Facility fined in rape of patient

Nursing home will fight $10,000 penalty

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Tribune staff reporters

A Bloomingdale health-care facility where a 23-year-old patient was raped and impregnated has been fined $10,000 by the state and given a six-month conditional license.

Alden Village Health Facility for Children and Young Adults has been cited by the Illinois Department of Public Health for failing to protect the severely mentally and physically disabled woman from abuse. The department also cited the center for not having qualified nurses supervise residents and not following written policies on abuse investigations.

A spokeswoman for Alden Management Services, which oversees the 109-bed intermediate-care facility for the developmentally disabled as well as 31 other facilities in the state, said a hearing to appeal the fine and conditional license has been requested. A spokeswoman for the Department of Public Health said the state has reinspected the facility twice and found that Alden has corrected its deficiencies.

The fine ends state and federal investigations into Alden, officials said. But a lawyer for the woman's family, who is su-

PLEASE SEE **FINE,** PAGE 12

FINE: Attorney decries 'slap on wrist'

CONTINUED FROM PAGE 1

ing the facility, said it's not enough.

"It's a stunning disappointment that the penalty is so little for such a dramatic wrong," said Ed Fox, attorney for Cheryl Hale-Crom, whose daughter prematurely gave birth to a girl by emergency Caesarean section July 20, five weeks after the pregnancy was discovered. Hale-Crom moved her daughter and the woman's similarly disabled twin sister to another facility and is raising her granddaughter.

"A $10,000 fine for a patient who's raped and gets pregnant is outrageous," Fox said. "It's less than a slap on the wrist."

Reynaldo Brucal Jr., 18, of Schaumburg, who worked as a nursing aide, was charged with raping and impregnating the woman. He pleaded not guilty to the charges last month and is being held in lieu of $1 million bail in the DuPage County Jail.

The facility has been cited by the U.S. Department of Health and Human Services for deficiencies in each of its annual surveys since 1996, a total of 154 deficiencies, according to state reports.

The deficiencies cited have ranged from minor incidents, such as failure to ensure residents used the right toothbrush, to more serious allegations of failing to investigate reports of abuse and neglect and failing to report deaths. Between 1995 and 1996, the facility failed to report seven deaths and 98 trips to the emergency room, according to state reports. In 2000, the facility failed to investigate 14 incidents of unexplained injuries to residents, according to the reports. The facility was sued in November 2003 by the family of an 11-year-old mentally retarded girl who the family says was repeatedly sexually abused between July 2000 and May 2001.

In 2004, the facility was fined $50,000 after a 12-year-old boy died when he became trapped between his mattress and crib.

In November, the Department of Public Health cited the facility with 19 deficiencies after it investigated the rape. The state alleged workers at the facility suspected for months that the patient was pregnant and told their supervisors, but administrators did not conduct a full investigation or report to the state as required.

The state could have imposed sanctions including curtailing admissions, appointing a temporary manager, suspending or revoking the home's license or closing the facility. A Department of Public Health spokeswoman said officials thought the fine was appropriate.

State guidelines make revocation of a facility's license rare. The Department of Public Health must find there is an immediate danger to residents that has not been addressed by administrators, or that a "type A" violation—in which there is a "substantial probability that death or serious mental or physical harm to a resident" will occur—has been repeated at the facility within a year. A repeat violation is not just another violation of the same type, but rather a continuance of the previous citation, according to state law.

Facilities can write plans of correction and pass inspections in follow-up visits, enabling many facilities cited with problems to continue operating for years, advocates for the disabled say. One advocate calls this a "fatal flaw" in the federal system.

"If you have a facility that's generally below standards and they just creep up to the [acceptable] line by coming up with a plan of correction, yet they still have a lot of the same problems, the vast, vast majority of the time, they're going to get a pass," said Zena Naiditch, executive director for Equip for Equality.

She says her organization, appointed by the state to monitor facilities for the disabled and make recommendations to the state, faces battles in trying to get facilities closed.

She pointed to the recent closing of These Are God's People Too after accounting problems were discovered. The state allowed the Matteson-based facility to reopen under a new name after it was said to have corrected its problems.

"How long do people with disabilities have to live in these dangerous circumstances?" she said, adding she was not referring to Alden.

Federal officials say it is not always in the best interest of the disabled to close facilities like Alden. Rather, the facilities should be improved, because many developmentally disabled people need a place to go.

"The goal and the purpose is to make sure there are facilities to service this population," said Nadine Renbarger, technical adviser for the U.S. Department of Health and Human Services. "The goal is to help these providers come into compliance."

Several advocates for the disabled said the incidents at Alden point to a problem with large-scale facilities for the disabled in Illinois. There's a growing national shift toward more individual care, such as in small group homes or care in the home with the help of nurses, they say. But Illinois has been slow to move in that direction, said Sheila Romano, executive director of the Illinois Council on Developmental Disabilities.

"We believe that inclusionary living does lead to a higher quality of life for people and also has fewer incidents of abuse and neglect, such as this tragic incident," she said.

Families, too, are sometimes reluctant to move for closing of a troubled facility, Naiditch said. That happened when Equip for Equality recommended in February that the state close Choate Developmental Center, a 200-bed facility in Downstate Anna, for allegedly failing to prevent two deaths and injuries to residents. The state kept the facility open.

"Sometimes parents are just grateful for something, and they rationalize it," Naiditch said. "There's a fair amount of inertia once you're living somewhere. Even if it's bad, the unknown is even scarier."

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