Concerns reported regarding Pomegranate:

Congregate care is a term that refers to group homes, residential treatment facilities, psychiatric institutions and emergency shelters. Research indicates that children and teens should be placed in the least restrictive, most family-like settings possible. Sadly, due to the opioid epidemic, overwhelmed child welfare agencies, and not having enough foster parents for teenagers, 12% of Ohio foster youth experience congregate care.

The Family First Prevention Services Act seeks to curtail the use of congregate or group care for children and instead places a new emphasis on family foster homes. This Act also sets a federal standard regarding what constitutes *Qualified Residential Treatment Program* in order to better ensure trauma-informed care.

Disability Rights Ohio has compiled a summary of Children's Rights when they live in a residential treatment facility. These include physical safety, respectful care and treatment, safeguarding the resident's belongings, and access to phone calls and visits.

We have outlined the concerns have been reported to us regarding Pomegranate Health Systems, and organized them to match the requirements for the "Licensing of Residential Facilities" are listed in Chapter 5122-30 of Ohio Administrative Code.

These include:

- Abuse *(OAC 5122-30-03 Section A-1)*
- Accommodations *(OAC 5122-30-03 Section A-2)*
- Administration of Medication and Chemical Restraint *(OAC 5122-30-03 Section A-3;10)*
- Assistance With Activities of Daily Living*:* which refers to structuring and supervising all activities to promote self care or emotional growth and stability, and to ensure the well-being of the resident, and also includes providing or arranging for the provision of clothing, education, medical and dental care *(OAC 5122-30-03 Section A-7*
- Neglect *(OAC 5122-30-03 Section A-32)*
- Physical Restraint and Seclusion *(OAC 5122-30-03 Section A-37; 45)*

From a licensing standpoint, these are major deficiencies that need correction.

We would like to know more about Ohio's provisions regarding a **statewide "Residential Rights Advocate"** as per (OAC 5122-30-03, Section A-40). What safeguard are – or could be – put into place to better safeguard residents?

2019 Summary of Pomegranate Concerns

We have outlined some of the concerns have been reported to us regarding Pomegranate Health Systems.

In an effort to be helpful, we are organizing them to match the requirements for the "Licensing of Residential Facilities" are listed in Chapter 5122-30 of Ohio Administrative Code.

Abuse:

- *"I was abused here, please do not send your children. Please. I understand it may be more affordable but if you truly wish for them to recover from the battles they're struggling with, do not place them anywhere that will only deepen or increase the number of battles. Work with the emergency room department or counselors or whoever is suggesting this and tell them you don't want Pomegranate as a last resort, that there is no circumstance you want to send your child somewhere unsafe. There are other financial options. I promise, there are always other options." (Posted on Yelp by a former Ohio foster youth on 12/30/19)*

- *"I was at Pomegranate in August 2010 to May 2011. There were numerous things that I witnessed. Some staff would fight the patients under the cameras where there were blind spots so if they were to run the cameras back you would not be able to see anything, a 3rd shift supervisor got escorted out by the police for punching a girl in the face, when it came to restraining they were not allowed to do floor restraints but they still did and sometimes the staff would punch and choke in restraints. There were sometimes patient staff relationships. Staff a lot of the time would instigate the patients and makes them go off too."*

Accommodations:

- *"I believe this place should be shut down because it is not sanitary, healthy, nor a good environment for young adolescents."*

Administration of Medication and Chemical Restraint:

- Reports from parents about not being notified about their teen's change in medication
- *"This was the worst place I was at. At first they had me as shelter care and after one month placed me as a resident. The psychiatrist I was telling you about was AWFUL. He was out of the country every other week and never listened. Literally at the time he put every single person on Seroquel without even talking to the patient. The first day I met him he didnt even give me time to talk before telling me he was putting me on Seroquel 4 times daily for 9 months."*

- *"There was a girl there who came like 2 days before I left. She seemed heavily sedated. She couldn't stand straight. She would walk a little then fall asleep anywhere. She wasn't really coherent"* (from a former resident who stayed in Pomegranate in 2013).

Assistance with Activities of Daily Living:

*Which includes structuring and supervising all activities to promote self care or emotional growth and stability, and to ensure the well-being of the resident, and also includes providing or arranging for the provision of clothing, education, medical and dental care

- *"I stayed there from April of 2011 until August of 2011. I was originally admitted for shelter care, which was not to exceed 30 days, but stayed longer because my depression deepened while I was there."*
- *"Staff meant to monitor us frequently slept on the job. Staff would incite arguments between residents and directly bully the residents themselves. If we challenged the way we were treated, we would have our daily points taken away. The doctors took these points into strong consideration when deciding how we were progressing."*
- *"When we had a conflict among residents, we were told to go to a room and literally and physically 'fight it out' for a 10 minutes in order to problem-solve."*
- Quote from a former employee: *"I worked there for 6 months and ended up with the biggest and only ulcer I've ever had in my life. I told every child welfare worker what was actually happening with their child in that facility. I can't believe either building is still open. Anytime any of my clients are in danger of going there I fight like hell to keep them far away from that place!"*

Neglect:

- *"One of my fellow residents had a back injury, and they refused to take her to a doctor for medical care. They told her that being checked by a doctor was a privilege, and she was "on restriction."*
- *"One of my fellow residents had her wrist broken and they didn't take her to the hospital."*
- *"One of my fellow residents was repeatedly being exposed to her allergen. She was expected to manage her diet and avoid coming into contact with the allergen. The nurse printed off a list to give to her, which detailed everything she was not to consume/be in contact with. I saw the list myself. Most of the words on the list were chemical names and long words you would see listed on the back of an ingredient label. They were not simple for a 15 year old to understand. The onus should have been on the kitchen staff and the general staff to help her avoid her allergen, but time and time again she had to be stabbed with an EpiPen. Her reactions*

started with her coughing and progressed to her throat closing within 60 seconds. She was not taken to the hospital after having the EpiPen administered. They expected a mentally distressed child to manage her own care."

Physical Restraint and Seclusion:

- *"It happened in August 2015 on the Celso unit. The staff used the 'chicken restraint' and had put so much weight on the girl while she was on the ground that she was unable to breathe. She died. The squad was called and all other youth on the unit were taken to another unit while she was being taken away. Following the death, they changed the training on how they restrain the youth." (reported by a resident who was on the same unit as the girl who died)*
- Reports from former staff members about high turnover rates, and lack of proper training for staff regarding physical restraints and de-escalation.