rosewood staff who work with Jason have very limited training in sign language, Rosewood does not provide him with a full-time sign language interpreter. As a result, Jason is isolated and shows signs of severe frustration. At one time, when he had a full-time interpreter who provided him with constant communication and sign language training, Jason acquired over 230 signs in American Sign Language (ASL).

*Twelve percent of Rosewood residents have hearing impairments and 63% have speech impairments.<sup>x</sup>*

Though his service plan says he should have more interpreter services, Jason can only count on having an interpreter for 2½ hours each Tuesday, Thursday, and Friday afternoon; otherwise he receives interpreter services “as available.” For the other 160 hours per week, Jason is deprived of the right and ability to express even his most basic needs and wants. With such significant gaps in his opportunities to communicate, Jason’s use of ASL has regressed.

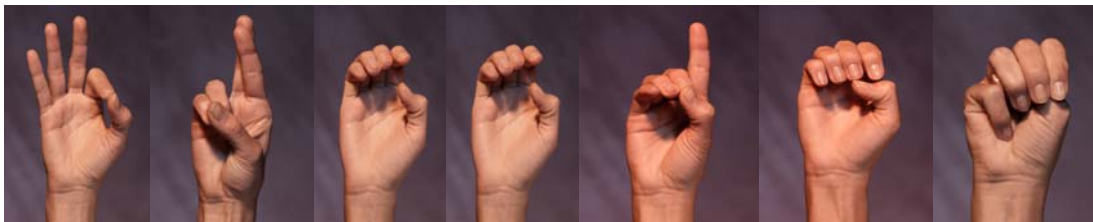
Rather than promote Jason’s communication skills so he can express his needs and desires, Rosewood has controlled Jason’s behaviors with physical holds and a “safety coat,” a device similar to a strait jacket that restrains a person from physical movement. These restraints incapacitate Jason’s hands, his only means of communication.

With MDLC intervention, a service provider specializing in serving people who are deaf or hard of hearing will provide Jason with staff fluent in ASL so he can learn about the opportunity to live in the community with other people who communicate through sign language.

But Jason is not the only deaf resident at Rosewood. OHCQ found that one resident was unable to go to school because the institution failed to provide him with an interpreter.<sup>xi</sup> Incredibly, OHCQ found that no interpreter was even “available” for the entire months of April, June, July, August and September.

In October 2006, OHCQ cited the institution’s failure to protect residents from serious physical injuries and found numerous significant deficiencies in the conditions of care.<sup>xii</sup> Rosewood submitted a plan of correction for the extensive deficiencies and has one year to achieve compliance with federal requirements.

Individuals have a right to thorough communication assessments, in-depth speech and hearing evaluations, and other services they need, according to reasonable professional and legal treatment standards.



**“Freedom”**

# Illegal Use of Restraint and Seclusion

MDLC has documented and reported to the state Rosewood's illegal and inappropriate use of restraint and seclusion to control behavior. For individuals with intellectual disabilities, behavior is often a principle means of communication. Best practices in providing behavior support include positive approaches rather than restraint or seclusion. For example, if a toothache causes a person to become distressed, restraining the person to control their agitation only worsens the situation.<sup>xiii</sup> Restraint does nothing to alleviate the pain or help to develop useful behavior skills.

Restraint and seclusion are dangerous interventions that can result in injury or death.<sup>xiv</sup> MDLC raised serious issues around the inappropriate use of restraints at Rosewood Center several years ago when a 30-year-old man died during a restraint.<sup>xv</sup> The man's death was especially poignant since he had been spending every weekend with his parents and was looking forward to his imminent move to a new home in the community. Rosewood's documentation of the death failed to cite a **single** problem with a face-down prone restraint of an overweight individual that resulted in death, leaving dangerous protocols in place and jeopardizing the safety of surviving residents.<sup>xvi</sup>

## Restraints

Of 190 providers of services to people with developmental disabilities in Maryland, only Rosewood and Potomac Center (another state-owned institution) continue to use the safety coat,<sup>xvii</sup> a mechanical restraint similar to a strait jacket.

In monitoring the use of restraints at Rosewood, MDLC has documented numerous examples of illegal use of the safety coat. Frequently, the behavior incidents that led to use of the safety coat should have been handled differently such as when:

- A resident was not allowed to have a cigarette;
- A resident refused to leave an area or refused to go to a program;
- A resident refused to bathe when requested;
- Staff entered a room with pizza and did not offer any to the residents;
- A resident made derogatory remarks to staff;
- Staff took away a resident's cigarettes as punishment; and
- A resident allegedly stole cigarettes from staff.

To use the safety coat, at least four staff people are required. They force an individual onto the ground against his or her will, place the person onto the

safety coat, wrap it around the entire body, and fasten straps securely so that the individual cannot move his or her limbs. Both resident and staff are at risk of physical and psychological injury during the struggle. Particularly vulnerable are individuals who have post traumatic stress disorder resulting from past assault or abuse, people with health conditions such as obesity or asthma, or those taking medications that put them at risk of heart attack.



**A Safety Coat**

Despite very detailed state and federal regulations restricting the use of restraints,<sup>xviii</sup> numerous professional staff at Rosewood repeatedly ignored the requirements, violating residents' rights.

***Matt*** “Matt” is a 21-year-old video game enthusiast who also enjoys watching television, listening to rap and hip hop music, and talking to his friends. At 19 years of age, Matt was sent to Rosewood. Rosewood staff responded to his behaviors by placing him in a safety coat and “chemically restraining” him with drugs. Since his admission about two years ago, Matt was forced into the safety coat over 20 times and has been the victim of chemical restraint 35 times. Because Matt is overweight, the frequent use of restraints to control his behavior presents a potentially life-threatening situation.



In response to MDLC's advocacy, Rosewood used the services of a psychologist to develop a plan for Matt that does not include the use of a safety coat or chemical restraints.

OHCQ has cited Rosewood for failing to obtain behavior planning services for residents, a failure particularly clear in Matt's case. The state found that Rosewood's psychology department delayed in responding to staff requests for assistance in creating and modifying care plans. OHCQ also found that Rosewood failed to monitor individual service programs. Corroborating MDLC's complaints, OHCQ found that Rosewood used invasive and restrictive chemical interventions before identifying and trying less invasive alternatives as required by sound practice and law.

## Seclusion

In April 2006, MDLC demanded that Rosewood release four people from seclusion. These residents were locked in rooms with bare white walls, frosted windows so they could not see outside, and had virtually no activities or social opportunities. Some had mattresses on the floor and inadequate bedding. Some had no television or radio. MDLC also demanded that Rosewood obtain a psychological consult to delete seclusion from the individuals' behavior plans and develop appropriate interventions in accord with individual rights.

*Seclusion is "the involuntary confinement of a person in a room or an area where the person is physically prevented from leaving."<sup>xxix</sup> Because seclusion is extremely dangerous and restrictive of human rights, it is strictly regulated by federal<sup>xx</sup> and state<sup>xxi</sup> law.*

### *Steven & Thomas*

For about two years, Rosewood forced "Steven" and "Thomas" to spend all of their time together, isolated from the rest of the residents. For 18 to 24 hours a day, they were confined in a single room that was divided by a partition into two small living areas. Daily, the two men were taken to another location on campus where they unwrapped and re-wrapped beach towels, still isolated from all other residents.



**Sleeping arrangement for an individual living in seclusion at Rosewood:  
bare mattress, no pillow, no personal effects.**

Though Steven and Thomas did not get along with each other, they were forced to share a television and furniture. They had no radio or telephone. At night, Steven had only a thin mattress between himself and the cold linoleum floor and had no pillow or sheets. Neither man could use the gym and had no way of getting exercise. The only time they spent outdoors was during cigarette breaks and a quick stride to and from the bus that took them to their work in another building.

**“It makes me sad to be in  
here. I cry.”  
- “Steven”**

Thomas said he was bored, angry and depressed about this living situation. He wanted to interact with others, attend church services and go out to eat. Thomas’s parents had been complaining, but nothing changed for their son. After MDLC intervened, Thomas’ restrictions were lifted. He can now move throughout the building to engage in activities of his choice. He hopes to leave Rosewood soon. In the meantime, he has obtained more useful work as a janitor and spends more time with his family.

Steven was unhappy spending so much time closeted with Thomas. He did not know why he could not leave his room. After the forced seclusion ended, Steven began to talk about going to motorcycle shops, police and fire stations, and on other outings with people. He hopes to live in the community soon and has a newfound excitement about experiencing life.



**Frosted windows**

*Lisa* For about a year, Rosewood kept “Lisa” locked up in a room for about 16 hours a day where she had no opportunity to interact with other residents. Her room and walls were barren, with no personal belongings, television, radio, telephone or means of entertaining herself. The windows were frosted and curtained so she could not see outdoors.

Every day Lisa left Rosewood for eight hours to successfully participate without special restrictions in a community-based day program. But every night, when she returned “home” to Rosewood, she was locked away in her room again. She was not even allowed to join her friends for meals, but instead had to eat alone in her room.

Upon intervention by MDLC, Lisa was released from seclusion. Now she can leave her room, interact with others, enjoy daily activities and eat meals with her friends. She has added decorations and personal effects to her room.

Significantly, mechanical or chemical restraints have been removed from her individual plan.

Each of these individuals has an intellectual disability and was admitted to Rosewood for services. Rosewood was unable to conform its practices to professional standards of care or to legal mandates. Although it agreed to improve the situation for a number of individuals identified by MDLC as subject to illegal restraint and seclusion, nine months later Rosewood has failed to implement at least half of the new behavior plans. As a result, people remain vulnerable to the safety coat or drugs instead of treatment. The inappropriate use of illegal seclusion was not an error, but rather consistent with Rosewood's institutional response to serving people entrusted in their care. The depth of the mistreatment speaks volumes about the depth of the problems at the institution.

## Failure to Support Community and Family Connections

Rosewood has also unjustifiably isolated individuals by preventing them from visiting friends and family. Failure to support these important relationships violates the residents' fundamental human rights.<sup>xxii</sup>

*Robert* A year after his admission to Rosewood, "Robert" still had not been home to visit his mother and father. Robert enjoys spending time with his family and wants to go home at least once a month for a family meal. His family wants him to be able to visit, but transportation presents a challenge for his mother, who does not drive. During the year, she paid someone to take her to Rosewood for a few short visits with Robert, making an effort to schedule her visits so she could attend important team meetings and participate in planning her son's care and services. At those meetings, Robert's mother always asked when her son could come home to visit. She was always told he could not, but she never understood why.

After continued advocacy by MDLC, Robert's team agreed to home visits and developed a plan for transportation and staffing. However, before the plan could be implemented, the Rosewood administrator overruled the treatment team decision. Soon after that, Robert was transferred from the facility.

Federal and state laws require Rosewood to respect a person's fundamental right to visit with family and friends.<sup>xxiii</sup> MDLC is aware of other infringements by Rosewood on the rights of individuals to leave campus and visit friends and families in the community.

# Failure to Protect the Right to Education

Within the last two years, approximately 15 special education students have been admitted to Rosewood Center, but many are being denied the right to continue going to school while living at the institution. Federal and state laws promise a “free appropriate public education” to everyone of school age. Youth with disabilities should attend school with non-disabled children and, whenever possible, go to their neighborhood school. These youth are entitled to continue school through the end of the school year in which they turn age 21.

*Kevin* “Kevin” is 19 years old. He is a quiet young man who enjoys reading and school. Just after his eighteenth birthday, Kevin was admitted to Rosewood. Though his Rosewood social worker was directed to pursue a school placement for him, he was not enrolled in school for almost one year after his admission to Rosewood. During that time, he had no meaningful day or educational program. After MDLC intervened, Kevin was enrolled in public school in Baltimore County. In addition to attending academic classes, he now participates in a vocational program. By greeting people, unpacking boxes, and helping on the floor of various retail stores, Kevin gains job readiness skills.

Rather than enrolling youth in school, Rosewood often requested the six hours/week of teaching that the public schools provide to children who temporarily cannot attend school. In July 2006, MDLC filed a complaint with the Maryland State Department of Education (MSDE) on behalf of a young man residing at Rosewood who was not attending school, requesting that MSDE investigate the situation of other students at Rosewood as well. MSDE confirmed the complaint for these students, and ordered compensatory education services.<sup>xxiv</sup> Yet MSDE did not make any findings regarding Rosewood and today many school age residents at Rosewood continue to be denied their right to a public education.

“I want to go to school... I want to learn to read and write.”  
- “David”

# The Failure to Protect from Harm

## Conditions of “Immediate Jeopardy” to Health and Safety

On September 26, 2006, the Office of Health Care Quality (OHCQ) issued a Notice to Rosewood Center that conditions at the facility posed an **immediate jeopardy** to residents.<sup>xxv</sup> Describing a long list of injuries resulting from violence, including numerous lacerations, nosebleeds, broken ribs, and a swollen face, OHCQ’s observations and reviews of numerous incidents revealed that:

- Rosewood failed to provide any psychology services or a behavioral plan to address the escalating needs of an individual who repeatedly injured herself for almost two months. As a result, she continued to harm herself.
- An individual’s treatment team waited until the end of a three-month period that included 14 restraints and at least five injuries to the individual, three of which required emergency medical treatment, before it recommended a change to the person’s behavior plan. Over a month later, OHCQ found Rosewood had still not made the revisions necessary to ensure the person’s safety.
- One resident known to make racist comments lived in the same cottage with an individual who became enraged by the comments, and beat him severely. OHCQ found that Rosewood negligently kept the two men in the same cottage even after the beating, placing them at continued imminent risk.
- Rosewood’s response to a fight was to seek psychiatric consultation only for the injured victim, but not for the individual who caused the harm and who clearly needed intervention.

Four months later, on January 22, 2007, after re-inspecting the facility, OHCQ **again found conditions of immediate jeopardy**, citing numerous failures to protect clients from harm and to protect clients’ rights.<sup>xxvi</sup> Again, OHCQ found numerous injuries, psychiatric emergencies, illegal use of restraints, suicide attempts, and assaults. According to OHCQ, Rosewood failed to develop, revise and implement treatment plans to prevent further harm to individuals, and failed to investigate numerous incidents altogether. OHCQ also found that when the facility failed to carry out a physical therapist’s orders to throw away a man’s ill-fitting shoes, he was injured to the point where he could not bear weight on one leg. Though a woman said she injured herself because her tooth hurt, Rosewood failed to take her to the dentist. OHCQ suspended admissions so Rosewood could focus on improving conditions for its residents.<sup>xxvii</sup>

OHCQ described the following conditions of immediate jeopardy:

- “[T]he facility failed to ensure that individuals are free from abuse, neglect and mistreatment and that the potential for harm existed.”
- “The facility staff had knowledge of individuals who physically abused other individuals and/or were self-injurious.”
- “The facility did not thoroughly investigate incidents and had not implemented effective preventative measures to protect the individuals from actual and potential physical abuse or self-injury.”
- “There were multiple incidents of actual harm arising from incidents of client to client abuse and client self-abuse.”
- “[I]ndividuals did not receive appropriate services.”

## **Failure to Protect from Sexual Assault**

In June 2006, months before it issued the notice of immediate jeopardy, OHCQ investigated an incident of sexual assault and found that the facility had failed to protect the victim. The attack occurred after a cottage supervisor ignored the protests of staff and placed a resident alone in a room with another resident known as a sexual predator.

For years, the resident who perpetrated the sexual assault had lived at the institution and was supposed to receive treatment. But during that time Rosewood ignored his doctor’s recommendations to provide him with services to address his sexual behaviors. In its January 2007 finding of immediate jeopardy, OHCQ points out that this individual’s treatment plan has still not been revised to address sexual aggression, so **the potential for harm has not been addressed in seven months.**

“I wouldn't even send a dog down there.”

- Mother of Victim of Sexual Assault,  
regarding Rosewood



## **Failure to Report and Investigate Allegations of Abuse and Neglect**

According to OHCQ, Rosewood does not report and investigate allegations of abuse and neglect as required by state and federal law. OHCQ found that of those incidents that Rosewood did report, the facility:

- Did not document thorough investigations;
- Did not complete investigations within the required timeframe;
- During ongoing investigations, failed to keep people safe by developing a plan to prevent recurrence of the abuse or neglect;
- Did not consider residents to be witnesses to incidents; leaving residents powerless to protect themselves or to make their concerns known; and
- For injuries “of unknown origin,” failed to conduct comprehensive and responsive investigations.

“...[T]he facility failed to conduct thorough investigations of all allegations of abuse, neglect or mistreatment as well as injuries of unknown origin.”

“...[T]he facility does not protect the individuals from further potential abuse or injury during the course of the facility’s investigations for every incident.”

“...[T]he facility does not complete the investigations within five days of the incident.”

- Maryland Office of Health Care Quality

# Illegal Segregation of People with Disabilities

“Unjustified isolation...is properly regarded as  
discrimination based on disability.”

- U.S. Supreme Court, *Olmstead v. L.C.* <sup>xxviii</sup>

In the landmark *Olmstead* case<sup>xxix</sup>, noting the pervasive history of isolating and segregating individuals with disabilities, the U.S. Supreme Court said that though it would not compel states to immediately move all individuals to the community, they would be in compliance with the Americans with Disabilities Act if they could demonstrate a “comprehensive, effectively working plan” for providing persons with disabilities services in their communities and a waiting list that moved at “a reasonable pace.” This decision is now seven years old, yet Maryland is spending more than ever on institutions.

Maryland has no excuse for keeping individuals with developmental disabilities isolated and segregated in the state institutions. Several other states have closed similar institutions, and Maryland has extensive experience closing institutions. Citizens with developmental disabilities in southern Maryland, Montgomery and Prince George’s Country remain institution-free since the closure of Great Oaks Center, the subject of a lawsuit and federal investigations for unconstitutional conditions of confinement.

People in those regions are no different from those at Rosewood, nor do they have an exclusive claim to the benefits of living in a desegregated community, where one may choose their friends, live in a home instead of an institution, have a voice in their meals, the movies they care to watch and more. Rosewood residents deserve nothing less than to have these choices too.

“At Rosewood, I couldn’t make choices. Now I can make choices like  
what food I want to eat and where I want to go.”

- Former Rosewood Resident of 50 Years

# Failed Mission of the Forensic Program

New admissions to Rosewood are now generally limited to individuals with apparent disabilities who are court-ordered to receive services. Some Rosewood residents allegedly committed a crime but the court found them incompetent to stand trial because of their disability. For others, the court found that an offense occurred, but because of disability, the individual was not criminally responsible.

The use of Rosewood for these forensic purposes is often inconsistent with its mission as a treatment facility for individuals with significant intellectual disabilities. For example, institutional regulations generally prohibit locking individuals into rooms or buildings. The two incompatible purposes have created a tension that contributes to poor outcomes for both. Even the Rosewood professionals who evaluate these individuals disagree sharply in their assessments of competency, dangerousness and other abilities, so planning services is very difficult.

The state could clearly provide services to some people charged with crimes without making them languish for months or years in a costly treatment facility. But the waiting list for such services from the Developmental Disabilities Administration is large enough to fill University of Maryland's Comcast Center. As a result, people are confined to a locked facility, totally stripped of their freedom for a crime for which they have not been found guilty or for behavior that would never cause a person without a disability to be institutionalized. Consider:

*Nat* "Nat" was committed to Rosewood in 2006. When he graduated from school at age 21, he continued to live with his parents. When they died, he went to live with his sister. He says "My sister was the best to me as anybody could be." Due to illness, Nat's leg was amputated and he uses a wheelchair. Nat had no criminal record until the incident that brought him to Rosewood. When Nat was about 61 years old, his 77-year-old sister became ill and every day Nat used to visit her at a nursing home. The nursing home provided meals to him. Nat said his sister told him that he would have to die with her because there would be no one to care for him.

When his sister was hospitalized in April 2006, Nat wanted to stay overnight in the hospital with her. A nurse refused his request and Nat reportedly struck her. He was immediately subdued by security officers and arrested for assault.

Nat never saw his sister alive again.

A judge ordered a competency assessment, so the Developmental Disabilities Administration (DDA) placed Nat at Rosewood. A Rosewood psychologist and psychiatrist agree that Nat may have Asperger's Disorder, a mild variant of autism. **Their agreement ends there.** The psychologist found Nat incompetent to stand trial and dangerous and recommended psychotropic medications. Apparently, the psychologist believes Nat would be a danger to himself because his health would be at risk due to his history of depending on others for personal care.

A Rosewood psychiatrist made contrary findings. He found Nat to be competent and not dangerous, the medications were contraindicated and Nat should not be at Rosewood. The psychiatrist believes that Nat's "aggressive reaction" to the nurse was due to stress from his sister's hospital admission and Nat's inability to stay with her, combined with the nurse's lack of skill in addressing someone with Asperger's Disorder.

Three days after he arrived, Rosewood decreased Nat's level of supervision and Nat has had no incidents of aggression at the institution. The next month, Nat's team recommended that he could live with drop-in support services in an accessible apartment such as an assisted living arrangement, but no such services have been arranged. DDA found that he does not meet the eligibility criteria for admission to Rosewood,<sup>xxx</sup> so the state is unable to bill Medicaid for any of the enormous cost of his institutional care.

Nat is unhappy at Rosewood and miserable about his sister's death. He believes the judge will only let him leave Rosewood when he finds a job and a place to live, but he cannot accomplish these tasks while confined.

*Bob* "Bob" was 28 years old when he was committed to Rosewood under a court order after being charged with stealing his mother's credit card. His mother wanted to drop the charges because he never used the card and promptly returned it. Nevertheless, he was detained for over a year in the institution though he has been described as pleasant and well-behaved.

*Joe* "Joe" is a 35 year-old man who has been diagnosed with cognitive and psychiatric disabilities. Before coming to Rosewood, Joe lived with his mother in a modest home and worked as a janitor for a vocational services program. He was unable to secure the mental health services he needed. With the hope of getting treatment for her son, Joe's mother called the police after Joe threw a can at her. Rather than securing the community services that his mother had hoped for, the court committed him to Rosewood.

Rosewood already has inadequate policies, practices and chronic staff shortages (including shortage of professional staff and high turnover). When DHMH places an ever increasing number of court committed individuals at Rosewood, it strains the facility beyond the breaking point. Rosewood has not developed or carried out treatment plans, has large congregate living areas that contribute to constant friction between individuals who lack skills to avoid conflict, and cannot ensure individual safety. Much to the frustration of the residents, the staff and the courts, the result is a facility that clings to an outmoded treatment model for its general population, who receive ever poorer care, while the changing dynamics of the court-committed population evolve without responsible planning.

We acknowledge that in contrast to Nat, Bob and Joe, some individuals are committed to Rosewood on allegations of serious offenses and need intensive and/or secure services, but as it is currently operated, Rosewood is ill-prepared to serve this population.

Leadership has been lacking. It is the opinion of MDLC and many state officials that Rosewood is the most troubled of the state institutions for persons with developmental disabilities and cannot be “fixed.” Continuing to place more court-committed persons into this institution will exacerbate existing problems. The institution is not safe. One proposal by DHMH is to build a new facility for the court-committed population by 2013, but rather than allow unsafe and deteriorating conditions to continue for a minimum of six years, DHMH must work more effectively with the judiciary on this issue and provide leadership and resources to find better solutions.

# Unjustifiable Institutional Costs

Rosewood and similar state institutions are gobbling funds that are urgently needed by thousands of individuals waiting for services from the Developmental Disabilities Administration. Almost 16,000 people in Maryland are waiting for services. About 4,500 of these individuals are homeless, in serious danger of abuse and neglect, or living with caregivers who are ill. About 2,500 have caregivers who are at least 61 years old. The state says there isn't enough money to meet their needs.

**The cost of care at Rosewood Center is over double the average cost of care in the community**, averaging over \$180,000 per resident each year.<sup>xxxix</sup> In contrast, community services for individuals with developmental disabilities average about \$77,000 each year per person.<sup>xxxix</sup> But even at Rosewood's astonishing cost, OHCQ cited poor and unsafe treatment conditions, leaking roofs and broken appliances that pose health risks.<sup>xxxix</sup>

In advising closure of Rosewood Center, DHMH pointed out that the state would save money.<sup>xxxix</sup> Right now, when an individual moves from Rosewood to the community, some funding transfers to the Waiting List Equity Fund to help pay for services for individuals in the community. Closing the institution and selling the \$35-million, 276-acre<sup>xxxv</sup> facility would free up sorely needed resources to serve the many individuals in the state whose critical needs are not being met.

**Maryland has new resources to make deinstitutionalization a reality.** In January 2007, the federal government awarded a \$67 million five-year grant to Maryland to implement the Money Follows the Person Demonstration Program to help individuals move from institutions such as Rosewood to community residences. The timing could not be more perfect. Beginning July 1, 2007, for each individual who moves from a state-funded institution, the grant increases the federal funding match that Maryland receives for the cost of home and community based services by 50% for one year. This presents an opportunity to transition all of Rosewood's residents to community based settings while reallocating scarce resources to some of the thousands on the waiting list for community based services.

# Conclusion

Maryland has the capacity to serve individuals with developmental disabilities who need supports in their own homes or in small living units, though it does not provide sufficient funding for thousands who are waiting for services. Recognizing that quality of life and social interactions are enhanced in small familiar settings, Maryland has closed most of its state institutions and chosen not to fund large group homes or private care facilities. On this score, Maryland can be proud.

There can be no justification, however, for continued use of Rosewood, a dinosaur of an institution that opened in 1895 as the Asylum and Training School for the Feeble-minded. Rosewood denies its residents the services needed to help them acquire life skills. It forces restraint and seclusion on people instead of offering proper care. It fails to conform to professional standards and has violated laws governing its operations. The incidents of forced seclusion and isolation of persons with developmental disabilities are shocking. Its failure to monitor its abuses is the strongest signal of its malfunctioning.

Individuals at Rosewood have suffered serious harm and remain at serious risk. Residents have been unable to participate in school, and have been deprived the association and support of their families. The institution not only violates the rights of residents, but does so at enormous cost to the state. In doing so, the state siphons funds from the large number of people who need community services.

The reasons for closing this facility are irrefutable. Consider Roy:

*Roy* “Roy” was at Rosewood for 20 years until his discharge in 2005. He has a strong work ethic and is employed as a janitor. While at Rosewood, his work was limited to a few housekeeping tasks each day. He now lives in a home with two former Rosewood residents. He often listens to music after work, but he also dances and plays bingo. He regularly meets his siblings at a local restaurant or mall to catch up and visit.

Roy is a member of our community living in a home. He isn’t shut away in a state institution. But he was.... for 20 years. It is long past the time to bring all of our people home.

# Recommendations

The State of Maryland must finally live up to its legal and moral responsibilities, as well as its previous commitments, and close Rosewood Center. It must do so in a manner that is carefully planned, but which nonetheless achieves the goal of moving all residents by the end of 2008. We recommend that the state:

- Adopt a target closure date and take immediate steps to move individuals to community-based programs;
- Immediately develop a means for independent professional monitoring of restrictive facility practices such as behavior plans, restraints, and denials of family visits;
- Hire an independent consultant to facilitate and monitor the transition process for persons out of Rosewood and to report to DHMH on each individual for at least six months after discharge from the facility;
- For all Rosewood residents, develop safe and appropriate service plans for the remainder of their time at Rosewood and for transition to the community, including:
  1. Screening for special needs such as traumatic brain injuries, sexual trauma or aggression histories, co-occurring mental illness, substance abuse and communication disabilities;
  2. Prioritizing discharge of those individuals who are deaf or hard of hearing to programs where they can communicate with others who use sign language; and
  3. Facilitating transitions by involving family and other members of the community.
- Assure that any staff in good standing will be able to move to other state jobs and receive any necessary job training;
- Ensure that any money saved from closure is transferred to the Waiting List Equity Fund; and
- For court-committed individuals, hire consultants to develop a program modeled on best practices<sup>xxxvi</sup> and giving due concern to protecting public safety. The program should provide for proper screening and evaluation for competency and dangerousness, treatment services in the most appropriate setting, aftercare plans and liaisons with the court. Once the program is developed, staff should receive thorough training and support to ensure competence with their new mission.



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<sup>i</sup> Maryland Disability Law Center, *A Death at Rosewood: December 21, 2000, A Public Report*, Baltimore, Maryland 2002.

<sup>ii</sup> Letter from Wendy Kronmiller, Director, Office of Health Care Quality to James Anzalone, Facility Director, Rosewood Center re: Notice of Immediate Jeopardy, Recommendation for Termination (Sept. 26, 2006) and attached Form CMS 2567, Statement of Deficiencies, Rosewood Center (Sept. 25, 2006).

<sup>iii</sup> Letter from Wendy Kronmiller, Director, Office of Health Care Quality to Joanne Knapp, Acting Facility Director, Rosewood Center re: Notice of Immediate Jeopardy, Recommendation for Termination (Jan. 22, 2007), and attached Form CMS 2567, Statement of Deficiencies, Rosewood Center (Jan. 28, 2007).

<sup>iv</sup> Letter from Wendy Kronmiller, Director, Office of Health Care Quality to Joanne Knapp, Acting Facility Director, Rosewood Center re: Notice of Imposition of Ban on Admissions (Jan. 23, 2007).

<sup>v</sup> See, e.g., Letter to Governor Robert Ehrlich from Maryland Coalition for the Civil Rights of Persons with Disabilities (Dec. 21, 2006); Letter to Secretary S. Anthony McCann from Maryland Developmental Disabilities Coalition (Oct. 6, 2006); Letter to Governor Robert Ehrlich from Maryland Disability Law Center (Sept. 29, 2006).

<sup>vi</sup> Governor Robert Ehrlich's New Freedom Initiative. See, e.g., [http://www.family-networks.org/New\\_Freedom.pdf](http://www.family-networks.org/New_Freedom.pdf).

<sup>vii</sup> State of Maryland Department of Health and Mental Hygiene, *Report to the Joint Chairmen on Maryland's Developmental Disabilities Services: Closure of a Residential Facility for People with Developmental Disabilities*, January 2004.

<sup>viii</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999).

<sup>ix</sup> *Youngberg v. Romeo*, 457 U.S. 307 (1982).

<sup>x</sup> State of Maryland Department of Health and Mental Hygiene, Developmental Disabilities Administration, *Rosewood Center*, Mar. 2006.

<sup>xi</sup> OHCQ did not specify what type of interpreter was needed, but an individual who needs either a foreign language or sign language interpreters who cannot communicate is unable to receive effective services.

<sup>xii</sup> Letter from Wendy Kronmiller, Director, Office of Health Care Quality to Alexis Melin, Acting Facility Director, Rosewood Center re: Notice of Current Deficiencies and Possible Imposition of Remedies (Oct. 17, 2006) and attached Form CMS 2567, Statement of Deficiencies, Rosewood Center (Sept. 29, 2006).

<sup>xiii</sup> See, e.g., National Association of State Mental Health Program Directors, Medical Directors Council, *Reducing the Use of Seclusion and Restraint, PART II: Findings, Principles, and Recommendations for Special Needs Populations*, Alexandria, VA: Mar. 2001.

<sup>xiv</sup> "Restraint is the partial or total immobilization of a person through the use of drugs, mechanical devices such as leather cuffs, or physical holding by another person. Seclusion is involuntary confinement in a room that the person is physically prevented from leaving." GAO/HEHS-99-176 *Improper Restraint or Seclusion Use Places People at Risk*, September 1999.

<sup>xv</sup> Maryland Disability Law Center, *A Death at Rosewood, December 21, 2000*, 2002.

<sup>xvi</sup> OHCQ's investigation of the incident was similarly deficient.

<sup>xvii</sup> The Developmental Disabilities Administration said it will develop a plan for finding alternatives to the safety coat with the goal of eventually eliminating the use of this mechanical restraint in Maryland. DDA/MDLC Quarterly Meeting Minutes, Dec. 7, 2005.

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- <sup>xviii</sup> COMAR 10.22.10 and 42 C.F. R. 483.450 et seq.
- <sup>xix</sup> Seclusion is defined at 42 C.F.R. §482.13(f)(1), which governs hospitals. The term is not used in the regulations governing institutions like Rosewood Center, but the definition at 42 C.F.R. §482.13(f)(1) is embedded in the restrictions on time-outs at 42 CFR § 483.450 (c).
- <sup>xx</sup> 42 CFR § 483.450 (c).
- <sup>xxi</sup> COMAR 10.22.10.06 (D)(4).
- <sup>xxii</sup> An individual has the right to receive services “in the most integrated setting that is available, adequate, appropriate, and in compliance with relevant laws and regulations”. Md. Code Ann. §7-1002 (b)(2).
- <sup>xxiii</sup> See, 42 C.F.R. 483.420(c)(5) and COMAR 10.22.04.02 (F)(3).
- <sup>xxiv</sup> Letter from Carol Ann Baglin, Ed.D, Assistant State Superintendent, Maryland State Department of Education, Division of Special Education/Early Intervention Services to Mr. Duane Scott, MDLC (Oct. 16, 2006).
- <sup>xxv</sup> *Id.* at ii.
- <sup>xxvi</sup> *Id.* at iii.
- <sup>xxvii</sup> *Id.* at iv.
- <sup>xxviii</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999).
- <sup>xxix</sup> *Id.*
- <sup>xxx</sup> The Developmental Disabilities Administration (DDA) found “Nat” eligible for Individual Support Services only, meaning DDA determined that he does not meet the statutory criteria for a person with a developmental disability.
- <sup>xxxi</sup> Maryland State Budget Fiscal Year 2008.
- <sup>xxxii</sup> *Id.*, Estimated as the sum of actual figures for the FY 2006 average annual cost per individual for community residential services (\$60,555), day programs (\$14,925) and resource coordination (\$1,349). Costs will vary for each individual, according to need.
- <sup>xxxiii</sup> OHCQ found that Rosewood failed to maintain its physical plant including:
- Damp ceiling tiles in the Clinical Services Building could foster the growth of mold and affect the respiratory health of building residents.
  - The door of a meat freezer was lined with ice and the hinge was broken.
  - A kitchen wall had deteriorated and developed a dark mold-like substance.
  - Broken furniture was left in client areas.
- <sup>xxxiv</sup> *Report to the Joint Chairmen on Maryland’s Developmental Disabilities Services, Id.* at vii.
- <sup>xxxv</sup> Maryland Department of Assessments and Taxation, Baltimore County, Legal Description: “276.2613AC PAR EXE ES Rosewood LA, 1825FT NE Reisterstown R”. Dec. 6, 2006.
- <sup>xxxvi</sup> For example, Special Offenders Services, a division of Lancaster County, Pennsylvania, Adult Probation and Parole, closely oversees programs and services for forensically-involved individuals with developmental disabilities as well as mental illness, none of whom live in large congregate settings. Such programs report a lower incidence of re-offense and violations for their clients.

## **About This Report**

Staff of Maryland Disability Law Center (MDLC) prepared this report.  
MDLC is the protection and advocacy system for Maryland,  
mandated to advance the rights of people with disabilities.  
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### **About Maryland Disability Law Center**

Maryland Disability Law Center (MDLC) works to create a just and inclusive society by advancing and defending the legal and human rights of people with disabilities. We join people with disabilities in expanding opportunities to participate fully in all aspects of community life, and champion rights to self-determination, dignity, equality, choice and freedom from abuse and neglect.

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