

# The Record

FRIEND OF THE PEOPLE IT SERVES

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## Report exposes chronic neglect and inaction in NJ disability services

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A report released Monday delivered a stark portrayal of how New Jersey cares for its residents with developmental disabilities.

Entitled "The Fierce Urgency of Now," its pages are filled with stories of systemic failures and personal tragedies faced by New Jerseyans who depend on the state's help.

Year after year disability ombudsman Paul Aronsohn highlights the urgent needs of the disability community and expresses frustration over the persistent lack of progress in addressing issues.

These are not isolated incidents but symptoms of a systemic failure that demands urgent and decisive action, he stated in the report.

The pages of his 2023 report are filled with people with developmental disabilities who have suffered. A 19-year-old group home resident was taken to the emergency room after being given an accidental double-dose of medication. A parent who discovered their son was eating raw, frozen meat in front of group home staff who didn't intervene. A 39-year-old man who died in a group home after trying to call 911 multiple times before his death.

The report contains multiple examples of "heartbreaking stories and horrifying pictures" like these including a 19-year-old group home resident who was reportedly abused and denied necessary medication. Her mother reeled at the state's finding of "unsubstantiated neglect" after a yearlong investigation, according to the report.

"My child was starved, locked in her room, locked in the basement, drugged, denied medication, lost all her hair and teeth, has been thrown into a psych ward where she was restrained unable to communicate that she was in excruciating pain from dental decay and an infected vulvar abscess, developed Rhabdomyolysis, ended up in a coma on a ventilator, has been made homeless illegally and without cause," said the mother.

Aronsohn criticized the state's investigation process after instances like this as woefully inadequate in the report, especially because they are "more often than not" carried out by the same agency that is under suspicion.

"When we do not conduct thorough, credible investigations, we are setting the system up for failure and endangering the lives of the people at the center of it," he said.

The report calls for an overhaul of this system, suggesting that independent bodies handle abuse and neglect investigations. Further compounding the crisis is the chronic understaffing and inadequate training of care workers.

### The ombudsman's recommendations

- Mandatory spending by home providers on care staff salaries to ensure competitive wages and reduce turnover.
- Establishment of minimum staffing ratios in state-licensed residences.
- Introduction of financial penalties for agencies failing to meet care and safety standards.