VIA FACSIMILE & POSTAL MAIL

July 12, 2007

Governor Rod R. Blagojevich
Office of the Governor
100 West Randolph Street, Suite 16-100
Chicago, Illinois 60601-3220

Dear Governor Blagojevich:

We are sending this letter to set forth our latest, serious concerns related to the Howe Developmental Center, the safety an care of the individuals residing at that institution and to call upon the State to take immediate action to remedy those problems.

As I am sure you are aware, our staff has spent significant time monitoring conditions at Howe. Despite the very serious problems resulting in the de-certification of Howe, other than this office, we are unaware of any other ongoing independent monitoring at the facility. Given the number of deaths that have occurred and the longstanding nature of the problems that continue at Howe, we believe that it is imperative for the State to have an independent interdisciplinary team of full-time monitors at Howe to ensure the safety of the individuals residing there while the facility remains open.

We are aware of the Department's intent to seek re-certification of Howe. However, the same kinds of serious problems that lead to the deaths of a number of individuals and to the decertification of the facility continue to be plainly evident during each of our visits, including our most recent visit on July 10, 2007, and include:

- Staff misuse of restraint through such devices as lap trays, mitts, and recliners.
- Routine hygiene practices, such as the use of gloves to address infection precautions, sanitizing furniture soiled by incontinence, cleaning feeding pumps, are ignored.
- Individuals warehoused without meaningful programming or activity.
- Individuals engaging in self-abusive and other maladaptive behaviors, including hitting and biting, with no staff intervention.
- Staff reassignments to other units or locations without apparently receiving essential information on the needs of each of the individuals under their care.
- Individuals left alone in living and dining areas of residential units.
- Interactions between staff and the individuals lacking in any clear purpose.
- Storage closets with chemicals, cleaning supplies and other dangerous items left open and unattended.

- A strong odor of cigarette smoke inside a residential unit with medically complex individuals.
- A fire drill that did not result in the evacuation of residential units.

Recent record reviews by our staff continue to reveal the same serious longstanding problems which have resulted in dire consequences for individuals and in the facility's decertification including:

- Failure to provide nursing assessments:

  On 5/22/07 nursing staff was asked to monitor a rash that had developed on an individual. Howe nursing staff failed to document any assessments between 5/24/07 and 6/2/07 where documentation indicates that the condition had resolved.

  A second individual was given 4mg of Ativan for sedation on 6/14/07 without any follow up assessment or monitoring of the individual's vital signs for two days in spite of a large dose of medication to calm the individual in order to undergo a procedure.

- Failure to follow doctors orders:

  On 4-29-07 a doctor ordered that neurological checks be done every four hours following a head injury. Contrary to the order the assessments were documented at 4:38 pm, 11:00pm and 2:30 am only.

  On 6/25/07 a doctor ordered vital signs every shift for 72 hours. Vital signs were not taken on the 25th,were attempted once on the 26th and were not attempted at all on the 27th.

  On 6-1-07 a doctor ordered for vital signs every shift for 72 hours. The chart contained no indication that this was done.

  A doctor ordered that he be notified when an individual's blood sugars were lower than 60 or above 400. The chart contained no documentation indicating that the doctor was notified on 7 occasions when the blood sugars were outside this range:

Date	Blood sugar level
5-2-07	52
5-4-07	41
5-18-07	421
6-7-07	59
6-19-07	51
6-20-07	53

- 6-21-07 48

  On 7-1-07 a doctor ordered vital signs every shift for 72 hours; temperatures were not taken as they should have been. On 7-2-07 direct care staff documented that the individual felt warm, nursing staff took his temperature and found it to be 102.5. The resident was promptly sent to the hospital.

  On 3-11-07 a doctor ordered that bacitracin be given for an injury. The chart contained no related nursing assessments, and no follow up by a doctor.

- Lack of Direct Care Staff Documentation:

  No direct care staff documentation between 3-25-07 and 4-26-07 and again between 4-26-07 and 5-29-07 in one individual's chart.

  No documentation for the month of May in another individual's chart.

  No direct care progress notes since February for one individual.

  One chart did not contain any nursing or physician progress notes.

- Lack of consult follow up:

  On 3-22-07 a cardiology consult recommended than an ECHO be performed. The test was scheduled for 6-11-07, but the individual went out on a site visit that day. The ECHO was not rescheduled as of 7-3-07.

  The results of a 3-22-07 TB test was not read within the 72 hour period, but was documented as "negative" anyway.

- Dental Care:

  Oral hygiene regarded as "poor" by a dentist. The dental assessment reflected that the individual's teeth were not well brushed. This individual relies totally on staff for oral hygiene care.

- Weight measurements:

  No weights for one individual were taken for the months of May or June

- Lack of Nursing/Medical follow up:

On 1-9-07 and 2-10-07 direct care staff documented incidents of loose stools for an individual. No nursing or physician follow up assessments were provided.

On 4-11-07 a resident fell and hit his head. A nursing assessment was not conducted for 12 hours. No physician was notified of the injury. No injury report was found in the chart.

On 4-4-07 a nurse conducting an assessment for a cough failed to monitor vital signs and did not assess the individual's lung sounds. The individual was later sent to the hospital.

- Failure to provide effective treatment:

  An individual has been engaging in self-injuries behavior hitting and biting himself since his admission in 1982.

The problems at Howe are so endemic and engrained within the culture of the institution that the likelihood of significant sustainable change is extremely minimal - yet the risk to the health and safety of every individual living there remains high. It is unconscionable that the State continues to allow its most vulnerable citizens to live under such deplorable conditions. In spite of the Department's stated intent to have Howe recertified, our recent series of observations and reviews document an institution that remains dangerous and that should be closed.

We call upon the State to immediately:

- Implement an independent, interdisciplinary team of full-time monitors to ensure the safety and well being of the individuals residing at Howe while the facility remains open.
- Make available to Equip for Equality all documents and materials related to Howe's recertification efforts to date.
- Notify all guardians that the Department will work with them on an expedited basis to move individuals to other licensed and certified settings of their choice.
- Shift the focus of the Department's efforts away from its futile attempt to save the institution to an effective and appropriate plan for the closure of Howe.

Sincerely,

Zena Naiditch
President & CEO

Deborah M. Kennedy
Abuse Investigation Unit Director

CCs:

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