AN INDICTMENT OF INDIFFERENCE

A Report of the Investigation of the Beatrice State Developmental Center
By Nebraska Advocacy Services, Inc.
The Center for Disability Rights, Law and Advocacy

December 5, 2007

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EXECUTIVE SUMMARY

The current, repeated inability of Nebraska state officials to protect and provide active treatment to the residents at the Beatrice State Developmental Center (BSDC) who are entrusted to their care did not materialize overnight. The problems and failures at the Beatrice State Developmental Center are systemic, chronic, and have persisted for years. Nebraska Advocacy Services, Inc. (NAS) has reviewed reports of surveys conducted by the United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS). Our review of CMS survey reports since November 2001 documents the critical and substantial failures of state officials to meet accepted professional standards of care at BSDC. The failure of state officials at BSDC to meet these standards as cited in the October 2006 and April 2007 CMS survey reports are merely the most recent. It is not acceptable that these failures have been known and tolerated for years by state officials who have the responsibility to protect and habilitate the 350 residents at BSDC.

On October 2, 2006 CMS found that BSDC was not in substantial compliance with the applicable federal rules, regulations and interpretive guidelines of accepted professional standards of care in a substantial number of critical areas, and the conditions at the facility constituted an **immediate jeopardy to resident health and safety**. During the course of a follow up visit on April 19, 2007 CMS surveyors again found that BSDC was not in substantial compliance with the applicable federal rules, regulations and interpretive guidelines of accepted professional standards of care in seven out of eight critical areas, and the conditions at the facility constituted **immediate jeopardy to resident health and safety**. These findings by CMS meant that over $28,000,000 in federal funds could have been withheld from the total BSDC budget of slightly more than $50,000,000.

Upon notification of the serious and substantial finding by CMS of **immediate jeopardy** in October 2006 Nebraska Advocacy Services, Inc., *The Center for Disability Rights, Law, and Advocacy* (NAS) immediately contacted CMS, the ARC of Nebraska, and the Acting Administrator of BSDC for documentation of the CMS findings. NAS negotiated an Access Agreement with the State of Nebraska for access to the BSDC facility, its residents and staff, and to review the records of BSDC residents. Only by this complete access to the facility, residents, staff, and records at BSDC, could NAS fulfill its federal mandate and monitor the safety of those residents.

Subsequently, NAS legal advocacy staff visited all residential and programmatic units to question staff and observe the residents living there. NAS also requested information about the specific residents (and their guardians) referenced in the CMS reports. Since November 2006, NAS legal advocacy staff has reviewed hundreds of incident reports and visited BSDC twice each month to conduct inspections and on-site reviews. As this report documents, from March 2007 through September 2007, NAS monitoring has

identified a relentless series of incident reports of serious harm and ineffectiveness in response to the needs of BSDC residents.

We find that, as a matter of law, state officials have violated and continue to violate the constitutional and statutory rights of BSDC residents. The U.S. Supreme Court has recognized that persons with developmental disabilities who reside in state facilities (such as BSDC) have a protected liberty interest in safety, a right to minimally adequate training to provide for their safety and freedom from unreasonable restraints, and adequate levels of care according to accepted professional standards of care. Further, CMS regulations require facilities like BSDC to protect people in their care from harm, provide them adequate staffing, protect them from abuse, and to ensure "active treatment" to reduce dependence on drugs and physical restraints. The evidence is clear that Nebraska state officials failed and continue to fail to provide adequate active treatment/habilitation for residents at BSDC; rather, staff convenience necessitated by chronic understaffing drives habilitation.

NAS also concludes that chronic and persistent staff shortages are impacting the safety and habilitation needs of the residents. Direct care staff members are working massive amounts of overtime and double shifts. Inadequate numbers of minimally trained direct care staff plus a greater number of residents who require significant behavioral interventions have **created an environment in which harm and risk of harm have risen dramatically**. Further, departure from accepted professional standards of care to provide active treatment escalates the maladaptive behaviors of residents, thereby **creating a downward spiral of greater chaos and violence within BSDC**.

To alleviate and remedy the harmful and chaotic conditions as they currently exist for residents at BSDC, NAS recommends:

- Establishing within BSDC a culture of respect and valuing of all people.
- Modeling habilitation and behavior programs on principles of consistent, positive reinforcement.
- Conducting comprehensive evaluations and assessments for all residents of BSDC.
- Preparing a timeline to significantly reduce the current population by placement into appropriate community settings.
- Substantially increasing compensation for direct care and professional staff.
- Providing staff with adequate competency-based behavior management training.

- Creating an Oversight Commission by the Legislature to envision a unitary integrative system of habilitation services and supports.

- Creating a Section of Civil Rights Enforcement within the Department of Health and Human Services for the protection of the civil rights of individuals residing within all of Nebraska's residential facilities.

NAS firmly believes that any effort to change the failures documented in this report must be grounded in the principles of respect for human dignity, affirmation of each resident as a valued citizen, assurance of the bodily integrity of every resident, and a commitment to the protection of their legal and human rights. It is our fervent hope that this report will move the public to say, "Enough! Enough of this relentless cycle of chaos and violence! Enough promises!"

It is time for Nebraska state officials, in both the Executive and Legislative branches, to take the action necessary to ensure the protection and safety of our most vulnerable citizens. It is time to put an end to the indifference of state officials that has resulted in the unfettered growth of institutional deficiencies, failures to meet accepted professional standards of care, and injury and harm to the people living at the Beatrice State Developmental Center.

PREFACE

Nebraska Advocacy Services, Inc. (NAS) is federally mandated to provide legal and other advocacy services on behalf of persons with disabilities, including persons with developmental disabilities and persons with mental illness. NAS is authorized to investigate potential abuse or neglect impacting such persons and to monitor their health and safety in both institutional and community settings. NAS is also authorized to pursue legal, administrative and other remedies and approaches to ensure the protection of the rights of persons with disabilities.[1] NAS is appreciative of those state officials, BSDC administrators, professionals, and direct care staff who have assisted NAS in fulfilling its federally mandated authority and responsibility.

We dedicate this report to all past, present and future residents of the Beatrice State Developmental Center (BSDC) and especially to the memory of Ms. Kristine Everitt (1946-1999). Both the historical record and recent federal surveys of BSDC evidence a long-term pattern and practice of failure on the part of Nebraska state officials responsible for the protection and treatment of people living at BSDC to acknowledge their humanity and respect their dignity and privacy. Their stories shall not be forgotten. It is our fervent hope that this report will not only serve to document their struggle to achieve full equality and liberty, but will also create an opportunity for the critical dialogue that is needed to address this deplorable situation.

[1] These authorities are conferred under federal statutes, including the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 ("the DD Act") U.S.C. § 15001 et seq. and its implementing regulations at 45 C.F.R. Parts 1385 and 1386; the Protection and Advocacy for Individuals with Mental Illness Act ("the PAIMI Act"), 42 U.S.C. § 10801 et seq., and its implementing regulations at 42 C.F.R. Part 51; and the Protection and Advocacy for Individual Rights Act ("the PAIR Act"), 29 U.S.C. § 794e and its implementing regulations at 34 C.F.R. Part 381. These statutes will be referred to collectively as "the P&A Acts."

HISTORICAL ORIGINS OF THE BEATRICE STATE DEVELOPMENTAL CENTER

In 1885, the Nebraska legislature established the Nebraska Institution for Feebleminded Youth (NIFMY) to be located at Beatrice, Nebraska.[2] The legislature appropriated an initial $100,000.00 and the City of Beatrice donated 40 acres of land for the site of the institution.[3] The purpose of the Nebraska facility was clearly set forth in the initial legislation of 1885:

> Besides shelter and protection, the prime object of said institution shall be to provide **special means of improvement** for that unfortunate portion of the community who were born or by disease have become imbecile or feebleminded, and by a **wise and well adapted course of instruction** reclaim them from their helpless condition, and through the **development of their intellectual** faculties, fit them as far as possible for usefulness in society. To this end there shall be furnished them such agricultural and mechanical education as they may be capable of receiving.[4] (Emphasis supplied)

The Nebraska Act in 1885 mirrored the national focus from external, community productivity to an internal custodial function for education.[5] The first three children arrived in 1887 and by the end of the year, 65 children were living at the institution.

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[2] Act of March 5, 1885, ch. 52, 1885 Neb. Laws.

[3] Id. The legislative enactment in 1885 established the funding mechanism to be an "annual tax levy on the taxable property of the state, not to exceed one-eighth (1/8) of one million the dollar." The Nebraska Institution for Feebleminded Youth at Beatrice conceptually rested on the educational ideology of Edouard Séguin of the Parisian institution, Bicêtre, but which had been significantly modified and popularized in America in 1847 by Samuel Gridley Howe in Massachusetts. In Séguin's ideology, "idiocy" was a failure of the will. Training techniques used by Séguin stressed excitation of the will, invigoration of the muscles, and controlling the senses which would lead to higher cognitive development. Proper education required physiological training to improve cognitive development. However, the American proselytizers, such as Howe, emphasized the pathological and degenerative properties of "idiocy." These medical categories would quickly dominate and replace the educational underpinnings. This burgeoning conflict between an educational ideology and the medical pathological view was reflected in the founding legislation in 1885 for the Nebraska Institution for Feebleminded Youth at Beatrice. See also Part II Physiological Education in Seguin, *Idiocy: and Its Treatment by the Physiological Method* (New York: William Wood & Co. 1866).

[4] §2 Act of March 5, 1885, ch. 52, 1885 Neb. Laws; See also: Seguin, *Idiocy: and Its Treatment by the Physiological Method* supra. Within the very seminal legislative foundation creating the Nebraska Institution for Feebleminded Youth at Beatrice in 1885 lurked the ascendant pathological medical premise that would stifle the educational ideology with all its promise of training and would become the very means of institutional perpetuation.

[5] See generally: Trent Jr., *Inventing the Feeble Mind: A History of Mental Retardation in the United States* (Berkeley, California: University of California Press, 1995) 11-39; Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little Brown and Company, 1971) 109-154; Schalock, ed., *Out of the Darkness and into the Light: Nebraska's Experience with Mental Retardation* (Washington, D.C.: American

The primary objective of the 1885 legislation creating the NIFMY was to establish a place where people could be sent to learn how to become productive citizens through education and training. The prevalent belief was that this could only occur in a school or setting segregated from family and community. Superintendents of facilities, such as the one at Beatrice, continued to use this assumption to justify expansion of the institutions. There were two primary justifications for the segregationist rationale. First, the *expertise justification* held that only special facilities could ease the burden of care of families and the community for their "feebleminded children". Second, the *only alternative justification* held that if they were not institutionalized they would eventually end up in prison or the poorhouse.[6] This fundamental and still fully unquestioned rationale, with its subsequently articulated dual justifications, continues to be rationale for the Beatrice State Developmental Center one hundred and twenty years later.

At the turn of the century, a brief twelve years after the first admissions, the seeds of the conflict between the educational ideology and the medical pathology view not only were firmly rooted into the institution at Beatrice, but had grown into a dual system of training "the educable" and segregating the "non teachable" in custodial confines.[7] By 1914, the pathological custodial asylum model became dominant and remained so until the 1960s. People that were forced to live at the Beatrice facility had become in the eyes of the public and policy officials, both nationally and at the state level, "menaces" lacking moral restraint; "degenerates" spreading venereal disease, prostitution, illegitimacy,

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Association on Mental Retardation, 2002) 103-122. Mason and Menolascino, The Right to Treatment for Mentally Retarded Citizens: An Evolving Legal and Scientific Interface 10 Creighton L. Rev. 124 (1976) 127-137.

[6] Mason and Menolascino, The Right to Treatment, supra at 130; see Wolfensberger (1976) The Origin and Nature of Our Institutional Models in R. Kugel and A. Shearer, eds., *Changing Patterns in Residential Services for the Mentally Retarded*, (Washington, D.C.: President's Committee on Mental Retardation 1969) 150-179.

[7] *Out of the Darkness*, supra at 11-113. The foundational philosophy of "moral treatment" and its requirement of humane, kind treatment with restraint sparingly used only to prevent immediate self harm or harm to others eroded as facilities like the Nebraska Institution for Feebleminded Youth at Beatrice transformed from schools to small institutions, and then to larger institutions emphasizing custodial confines.

pauperism, and other forms of social evil and social disease.[8] Segregation and sterilization to protect society from "deviant" individuals with mental retardation became the *raison d'être* for the Beatrice facility.[9]

In 1915, in rapid succession, the Nebraska legislature enacted legislation designed to stop the spread of "the menace." The year 1915 would be "the year of three strikes and you're out" for individuals with mental retardation in Nebraska. First, a sterilization law was passed to prevent reproduction by individuals with mental retardation.[10] Next, the legislature enacted the first civil commitment law including individuals with mental retardation.[11] Finally, the legislature mandated the Nebraska Institution for Feebleminded Youth at Beatrice to accept people who were judicially determined to be "idiot, imbecile, or feebleminded."

The first sterilization occurred at Beatrice in 1917, and when the sterilizations ended in 1966, 752 persons at the Beatrice facility had been denied their fundamental human right to reproduce and had their right to their physical bodily integrity violated under the mandate of the Nebraska legislature and the authority of the Nebraska Supreme Court.[12] In 1921, the *de facto* segregative role of the Nebraska Institution for

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[8] Wolfensberger, supra. at 155; Mason and Menolascino, supra at 131 ftnt. 17; Trent, supra 131-183.

[9] Mason and Menolascino, supra at 133 ftnts 21-23. See also *Out of the Darkness*, supra 117-119.

[10] Act of April 8, 1915 ch. 237, 1915 Neb Laws 554 (repealed 1929). Under the provisions of the 1915 Sterilization Act, the Board of Examiners created by the Act was required to examine any individual eligible for discharge or parole from the institution at Beatrice. If after examination the individual was found to be (1) capable of reproduction, (2) likelihood that offspring would inherit mental retardation, and (3) the offspring would likely become "a social menace", then sterilization would be a mandatory condition before freedom from Beatrice.

[11] Act of April 14, 1915 ch. 131 § 1, 1915 Neb. Laws 294.

[12] The Nebraska Supreme Court in 1931 upheld the constitutionality of the Sterilization Act as amended in 1929 in the decision of *In re Clayton*, 120 Neb. 680, 684, 234 N.W. 630 (1931). The Court in *Clayton* starkly stated: "The legislative act before us is in the interest of the public welfare in that its prime object is to prevent the procreation of mentally and physically abnormal human beings. We think it is within the police power of the state to provide for the sterilization of feeble-minded persons as a condition prerequisite to release from a state institution.". See Law of April 30, 1929 ch. 163, § 1 [1929] Laws of Neb. 564 (repealed L.B. 547 § 1, [1969] Laws of Neb. 3132). The United States Supreme Court earlier in 1927 had placed its imprimatur on sterilization. In the decision *Buck v. Bell*, 274 U.S. 200, 204 (1927), while upholding the constitutionality of sterilization, Justice Oliver Wendell Holmes opined, " It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains

Feebleminded Youth at Beatrice became *de jure* when its name was changed to the Nebraska Institution for the Feebleminded with its new objective to provide "custodial care and humane treatment for those who are feebleminded; **to segregate them from society** (emphasis supplied); to study to improve their condition; to classify them; and to furnish such training in industrial mechanics, agriculture, and academic subjects as fitted to acquire."[13] This change by the State of Nebraska in both the name and the stated objective of the facility significantly drove upward the population at the facility.

Between 1919 and 1959, a total of 5,420 individuals were admitted to the Beatrice facility.[14] This state sponsored segregation of people with mental retardation at the Nebraska Institution for the Feebleminded at Beatrice allowed families to dissociate themselves from their children or adult relatives with mental retardation.[15] In 1942, the Beatrice facility changed its name for the third time when it became the Beatrice State Home. However, during the 1940s and 1950s, the Beatrice State Home resembled a warehouse more than a home as the population continued to swell and row after row of

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compulsory vaccination is broad enough to cover cutting the Fallopian tubes…Three generations of imbeciles are enough." See Bruinius, *Better for All the World: The Secret History of Forced Sterilization and America's Quest for Racial Purity* (New York: Alfred A' Knopf, 2006); and B. Mason, Segregating the Menace and the Chaining of Liberty: The Spectre of *Buck v. Bell in the 21st Century* (Missouri Valley History Conference, Omaha, Nebraska March 2006). It is an inescapable truth that at the Beatrice facility, as well as other facilities across the country, sterilization in the 1940s became not only an external means of social control but an important means of enlarging the authority of superintendents for the institution, apart from the stated medical purpose. Sterilization became a means of keeping higher functioning residents working for pennies in the institution understaffed during the labor demands of World War II. Thus, sterilization provided another means to ensure the survival of the custodial institution. Trent, Jr. *Inventing the Feeble Mind*, supra at 223.

[13] *Out of the Darkness*, supra at 106.

[14] Wolfensberger & Menolascino, Reflections of recent mental retardation developments in Nebraska I: A new plan. Mental Retardation 8(6) (1970): 20-28. Kurtz & Wolfensberger, Separation experiences of residents in an institution for the mentally retarded: 1910-1959. American Journal of Mental Deficiency 74(3) (1969): 389-396.

[15] The segregating stigmatization continued even in death for those individuals confined at the Beatrice facility. Beginning in 1935, tombstones of deceased persons at the Beatrice facility's cemetery were inscribed not with names but numbers. For the growing number of individuals at the Nebraska Institution for the Feebleminded at Beatrice, who were viewed as a social menace in life by society and state policy makers, confined in custodial warehouses, forced to labor to support the very institution which denied them their humanity, they became forgotten with their life stories of hope, despair, love, and anguish buried under numbered tombstones at the Beatrice facility's cemetery. Abandoned in life, they had become nameless in death.

beds in large dormitory style bedrooms became the norm.[16] Death became the predominant mode of leaving the Beatrice facility.[17] By the late 1960s, 2,300 people lived at the Beatrice State Home in facilities which a commissioned architectural engineering study found to be fit for only 800. The overcrowding led to the inevitable lack of training and habilitation for the residents who actually survived and remained warehoused at the Beatrice facility.[18] Residents who were functioning at a higher level were dressing, bathing, feeding, and taking care of the more vulnerable who needed more assistance.[19]

By the summer of 1972, serious injuries and the incidents of abuse of the citizens still crowded into the facility were prevalent at an alarming rate. Inadequate numbers of poorly trained staff, overcrowding of the facility and reliance upon the residents to care for the other less able residents had created a dangerous and dehumanizing institution where habilitation remained illusory. During the summer of 1972, the Nebraska Association for Retarded Children (NebARC) attempted to meet with Governor J. James

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[16] Wolfensberger & Menolascino, Reflections of recent mental retardation developments in Nebraska I: A new plan. Mental Retardation 8(6) (1970): 20-28.

[17] Kurtz & Wolfensberger, Separation experiences of residents in an institution for the mentally retarded: 1910-1959.supra at 389-96; see also *Out of the Darkness*, supra at 24 and see also statement by Ms. Ollie May Webb who was committed to Beatrice at 19: "My family committed me at 19 to Beatrice. Beatrice was where people like me went when their families couldn't take care of them. When people went to Beatrice they were sentenced to life---with no hope, with no freedom and with no meaning. Their crime…being mentally retarded. But I was in the main building in the institution. I was taking care of all the little babies, wild babies, thou babies… I watched two little kids die in my arms." Id., 55-56. The children admitted to the Beatrice State home suffered the highest mortality rate. Between 1920 and 1960, almost one-half (1/2) of the children admitted before the age of two died within 12 months; twenty-five percent (25%) died within the first three months of admission to the Beatrice State Home. Children died in droves under the dominant pathological medical model at the facility in Beatrice. Kurtz & Wolfensberger, Separation experiences of residents in an institution for the mentally retarded: 1910-1959.supra at 389-96.

[18] See *Report of the Human and Legal Rights Committee to the Board of Directors of the Association for Retarded Citizens* (Lincoln, Nebraska: Nebraska Association for Retarded Citizens, 1972). The *Report of the Human and Legal Rights Committee* detailed the deplorable conditions that existed at the Beatrice State Home in July 1972. See also: *Into the Light:* Report of the Nebraska Governor's Citizens' Committee on Mental Retardation (Lincoln, Nebraska: Nebraska Department of Public Institutions, 1968). *Into the Light* is the summary, highly critical of the dehumanizing conditions at the Beartice State Home, of the lengthy report of the Citizens' Committee appointed by Governor Norbert T. Tiemann. See: Report of the Nebraska Governor's Citizens' Committee on Mental Retardation Vol. I and Vol. II. (Lincoln, Nebraska: Nebraska Department of Public Institutions, 1968).

[19] *Out of the Darkness*, supra., 57-59; 86-87; 141.

Exon to seek solutions to the increasingly deteriorating and dehumanizing conditions at the Beatrice State Home. The Governor refused to even meet with NebARC. In the fall of 1972, after Governor Exon's failure and default to even consider the plight of the 1,347 people enduring the dehumanizing conditions of their confinement at the Beatrice State Home, the United States District Court of Nebraska became the hope of those who languished at the Beatrice State Home.[20]

On September 28, 1972 five persons confined at the Beatrice State Home filed a class action complaint in the United States District Court of Nebraska alleging that the State of Nebraska and its officials, by their failure to provide them with individualized habilitation plans, sufficient staff, and a safe environment, deprived them of liberty and their privacy and dignity under the Due Process Clause of the Fourteenth Amendment to the United States Constitution. The five residents, who had been ignored long enough by state officials, further alleged that their confinement at the Beatrice State Home constituted a violation of the Equal Protection Clause of the Fourteenth Amendment because individuals with similar disabilities were being habilitated in a system of community programs far less restrictive of personal liberties and substantially superior as to the level of habilitation than at the Beatrice State Home. Finally, they contended that the deplorable and dehumanizing conditions they were forced to endure at the Beatrice State Home constituted cruel and unusual punishment prohibited by the Eighth Amendment to the United States Constitution.[21]

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[20] Id., 86; 166; 182.

[21] *Horacek v. Exon*, 357 F. Supp. 71, 72 (D. Neb. 1973) (Memorandum and Order on Motion to Dismiss); Complaint in *Horacek v. Exon*, Civil No. 72-L-299 (Filing 1). The State of Nebraska filed a motion to dismiss the complaint which District Court Judge Warren Urbom denied on March 23, 1973. The State of Nebraska later filed a motion for summary judgment. Judge Urbom, while certifying the case as a class action, on June 5, 1974 also denied the motion for summary judgment and granted the National Center for Law and the Handicapped and NebARC amicus status, *Horacek v. Exon*, Civil No. 72-L-299 (Memorandum and Order of Motion for Summary Judgment, Declaring

On October 31, 1975, Judge Schatz, after a fairness hearing, entered a consent decree approving a settlement agreement between the class of private plaintiffs, the United States of America and the State of Nebraska which had been reached earlier on August 6, 1975 during lengthy and extended negotiations after the trial had commenced in July of 1975.[22]

The *Horacek* consent decree recognized the constitutional right of individuals with mental retardation at the Beatrice State Developmental Center[23] to be protected from physical and psychological harm while in the custody of state officials, and their constitutional right under the Fourteenth Amendment to habilitation, which is the least restrictive of their personal liberty. The consent decree approved the reduction of the population from approximately 1,200 to a "goal" of 250 within three years under the supervision of the Nebraska Mental Retardation Panel mandated by the consent decree.[24]

The State of Nebraska, with legislative rejection of funding for the Nebraska Mental Retardation Panel, in 1976 attempted to circumvent and obstruct the enforcement

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Class Action and Granting Amicus Status June 5, 1974). On March 25, 1975, the original five plaintiffs who had courageously demanded of state officials that their constitutional rights be recognized and protected, no longer stood alone when Federal Judge Albert Schatz allowed the United States Department of Justice, Civil Rights Division to intervene as a plaintiff with them. The authority and resources of the Federal Government now stood side by side with them in their struggle for equality and liberty. *Horacek v. Exon*, Civil No. 72-L-299 (Application to Intervene as Party Plaintiff of March 10, 1975 and Order Granting Intervention as Party Plaintiff March 28, 1975); See also Mason & Menolascino, The Right to Treatment, supra at 165 ftnt.178; *Out of the Darkness*, supra 164-168.

[22] Settlement Agreement of August 6, 1975, *Horacek v. Exon*, Civil No. 72-L-299 (D. Neb., consent decree approving settlement agreement entered October 31, 1975).

[23] July 1, 1975 the Beatrice State Home became the Beatrice State Developmental Center

[24] *Horacek v. Exon*, Civil No. 72-L-299 (D. Neb., consent decree entered October 31, 1975). The consent decree required Governor Exon, who had refused to even meet with NebARC in the summer of 1972, to form the Nebraska Mental Retardation Panel to prepare a statewide plan to address the population reduction goal and the timeframe necessary to achieve that goal; identify the method by which the reduction was to be achieved; establish assessment teams to evaluate each individual at the Beatrice State Developmental Center; and prepare individualized evaluations, treatment plans and placement recommendations. Furthermore, any new capital construction at the Beatrice facility needed to be approved only to habilitate the residual population under the terms of the consent decree. Settlement Agreement of August 6, 1975, *Horacek v. Exon*, Civil No. 72-L-299 (D. Neb., consent decree approving settlement agreement of August 6, 1975 and incorporating its provisions entered October 31, 1975).

of the constitutional rights of the citizens confined at the Beatrice State Developmental Center.[25]

On April 6, 1979, newly elected Governor Charles Thone filed with the District Court an alternative plan (Thone I Plan) to implement the provisions of the 1975 consent decree. The initial Thone plan was amended and supplemented on June 28, 1979 (Thone II Plan).[26] By 1985, the population at the Beatrice State Developmental Center had decreased to 452 residents, almost a 66% decline from the inception of the *Horacek* litigation in 1972. Additionally, units for people with developmental disabilities at the Hastings Regional Center and the Lincoln Regional Center operated by state officials had been shut down.[27] The Beatrice State Developmental Center had assumed a "lesser" role in Nebraska with state planners and officials and its primary purpose was to *support rather than supplant* the community-based services.[28] This purpose never left the conceptual stage of state planners as BSDC, during the late 1980s and through the 1990s, remained constant in its population and static in its institutional culture.[29]

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[25] In September of 1976, the Department of Justice, joined by the private plaintiffs, returned to the courtroom to enforce the provisions of the consent decree of 1975. In February of 1978, Judge Schatz amended the consent decree and created a three person Nebraska Mental Retardation Panel under the Court's supervision to develop a Plan of Implementation to finally implement the provisions of the consent decree of 1975.

[26] After the United States and the private plaintiffs filed objections to Thone I and Thone II Implementation Plans, the final State of Nebraska's Implementation Plan was filed with the United States District Court on October 9, 1980, almost five years after the entering of the consent decree. The private plaintiffs withdrew their objections to the amended State of Nebraska Plan. However, the United States continued to object to provisions in the amended State of Nebraska Plan. On September 28, 1981, the District Court denied the Department of Justice's objections and adopted the amended Thone five-year plan of Implementation. *The Plan of Implementation*, Nebraska Department of Institutions (Omaha, Nebraska: Cockle Printing, 1980); see also *Out of the Darkness*, supra, 168-169, 178-184. Frohboese and Sales, Parental Opposition to Deinstitutionalization: A Challenge in Need of Attention and Resolution 4 Law and Human Behavior 1, 31-35 (1980).

[27] *The Plan of Implementation Summary Report.* (Lincoln, Nebraska: Nebraska Department of Institutions, 1985).

[28] Id.

[29] Programmatically, state officials with BSDC remained predictable and cautious with few innovative models designed to integrate and return individuals to the community. Staff shortages continued during this period of time as the rural location of the facility and the low salaries were still less than desirable in attracting professionals and skilled direct care workers to the facility. Staff shortages have consistently plagued the Beatrice facility. Those shortages are a significant contributing factor in failure of the facility to meet the standard of professional practices required under federal regulations. See N. Hicks, "Beatrice center in staffing crisis" Lincoln Journal Star (May 8, 2007). Marvin, "Worse than Wal-Mart" Letter to Editor, Omaha World Herald (May 24, 2007). According to Mike

As the new century dawned, the persistent problems of staff shortages, residents with greater behavioral demands, the lack of innovative and creative solutions to the needs of the residents living at BSDC, the absence of integrative approaches and utilization of community resources, and an administration isolated and dissociated from the residents with whom it was entrusted to protect and treat remained embedded and combined into the downward spiral documented in the CMS investigations from 2001 through 2007.

The static and stagnant nature of the facility's officials with its focus on institutional preservation, reminiscent of earlier efforts in the early and mid 20th Century, was reflected in the fact that during the twenty plus years from 1985 to 2007 the Beatrice State Developmental Center has reduced its 1985 population by less than 100 residents while its budget which was $17, 523,479.00 in 1985 has nearly tripled, ballooning to $50, 226,416.00 for current fiscal year 2007-2008.[30] The immediate jeopardy findings by CMS in the Fall of 2006 and the Spring of 2007 meant that over $28,000,000.00 in federal funds could have been withheld. The departure from generally accepted professional standards of care by state officials at BSDC in 2006 and 2007, by failing to meet the minimally accepted professional standards in the regulatory requirements of 42 C.F.R. § 483 Subpart I, shook the very core of the facility's long standing justification for its continued existence: humane treatment and care which could be obtained nowhere else.[31]

Marvin, the Executive Director of NAPE/AFSCME Local 61 AFL-CIO, the starting wage for Developmental Technicians at BSDC is $8.54 per hour. Of the 655 full-time bargaining unit workers at BSDC, 285 make under $11.00 per hour.

[30] Sec. 121, Laws_____ LB 321.___. For a funding history of the Beatrice State Developmental Center and Community-Based Mental Retardation Programs from 1969 to 1980 see *Out of the Darkness*, supra 165.

[31] See generally CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (survey completed 09-29-2006) (1-413) and CMS Statement of Deficiencies and Plan of Correction for the

A CHRONOLOGY OF FAILURE: A REVIEW OF THE CENTER FOR MEDICARE AND MEDICAID SERVICES' SURVEYS OF THE BEATRICE STATE DEVELOPMENTAL CENTER 2001—2007

As of October 2007 the Beatrice State Developmental Center (BSDC), the State of Nebraska's owned and operated intermediate care facility for individuals with mental retardation (ICF/MR), is home to approximately 350 residents with developmental disabilities who possess diverse abilities and functional levels. Over three-fourths (3/4) of the residents at BSDC have speech/language impairments; one-third (1/3) have visual impairments, with thirty-two (32) being totally blind; and almost one-half (1/2) are non-ambulatory and non-mobile. Additionally, approximately two-thirds (2/3) of the residents have seizures or a history of seizures, with nearly ten percent (10%) uncontrolled. Nearly fifty percent (50%) of the residents at BSDC receive medications to control injurious behaviors to themselves or others, and over forty percent (40%) have significant behavioral needs requiring behavior program intervention. The population at BSDC is aging, with two-thirds (2/3) of the residents between forty-six (46) to sixty-five plus (65+) years of age. However, there are approximately seventeen (17) residents under the age of twenty-two (22). Almost all the residents at BSDC have guardians, and slightly fewer than ten percent (10%) are committed under court order. The facility provides support and services to persons who have a dual diagnosis of developmental disabilities and mental illness. BSDC also operates a program licensed as a Center for

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Beatrice State Developmental Center (survey completed 09-20-2006) (1-192). Compare the 2007 stated goal of "providing services at BSDC that are of high quality and which protect the rights of individuals served there, while promoting independence and ***ensuring that their health and safety needs are met***" with the purpose clause of the 1885 legislation establishing the facility at Beatrice, "Besides shelter and protection, the prime object of said institution shall be to provide **special means of improvement (emphasis supplied)** for that unfortunate portion of the community who were born or by disease have become imbecile or feebleminded, and by a **wise and well adapted course of instruction (emphasis supplied)** reclaim them from their helpless condition, and through the **development of their intellectual faculties (emphasis supplied),** fit them as far as possible for usefulness in society. "Three-Year State Plan" (Lincoln, Nebraska: State of Nebraska Health and Human Services System Developmental Disabilities System, June 2007) Goal A-2, page 10; §2 Act of March 5, 1885, ch. 52, 1885 Neb. Laws.

the Developmentally Disabled (CDD) at the Hastings Regional Center (the "Bridges" program) and a hospital unit on the grounds of the state institution at Beatrice, Nebraska. Each of these facilities and programs is licensed separately.

BSDC, as an ICF/MR, is subject to periodic surveys and inspections by the United States Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS). In September of 2006, CMS conducted a comprehensive survey to assess BSDC's compliance with federal ICF/MR regulations which is a required condition for participation in the Medicaid Program. On October 2, 2006 CMS found that BSDC was not in substantial compliance with the applicable federal rules, regulations and interpretive guidelines for accepted professional standards of care in a substantial number of critical areas, and the conditions at the facility constituted an **immediate jeopardy to resident health and safety**.[32] During the course of a follow up survey on April 19, 2007 CMS surveyors again found that BSDC was not in substantial compliance with the applicable federal rules, regulations and interpretive guidelines for accepted professional standards of care in seven out of eight critical areas, and the conditions at the facility constituted **immediate jeopardy to resident health and safety**.

This current repeated inability of state officials to protect and treat the residents at BSDC who are entrusted to their care did not materialize overnight. CMS has surveyed BSDC repeatedly. Our research and analysis of CMS survey reports has focused on the period 2001-2007. The CMS survey reports during this time period clearly document that the critical and substantial failures to meet accepted professional standards of care at BSDC cited in the October 2006 and April 2007 CMS survey reports are merely the most

[32] Use of the term "professional" in this context means not only physicians, psychologists, nurses, social workers, therapists, etc. but includes any and all direct care staff, therapy assistants, etc., who provide care, treatment and services under the supervision and direction of such individuals.

recent in years of failures that have been known and tolerated by state officials with the responsibility to protect and habilitate residents at BSDC. The problems and failures at BSDC are systemic, chronic, and have persisted for years.[33]

In the following section, we provide a brief summary of the major findings contained in the reports of CMS surveyors during surveys conducted at BSDC in 2001, 2003, 2004, 2005, 2006, and 2007. Later sections of the report will address in greater detail the findings contained in the CMS reports of surveys at BSDC in 2006 and 2007.

> **November 2001.** CMS surveyors found facility policy and procedure allowed staff with substantiated allegations of physical abuse or neglect which constituted a serious threat to clients to return to work in direct care of residents. This finding resulted in the Facility Administrator being notified that an **immediate jeopardy situation** was found to exist. Surveyors also found the facility did not ensure the rights of all residents, including the right to file complaints and the right to due process. The facility also failed to: 1) provide compensation to clients who work for the facility; ensure that residents have the right to communicate, associate and meet privately with individuals of their choice; and ensure that residents have the right to retain and use appropriate personal possessions and clothing; 2) notify promptly a resident's parents or guardians of any significant incidents or changes in the resident's condition, including serious illness, accident, death, abuse or unauthorized absence; 3) develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of residents; 4) ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source are reported and thoroughly investigated; and that the results of all investigations are reported immediately in accordance with state law (within 5 working days of the incident); 5) ensure the prevention of further potential abuse while an investigation is in process; 6) ensure that appropriate corrective action was taken in situations where the allegations were verified; 7) adequately monitor programs and failed to secure the required consent of the client, parents or legal guardian; and 8) ensure that the resident records documented the use of less

[33] Stoddard, M. "Agency was told of flaws in care" Omaha World Herald (October 7, 2006); Stark, S. "Patient care criticized at Beatrice State Developmental Center: Federal Investigation finds patients jeopardized" www.NewsNetNebraska.org (December 31, 2006). Earlier critical reports of the lack of care at the State operated residential facility for individuals with developmental disabilities have been documented for almost forty years. These investigations evidenced similar, if not identical, deficiencies at BSDC as the 2006 and 2007 investigations did. See e.g., *Report of the Human and Legal Rights Committee to the Board of Directors of the Association for Retarded Citizens* (Lincoln, Nebraska: Nebraska Association for Retarded Citizens, 1972). The *Report of the Human and Legal Rights Committee* detailed the deplorable conditions that existed at the Beatrice State Home in July 1972. See also: *Into the Light:* Report of the Nebraska Governor's Citizens' Committee on Mental Retardation (Lincoln, Nebraska: Nebraska Department of Public Institutions, 1968). *Into the Light* is the summary, highly critical of the dehumanizing conditions at the Beatrice State Home, of the lengthy report of the Citizens' Committee appointed by Governor Norbert T. Tiemann. See: Report of the Nebraska Governor's Citizens' Committee on Mental Retardation (Lincoln, Nebraska: Nebraska Department of Public Institutions, 1968) Vol I and Vol II.

restrictive techniques prior to the use of more restrictive techniques. It was also noted that techniques to manage inappropriate resident behavior were being used as a substitute for an active treatment program.[i]

January 2003. CMS surveyors found that the facility failed to assure that abuse or neglect allegations were reported immediately, almost one-half of allegations of abuse or neglect logged by the facility were not reported to state authorities as required by law, and the facility failed repeatedly to investigate serious injuries to residents, such as fractures of unknown origin and peer-on-peer sexual behavior.[34]

April 2003. The facility failed to meet the timelines of the Plan of Correction it had submitted, continued to fail to investigate injuries of unknown or suspicious origins for several residents, failed to conduct follow up investigations, failed to promptly investigate and discipline staff for hitting a vulnerable resident, and took several weeks to complete investigations of abuse and neglect which were to be completed within five (5) working days.[ii]

October 2003. The facility still failed to thoroughly investigate incidents and complete investigations in a timely manner, despite repeated promises in its previously submitted Plans of Correction to remedy its deficiencies. Surveyors found a repeated pattern of systemic deficiencies in the area of incident management and included detailed findings of the neglect of two of the residents' medical needs who had Gastric (G) and Jejunostomy (J) feeding tubes resulting in the death of one resident due to peritonitis and a "near miss" of another by peritonitis as a result of staff misplacement of the feeding tubes.[iii]

January 2004. The evidence mounted that the officials at BSDC were not implementing their previous assurances to CMS of immediately reporting all injuries of unknown origins suffered by the residents living at BSDC. The facility failed to assess and implement safeguards to protect residents from documented self-injurious behavior. A behavior management plan did not exist for a resident who, for over a year, exhibited documented self-injurious behaviors, including slapping himself, banging his head, biting his arms, or aggressive behaviors to other residents and staff, slapping peers and staff, pinching staff and peers, and property destruction.[iv]

[34] CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 01-31-2003) pgs 1-59; See § 28-372 of Adult Protective Services Act, Neb. Revised Statutes requires any employee of any facility licensed by the Department of Health or Human Services who has reasonable cause to believe that a vulnerable adult has been subjected to abuse …shall report to the appropriate law enforcement agency or to the department. See also: § 28-715 (Abused or Neglected Child Registry) requires that reports of suspected abuse or neglect be filed in special state Abused or Neglected Child Registry.

> **Mid March 2004**. BSDC failed to ensure immediate reporting of abuse, neglect, and injuries of unknown origins. Nursing staff failed to take appropriate nursing actions examining a resident in respiratory distress at 9:15 a.m. and took no action but instead told the staff, "He's fine, there's nothing wrong with him, quit telling him he's sick." The resident remained in respiratory stress from 9:15 a.m. until the nurse returned to his room between 12:15 p.m. to 12:20 p.m. for a Nebulizer treatment at which time he quit breathing and turned blue. Artificial respiration was initiated, a Code Blue was called, and the resident was transported to community hospital where he was pronounced dead.[v]
>
> **Late March 2004.** CMS cited BSDC for the facility's failure to meet the dietary needs of the residents living there.[vi]
>
> **October 2004.** The facility was placed in an **immediate jeopardy situation** due to a resident being seriously hurt after a fall from a mechanical lift and the facility failed to initiate interventions by training or re-training care staff in the use of mechanical lifts.[vii]

However, the warning signs of serious problems at BSDC grew more ominous in 2005 as a CMS surveyor found that the facility was not providing adequate supervision of the people living at the facility.

> **May 2005.** The facility failed to remedy the lack of supervision resulting in behavior management plans not being current and appropriate to meet the habilitation needs of the residents. Inadequate supervision resulted in increased elopements from the facility by residents (one of whom had a previous history of inappropriate sexual behaviors) and one resident was allowed to roam the halls at night consuming food/edibles for over a year. The same resident had an outdated treatment plan that included the use of edibles as behavioral reinforcement two years after he had received a G-tube and could no longer consume edibles. A resident with a well documented and known history of pica disorder was allowed to go unsupervised throughout the facility and nearly died after two days of vomiting because of swallowing a cork taken from another resident's room. A resident, with a history of choking that resulted in his being placed on a pureed diet, was fed a peanut butter sandwich against the dietary plan in place for over two years. He began choking, lapsed into unconsciousness and was hospitalized in the intensive care unit at the Community Hospital for four days.[viii] When the facility did investigate an allegation of abuse and neglect, it consistently and continually failed to follow its own policies of suspending from the workplace staff members who were being investigated for abuse and neglect.[ix]

> **August 2005.** Incidents of staffing shortages, verbal abuse of vulnerable adults, and team managers neither investigating nor reporting incidents of abuse and neglect were found to be prevalent and still not in compliance with federal requirements.[x]
>
> **October 2006 and April 2007.** The facility was cited for: (1) not meeting the applicable federal rules, regulations and interpretive guidelines of accepted professional standards of care in a substantial number of critical areas necessary to protect the residents from harm; and (2) not meeting the applicable federal rules, regulations and interpretive guidelines for acceptable professional standards of care in a substantial number of critical areas necessary to ensure active treatment for those residents. More importantly, CMS found that the practices and conditions at BSDC in the Fall of 2006 and the Spring of 2007 were so deficient that a finding of **immediate jeopardy** was necessary. Those findings and their consequence will be discussed in much greater detail in subsequent sections of this report.

As a result of our extensive review and analysis of CMS survey reports of BSDC from 2001 to 2007 the evidence demonstrates clearly that state officials have repeatedly:

- Failed to provide adequate supervision.
- Failed to report or investigate immediately abuse and neglect allegations.
- Failed to suspend offending staff members.
- Failed to implement behavior management programs.
- Failed to provide for proper nursing care resulting in unnecessary pain for a resident who died.
- Failed to address nutritional and dietary deficiencies.
- Failed to provide adequate numbers of appropriately trained direct care staff, and
- Failed to follow BSDC's own policies.

Beginning in the Fall of 2006 and continuing through the Spring of 2007, this pattern of failure has become an indictment of indifference against the state officials responsible for the protection and treatment of vulnerable residents at BSDC entrusted to their care.

CHRONOLOGY OF NEBRASKA ADVOCACY SERVICES' INVESTIGATION

Upon notification of the serious and substantial finding by the Center for Medicare and Medicaid Services (CMS) of **immediate jeopardy** in October 2006 Nebraska Advocacy Services (NAS), acting under its authority within the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. § 15001 et seq., immediately contacted CMS, the ARC of Nebraska, and the Acting Administrator of the Beatrice State Developmental Center (BSDC) for documentation of the CMS findings. On October 5, 2006 three (3) days after the CMS finding, NAS received a faxed copy of partial findings by CMS. Although partial in nature, an examination and analysis of the preliminary findings raised substantial concerns that systemic deficiencies existed at BSDC that placed people residing there at a risk of serious harm or danger.

NAS determined that the preliminary findings demanded a thorough and comprehensive investigation of alleged violations of both constitutional and federal statutory rights of persons with developmental disabilities residing at BSDC. The following is a simple chronology of our investigations:

> **Early October 2006**. After completing a preliminary analysis, NAS formally requested the entire CMS survey report and the plan of correction prepared by BSDC in response to the findings in the CMS survey report from the State of Nebraska. Simultaneously, NAS began negotiations with the State of Nebraska for an Access Agreement to the BSDC facility, its residents and staff, and to review the records of BSDC residents. Only by this complete access to the facility, residents, staff, and records at BSDC, could NAS fulfill its federal mandate and monitor the safety of those residents.
>
> **November 2006.** Negotiations on access to BSDC proceeded rapidly and on November 2, 2006, a month after the initial CMS report, an Access Agreement was approved between NAS and the State of Nebraska. With approval of the Access Agreement, NAS initiated its new presence at the facility. NAS legal advocacy staff met with the Acting Administrator and visited all residential and programmatic units to question staff and

observe the residents living there. NAS also requested demographic information and the identification of the residents and their guardians referenced in the CMS reports. The State of Nebraska complied expeditiously with all of NAS' requests for data and resident information.

December 2006. On December 9th the NAS Chief Executive Officer, Litigation Director and Director of Legal Services met with parents of BSDC residents to explain what NAS had done to date and planned to do in the future to not only meet its federal mandate but to advocate and protect those residents living at the facility. NAS legal advocacy staff returned to BSDC for an additional on-site inspection.

January 2007. All incident reports of any physical injury that occurred during December, 2006 and January, 2007 were reviewed by the NAS Litigation Director and Case Advocate. Hundreds of reports, filling eight (8) three-ring binders, were examined to establish a base line so that NAS could understand and verify the accuracy of the levels of severity contained in the BSDC reporting procedures. Furthermore, all BSDC policies and procedures were analyzed by the same NAS personnel to obtain an understanding of the operational aspects of BSDC. NAS staff received and began analyzing the entire October, 2006 CMS survey report. NAS staff began identifying specific problematic areas and troublesome units with either a higher degree of the number of incidences of injuries or a higher degree of severity of the injuries.[35]

February 2007. NAS staff continued to analyze the entire CMS survey of the Fall of 2006.

March 2007. NAS received the 450 page BSDC response and plan of correction for review and analysis.

April—June 2007. NAS reviews BSDC response and plan of correction. Staff continues to visit BSDC and investigate cases of abuse and neglect based on probable cause.

July 2007. NAS received and analyzed the CMS survey report of April of 2007 and the BSDC response and plan of correction submitted the middle of July of 2007.

[35] As a result of the directed focus by NAS staff, one unit at BSDC (108 Kennedy) was identified as experiencing unacceptable high levels of peer-to-peer aggression, a high number of violent incidences, and a high degree of staff turnover and absenteeism. NAS met with the BSDC Acting CEO, the State of Nebraska's Ombudsman's Office and the 108 Kennedy Treatment Team to communicate NAS' concerns and to present our intention to monitor the treatment plans of three (3) residents for whom we shared significant concerns. Those heightened concerns resulted in NAS opening active cases for the three residents. As a result of the meetings, personnel changes were made on the unit and NAS continues to represent those three (3) residents.

August 2007. NAS opened cases for further specific investigations on twenty-six (26) additional residents. Individual records are being received and continue to be reviewed by NAS for these twenty-six (26) residents.

Since November 2006 NAS legal advocacy staff has made bimonthly inspections and on-site reviews at BSDC. During this time NAS legal advocacy staff has interviewed direct care staff, professional staff, residents and administrators at the facility. NAS staff has compiled extensive records, conducted detailed document reviews and met regularly with the supervisor of the four (4) recently hired abuse investigators.[36] NAS continues to receive monthly summaries of the more serious level of incident reports. In addition, the NAS Director of Litigation conducted several extensive on-site inspections, including interviews with facility staff, people who reside at the facility and facility administrators. He has reviewed and analyzed over eleven (11) months of individual resident records, facility records, incident and investigation reports, facility policies and procedures, as well as the CMS survey reports for 2001, 2003, 2004, 2005, 2006, and 2007. He has also consulted with nationally recognized experts in the residential treatment of persons with developmental disabilities.

During the course of our investigation, NAS staff visited people living at BSDC in their residences, at activity areas, and during meals. Our review and analysis of relevant state and facility documents has been extensive, including policies and procedures, as well as medical records, medication records, treatment plans, restraint records, and behavior management plans for people residing at the facility. We have reviewed and analyzed countless pages of: 1) incident reports of physical injuries, sexual assaults, verbal abuse, and deaths; and 2) reports of investigations for physical injuries, sexual assaults, verbal abuse, elopement, and deaths for the individual living units. We

[36]BSDC is currently attempting to fill two (2) vacant investigative positions due to resignations.

have also examined other historical documents, including legislative enactments, budget appropriations, executive and legislative and citizen group reports or recommendations, and prior court pleadings and reports arising from the class action right to treatment litigation involving conditions at BSDC: *Horacek v. Exon*, 357 F. Supp. 71 (D. Neb. 1973) (Consent Decree entered October 31, 1975).

The monitoring of BSDC by NAS remains ongoing at the current time. As a preliminary matter, NAS notes that BSDC is staffed predominately by dedicated individuals who are genuinely concerned for the well-being of the residents in their care. However, the evidence demonstrates unequivocally that they are underpaid, undertrained and overworked by state officials. NAS is now issuing its preliminary findings and recommendations in this report due to the persistent and chronic nature of the problems existing at the Beatrice State Developmental Center.

CONSTITUTIONAL AND STATUTORY OBLIGATIONS OF STATE OFFICIALS AT THE BEATRICE STATE DEVELOPMENTAL CENTER

State officials must provide citizens who live at the Beatrice State Developmental Center (BSDC) with supports and services in accordance with the state's federal constitutional obligations. see: *Youngberg v. Romeo*, 457 U.S. 307 at 322-323 (1982). The U.S. Supreme Court has recognized that persons with developmental disabilities who reside in state facilities, such as BSDC, have a "constitutionally protected liberty interest in safety." *Youngberg* at 318. The Court held that the state "has the unquestioned duty to provide reasonable safety for all residents" within the institution. *Id.*, at 324. Furthermore, persons with developmental disabilities residing at BSDC have a constitutional right to "minimally adequate training." *Youngberg* at 322. Specifically,

"the minimally adequate training required by the Constitution is such training as may be reasonable in light of [the institutionalized person's] liberty interests in safety and freedom from unreasonable restraints." *Youngberg* at 319. An essential component of habilitation treatment for persons with developmental disabilities is the regular provision of activities designed to help them develop new skills and practice skills already learned.

The test of whether a facility, such as BSDC, has provided adequate minimal levels of constitutionally required care and treatment depends on if that facility's practices substantially depart from generally accepted professional judgment. *Youngberg* at 323. Evidence that a facility has engaged in practices that constitute a substantial departure from accepted professional standards of care is available by both the opinions of experts knowledgeable in the profession and violations of national regulatory standards or guidelines.

The Center for Medicare and Medicaid Service's (CMS) regulations require that Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) must protect residents with developmental disabilities from harm, provide adequate staffing, protect them from abuse, and ensure the provision of **active treatment** to reduce dependence on drugs and physical restraints. In particular, 42 C.F.R.§ 483.420 (a) (5) requires that the facility "ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment". 42 C.F.R. § 483.430 (d) (1) requires facilities to "provide sufficient direct care staff to manage and supervise residents", while 42 C.F.R. § 483.420 (6) requires facilities to "ensure that clients are provided active treatment to reduce dependency on drugs and physical restraints".

FINDINGS OF VIOLATIONS OF THE CONSTITUTIONAL RIGHTS OF CITIZENS LIVING AT THE BEATRICE STATE DEVELOPMENTAL CENTER BY STATE OFFICIALS

Nebraska Advocacy Services (NAS) incorporates, as an integral part of its own findings and conclusions of constitutional violations at the Beatrice State Developmental Center (BSDC), those findings and conclusions of the Center for Medicare and Medicaid Services (CMS) in its investigations of the Fall of 2006 and the Spring of 2007. Both sets of findings demonstrate that practices at BSDC substantially departed from accepted professional standards of care in violation of federal regulations. Observations, analyses, inspections, record reviews, and consultations with experts by NAS since November of 2006 confirm the earlier CMS findings. We present an overview and summary examination of the CMS findings from October of 2006 and April of 2007 that is further supplemented and illustrated by more recent findings from the ongoing investigation at BSDC being conducted by NAS.

FINDING I

Nebraska State Officials Have Failed and Continue to Fail to Protect Vulnerable Individuals at the Beatrice State Developmental Center from Physical, Verbal, Sexual, and Psychological Harm and Abuse in Deprivation of Their Constitutional and Statutory Rights.

Nebraska Advocacy Services (NAS) finds that certain conditions and practices at the Beatrice State Developmental Center (BSDC) violate the constitutional and federal statutory rights of citizens who live at the facility. Specifically, NAS finds that residents living at BSDC suffer harm and the continued risk of harm from the facility's failure to keep them safe.[xi] The facility regularly subjects the vulnerable residents who live there

to physical abuse, neglect, and serious physical injury.[37] This is a recurrent and chronic problem pervading the institutional culture from the CEO down to the direct care staff. It continued to blatantly manifest itself even after state officials provided later assurances that it had been eradicated.[38] NAS further finds that there exists a pattern and practice, extending for years, that state officials have not protected people living at BSDC from harm and the risk of harm.

The level of harm and violence for residents living at BSDC continues to escalate as a consequence of historically chronic staff shortages, inadequately trained staff and lack of professional assistance at the facility. This persistent reality impacts not only the immediate safety issue, but also the ability of state officials to provide active treatment, which requires a continuous process for the development, implementation, monitoring, assessment, and modifying of behavior interventions.

[37] This finding by NAS is not recent. In 2002, NAS successfully settled a wrongful death action against the State of Nebraska for the negligent failure by state officials at BSDC to protect Kristine Everitt, a 43 year-old woman with a well-documented history of seizures, who died while left unattended in a bath at the facility. She drowned while alone and unsupervised for 15 to 25 minutes in a whirlpool bath on February 15, 1999. Her death did not need to happen. Seventy-five days before her death on February 15, 1999, she had been left alone and unsupervised in the same whirlpool. At that earlier failure of supervision she had a seizure and had to be resuscitated. Kristine Everitt, according to records at BSDC, had multiple seizures daily at the facility. As part of the settlement, which included a significant monetary award for her estate and dismissal of the State of Nebraska's claim for reimbursement for her care, state officials agreed to erect a memorial to Kristine on the grounds of BSDC in her memory and as a reminder of the devastating consequences of the failure to meet their primary duty to protect individuals at BSDC. *E. Dean Everitt Sr., Personal Representative of the Estate of Kristine Everitt, Deceased v. State of Nebraska,* Case No. C100-25 (District Court of Gage County) (Settled 2002).

[38] In the Fall of 2006, the CMS survey on placed the facility at Beatrice in immediate jeopardy for this systemic failure. Id., 43-72. BSDC in its plan of compliance provided assurances that the failures to meet acceptable professional standards had been eliminated. However, in April 2007, a CMS survey again placed BSDC in immediate jeopardy because, "The facility's system to prevent and detect abuse, neglect and mistreatment failed to adequately protect individuals from harm or potential harm. **The facility did not thoroughly investigate all allegations of abuse, neglect, mistreatment and injuries of unknown source; the facility failed to ensure that sufficient safeguards were in place during the course of these investigations; and the facility failed to take appropriate corrective action when a violation was verified (**emphasis supplied)". CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 04-20-2007) (1-192) 2-3.

A. Center for Medicare and Medicaid Services Findings of Violations of Federal Regulations and Standards at the Beatrice State Developmental Center in October of 2006 and April 2007

In October, 2006 the Center for Medicare and Medicaid Services (CMS) found that the Beatrice State Developmental Center (BSDC) failed to meet the requirement of § 1905 (d) of the Social Security Act and substantially departed from the accepted professional standards of care as established in federal regulations for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). Specifically, CMS found that BSDC and state officials had departed from federal regulations in **seven out of eight critical areas** (emphasis supplied) that directly impacted the lives of all residents living at the facility. Two of those areas relate to the repeated failure of state officials to protect the residents from harm: 1) BSDC violated 42 C.F.R. § 483.10 (Governing Body and Management) because the facility's governing body failed to exercise general operating direction over the facility which CMS found potentially affected all residents living at BSDC;[xii] and 2) BSDC violated 42 C.F.R. § 483.20 (Client Protections) in that state officials at the facility failed to ensure that residents were free from abuse, neglect and mistreatment.

The above findings resulted in the identification of two **immediate jeopardy** situations which had not been removed at the time CMS left on September 29, 2006: 1) "the facility failed to ensure that clients were free from abuse and mistreatment … potentially affecting all 367 clients in the facility"; and 2) "the facility failed to develop and implement written policies and procedures that prohibit abuse and neglect as evidenced by the lack of adequate supervision provided to prevent client abuse… potentially affecting all 367 clients."[xiii] State officials at the facility also violated the rights of BSDC residents in that they "***failed to ensure due process*** (emphasis supplied)

for clients with rights restrictions and failed to obtain informed consent for restrictive practices" for residents at the facility. Additionally, the facility failed to promote community participation and integration for individuals in the residence which had the potential to affect all residents in the facility.[xiv] In the major areas of failure to protect BSDC residents, CMS continued to document the mounting list of failures by state officials to protect the vulnerable citizens in their custody. Specifically, state officials had failed to:

- develop, establish, maintain, and monitor a system to investigate all allegations of abuse, neglect, mistreatment and injuries of unknown sources at BSDC in a timely manner;
- report ***102 of 193 injuries of unknown origin*** in a three-month period to the administrator;
- conduct a thorough investigation of allegations of abuse and neglect as well as injuries of unknown origin;
- ensure that sufficient safeguards were in place during the course of these investigations and to take appropriate corrective action when a violation was verified or substantiated;[xv] and
- put safeguards in place during investigations of allegations of abuse and neglect and failed to take appropriate corrective action for injuries of unknown origin and allegations of abuse, neglect, and mistreatment.

These failures, in the judgment of the federal CMS surveyors, directly impacted all residents at BSDC.[xvi]

In April of 2007 surveyors for the Center for Medicare and Medicaid Services (CMS) returned to survey the Beatrice State Developmental Center (BSDC) and found that the facility failed to meet the requirement of § 1905 (d) of the Social Security Act and substantially departed from the accepted professional standards of care established by federal regulations for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).

Specifically, CMS found that BSDC and state officials had again continued to violate federal regulations 42 C.F.R. § 483.20, as they had six months earlier, by failing to ensure **client protections** (emphasis supplied) that directly impacts the lives of all residents living at the facility[39]. Specifically, state officials again failed to:

- implement and monitor a system to prevent abuse, neglect and mistreatment and failed to adequately protect residents from harm or potential harm;
- investigate all allegations of abuse, neglect, mistreatment and injuries of unknown source;[xvii]
- conduct thorough investigations;[xviii]
- ensure that sufficient safeguards were in place during the course of these investigations and take appropriate corrective action when a violation was verified or substantiated;[xix]
- complete and report investigations to the administrator within the required five (5) day time period;[40] and
- take appropriate corrective actions when a violation was verified.[41]

CMS also found a <u>new and critically important violation</u> by those state officials in that they **failed to recognize client-to-client abuse as "abuse"** (emphasis supplied) in that they did not require specific levels of injury to be reported to the administrator.[xx] This failure impacted all residents at BSDC.

[39] CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 04-20-2007) (1-192); Letter with Enclosures of Immediate Jeopardy from Centers for Medicare & Medicaid Services to Lawrence Pezley, Acting Chief Executive Officer, Beatrice State Developmental Center (April 24, 2007).

[40] Id. 56-62. CMS reported that many investigations languished for as long as two weeks. Id.

[41] Id. 53-56; 62-98. CMS found that state officials took no corrective actions for over 50% of the injuries of unknown origin which occurred in March of 2007. Between January 17, 2007 and April 20, 2007, state officials took no corrective action for 25% of injuries of unknown origin. Id. 62.

B. Further Examples of Violations of Federal Regulations Supportive of Nebraska Advocacy Services' Findings of Deprivations of Constitutional Rights at the Beatrice State Developmental Center

During the course of our ongoing investigation of conditions at the Beatrice State Developmental Center (BSDC) we documented that many of the practices of state officials at BSDC that violated and departed from the standards of care in 42 C.F.R. § 483.20 and 42 C.F.R. § 483.440, have continued unabated after state officials submitted their last Plan of Correction to the Center for Medicare and Medicaid Services (CMS) in July of 2007. Of significant concern to Nebraska Advocacy Services (NAS) is the repeated failure[42] of state officials at BSDC to: 1) report, thoroughly investigate, and take immediate corrective action; 2) initiate appropriate interventions involving the significant number of injuries of unknown origins; and 3) decrease the escalating peer-to-peer violence that continues to permeate the facility.[43] Despite assurances contained in the Plan(s) of Correction submitted to CMS by state officials in 2001, 2003, 2004, 2005, 2006, and 2007 to bring BSDC into compliance with the federal standards of professional care, they have failed to do so and still do depart substantially from those accepted standards of care.[44]

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[42] Repeatedly, in 2001, 2003, 2004, 2005, 2006, and 2007 CMS surveyors cited State officials for this systemic failure.

[43] Evidence indicates that individuals who are non verbal at BSDC continue to be at risk of significant bone fractures. See the following similar incidents: **(Incident #013)**-Non-verbal individual has broken humerus of unknown cause; **(Incident #056)-**Non-verbal individual has fracture of surgical neck of left humerus and fragment fracture of the humeral head; see also: **(Incident # 008)-** Fracture of arm of unknown cause; **(Incident #020)**-Fracture of left foot of unknown cause. Investigation noted that roommate had a similar fracture. Since September 27, 2007, four individuals at BSDC have suffered bone fractures. Two suffered fractures of the legs with the cause of "unknown origin". One other individual suffered a broken finger. NAS is still attempting to ascertain what bone(s) were fractured of the fourth individual. The individuals who have the fractures of the legs and the individual who has the unknown fracture are **non-verbal**.

[44] Compare the CMS surveys of 2003, 2004, and 2005 with those of 2006 and 2007 and the same failure to thoroughly investigate is cited by the federal surveyors. CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 01-31-2003) pgs 1-59; CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 04-17-2003) pgs 1-13; CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 10-09-2003) pgs 1-54; CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 01-22-2004) pgs 1-24; and CMS Statement of Deficiencies and Plan of Correction for the Beatrice

NAS has included a brief sample of illustrative cases which, in our judgment, demonstrates and supplements the more than 600 pages filled with countless individual examples in the 2006 and 2007 CMS survey reports. These examples clearly demonstrate the facility has failed to meet its fundamental responsibility under the United States Constitution and federal statutes and implementing regulations to provide treatment and protect the residents living at the facility from harm, rape, or sexual assaults.[45] The significant importance of the following sample of illustrative cases is that they establish the continuing violations of constitutional rights, federal regulations and the departure from accepted standards of professional care by state officials responsible for BSDC. These brief summaries were prepared by NAS staff; however, NAS disagrees with the conclusion that there was neither abuse nor neglect in several of those investigations. The examples are presented in a chronological sequence in order to illustrate the scope and extent of the continuous violations at BSDC. We believe these incidents serve to corroborate that the problems at BSDC are sweeping in their scope

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State Developmental Center (Survey Completed 05-11-2005) pgs 1-14, with CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 09-29-2006) (1-413) and CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 04-20-2007) (1-192).

[45] CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 09-29-2006) (1-413) pgs 43-105 documents a rape of an 18 year old female in BSDC school reading room by an 18 year old male who had a well documented history of sexual predation and impulse control and for whom BSDC failed to supervise under the pre-admission requirement "that he was being placed at BSDC for supervision and structure due to sexual activity and impulse control and required 24 hour awake visual supervision." Privacy and human dignity dissipate in staff convenience. CMS surveyors describe its demise, "Two staff was observed with client 33 in the bathroom. The door to the bathroom was open and staff verbally prompted client 33 to take her robe off. The two staff assisted client 33 in taking her clothes off and client 33 stood naked in the bathroom in full view of clients and staff that passed by. Staff then proceeded to assist client with a shower while the bathroom door remained open."Id. 76. Individuals at BSDC are sexually assaulted by staff. The CMS surveyor details, " A technician went into the restroom in the coed dining area and discovered client 56 sitting on a stool in a stall while (Former Employee 1), Food Service Aide, was masturbating (Client 56) who had an erection…The client indicated that this was the second incident in which (former employee) had touched him….The investigation revealed a second allegation of abuse by former Employee 1 that involved client 56; this allegation was noted by both the Administrator and the investigator. The Administrator confirmed that there was no further investigation into this second allegation." Id. 117-118. NAS notes that a sexual assault of vulnerable adults in the custody of state officials is a felony in Nebraska. No felony prosecution ensued of the food service aide. Nor is there evidence that the information of the observed sexual assault was provided to either the County Attorney of Gage County or the State Patrol. See also: **(Case # 012)-April 6, 2007**-Peer-on-peer sexual assault while staff members played cards.

from the *alpha* of critical, life-endangering staff abuse and/or neglect, to the *omega* of staff shouting at individuals. It is this spectrum of illustrative cases that we believe evidences a culture of dismissive disrespect and devaluation for the personhood of individuals living at the facility.

JANUARY 2007

(Incident #001)—A woman who resides at BSDC was receiving assistance in bathing from a staff member. The staff member noticed that the woman's breast area and naval appeared to be shaved. She was taken to the Beatrice Community Hospital for a possible sexual assault examination. The Beatrice Community Hospital report indicates that the woman possibly did have her naval and breast area shaved. BSDC investigation concluded: Staff where she lives had a heightened awareness of incidences where other people living on the unit had been shaved in their pubic area without medical authorization. Her loss of hair could have been from using adhesive tape for her briefs or from topical lotions that were used to clean her feeding tube; no abuse or neglect occurred.

(Incident #002)—A man who resides at BSDC was eating an apple for a snack, tried to eat it, and then spit it on the floor. Staff did not clean up the apple mess from the floor and the man has a history of eating food off the floor. BSDC investigation concluded: Staff was neglectful in this situation.

FEBRUARY 2007

(Incident #003)—Staff observed a discoloration on the left calf of a woman who resides at BSDC. In an internal BSDC investigation, the investigator questioned whether she received this "bruise" while staff was "holding her down to change her brief." The investigation concluded: Staff did not neglect or abuse her in receiving this injury. The investigation did not have a conclusive explanation as to how she acquired the injury.

(Incident #004)—BSDC conducted an internal investigation when a web moderator of a website contacted Nebraska Department of Health and Human Services and reported that a woman was posting on her website and reporting about abuse and neglect of people who receive services at BSDC. The staff member writing on this website talked specifically about two people being abused by staff members. The staff member alleged two other staff members were propping a chair in front of a woman's door so they would be alerted if she attempted to leave her room. Another allegation stated that staff would sit on a woman in order to "calm her down." A third allegation stated that a woman woke up upset and the staff "dealt with" her. BSDC investigation concluded: Abuse occurred in posting this information on a website, failing to report verbal abuse, and for propping a chair in front of a woman's bedroom door.

(Incident #005)—A BSDC staff person wrote in a web-based "journal" that she felt like killing a woman who resides at BSDC. She also called this woman a "psycho lady" in the journal. These statements by the BSDC staff person were posted on a website. Also this woman who receives services from BSDC was wrapped up in her blanket to the point that she was not allowed to free her arms. BSDC investigation concluded: Abuse on the part of staff members that were restraining her with the blanket.

(Incident #006)—A woman who resides at BSDC was grabbed without a gait belt and roughly placed in her wheelchair by a staff member. She fell to the floor and injured her lower right leg and left ankle. BSDC investigation concluded: Staff member physically abused her.

MARCH 2007

(Incident #007)—A man who resides at BSDC has a doctor's order for the use of a mechanical lifting device when making transfers from one surface to another. The method the staff used was a method that was taught in staff orientation. BSDC investigation concluded: Staff did not neglect him when they transferred him without a lift. The investigation also noted the reporting staff member did not like the staff member she was alleging used the improper lifting methods.

APRIL 2007

(Incident #008)—A man who resides at BSDC was found to have a fractured arm. One staff member reported seeing another direct care staff member transferring him without the use of the doctor-ordered mechanical lift. The reporting staff member was concerned about whether this may have caused his broken arm. BSDC investigation concluded: Neglect did take place.

(Incident #009)—A man who resides at BSDC was assigned one-on-one supervision for sexually inappropriate behaviors, physical aggression, and property destruction. He reported on this night he was able to roam freely around the residence. Instead of providing supervision, the direct care staff played a card game leaving several people unsupervised. BSDC investigation concluded: Staff was neglectful in failing to supervise.

(Incident #010)—Staff was required to provide 30-minute checks on two men who reside at BSDC while they are asleep. These checks are the result of a previous incident in which one of the gentlemen sexually assaulted the other. A direct care staff member documented that she conducted the checks when she did not. BSDC investigation concluded: She had neglected the men.

(Incident #011)—A man who resides at BSDC reported to staff that he was sexually assaulted by a peer the night before in his bathroom. The aggressor in this situation had been assigned one-on-one supervision, but was not being adequately supervised. The man who was assaulted was to have staff check on him every 30 minutes

while he was asleep, however this did not happen. The BSDC investigation showed that while the alleged assault took place, staff members were playing cards at a table. BSDC investigation concluded: A "sexually inappropriate" act took place. However, the investigation could not determine whether or not the act was consensual or an act against the man's will. The investigation found that the staff did neglect this man. The report further concluded that if staff had provided appropriate supervision, the incident would have been interrupted or prevented.[46]

(Incident #012) April 7, 2007—A man who resides at BSDC fractured his right humerus. Staff noticed him refusing to eat and that he complained of pain in his arm. He was taken to the Beatrice Community Hospital where a doctor found that he had fractured his right humerus most likely through blunt force trauma. In an internal investigation, BSDC was unable to find documentation or reports from staff or the man that provided information of the blunt force trauma that could have caused his fracture. BSDC concluded: There was no abuse or neglect. The man is non-verbal and could not participate in the investigation.

(Incident #013) April 12, 2007—A staff member pushed a man into the wall and was also seen "teasing" the man by attempting to take his food from his plate. The same staff member had been accused of physically abusing him three other times in the past nine months. In the previous three investigations, the staff member was not found to be physically abusing the man. BSDC investigation concluded: Staff member did abuse him both physically and mentally in this incidence.

(Incident #014)—A staff member at BSDC held a man's head back against the headrest of his wheelchair, forced a spoon into his mouth, and held a washcloth over his mouth to prevent him from spitting out his medication. While she did this, she stated, "You're not going to do this to me." Two other staff members observed this incident, but did not immediately intervene or report it to appropriate personnel. BSDC investigation concluded: Staff member administering the medication was physically and verbally abusive to the gentleman. The other two staff members were found to have neglected him by failing to intervene and appropriately report the abuse.

(Incident #015)—A woman who resides at BSDC requires enhanced supervision when food and liquids are present. She has a G-tube and it could be life-threatening if she ingests food or liquids. During mealtime, a staff member was initially providing appropriate supervision. The staff member was then called upon to assist with another task and focused her attention elsewhere. When she turned her attention back, the woman was ingesting a cup of gelled liquids. BSDC investigation concluded: Staff member neglected her.

[46] NAS disputes the BSDC investigator's characterization of sexual assault of an individual at BSDC as a "minor" injury. Such a characterization reflects, in the judgment of NAS, continued social devaluation of individuals at BSDC. See Osburn, An Overview of Social Role Valorization theory 1(1) The SRV Journal 4, 4-5 (2006).

(Incident #016)—A man who resides at BSDC experienced multiple fractures to his left great toe when a door on his wardrobe unit fell on it. The man's father had sent replacement hinges to BSDC; however, six weeks later, when the incident occurred, the hinges had not been attached. BSDC investigation concluded: Staff was neglectful in not ensuring that hinges to the wardrobe were replaced.

(Incident #017)—A non-verbal woman who resides at BSDC moved off the toilet and a staff member noticed she left blood on the toilet. The staff member checked her genitalia and found a one-inch laceration on the inside of her left labia. The non-verbal woman was first seen at the BSDC Outpatient Clinic and then sent to the Beatrice Community Hospital which concluded that the injury was a suspected mechanical trauma. BSDC staff reported to the hospital staff that this woman with a disability sits down with a "plop" on the toilet seat. BSDC investigation concluded: No abuse or neglect on the part of BSDC staff. This non-verbal person with a disability was not able to participate in the investigation.

MAY 2007

(Incident #018)—A man who resides at BSDC was required to wear a one-piece pajama due to a history of chewing on his colostomy bag. One staff refused to comply with this requirement due to the difficulty of dressing him in the one-piece pajama and her concern that this would also restrict him from masturbating. BSDC investigation concluded: Staff member was found to have neglected this man.

(Incident #019)—A man who resides at BSDC left his home and was found at an apartment complex adjacent to the BSDC campus 20 minutes later. He is required to have one-on-one supervision. He also has a Wanderguard for elopement issues. The staff members were not supervising him appropriately at the time of the incident. The alarm went off when he opened the door and staff was unable to turn off the alarm as they did not know the code. BSDC investigation concluded: Staff neglect for not providing appropriate supervision.

(Incident #020)—A man who resides at BSDC was found to have a swollen and bruised left foot during his evening bath. When X-rays were performed it was discovered that he had a fractured left foot. The way in which he fractured his left foot is unknown. BSDC investigation concluded: Staff was not found to be neglecting him; however, the investigation did note that a similar unknown injury took place with his roommate.

(Incident #021)—A man who resides at BSDC was under routine supervision, meaning that staff was not required to provide any further supervision during meals. He has a G-tube and it can be life-threatening if he ingests food or liquids. He ingested a ¼ glass of grape juice. BSDC investigation concluded: Staff did not neglect him; however, the supervision level was changed to one-on-one when foods or liquids are present.

(Incident #022)—A man who resides at BSDC was placed in an unapproved Mandt hold by a security guard and a staff member. During this incident, staff that were aware that the guard and a staff member were using inappropriate techniques failed to intervene and stop the hold. The security guard had received advanced training in Mandt and still was not aware of the inappropriateness of his technique. BSDC investigation concluded: Staff had abused the man in the use of the unauthorized Mandt hold. The investigation also showed that staff had neglected him when they did not intervene upon discovering the guard was using inappropriate techniques.

(Incident #023)—A man who resides at BSDC received seven different medications that were prescribed for a peer in his home, as well as his own prescribed medication. The staff member who administered the medication was highly frustrated that evening. The man was admitted to Outpatient Clinic and monitored for the evening. His blood pressure fell to 70/40 as three of the medications mistakenly given were for high blood pressure. BSDC investigation concluded: Staff member neglected the man.

(Incident #024)—A woman who resides at BSDC was seen outside at the end of the sidewalk without supervision. She was discovered to still have her napkin tucked into her shirt and her spoon from lunch. She was to be on "enhanced supervision" within sight of staff at all times. Staff members at her home were not aware that she was gone. BSDC investigation concluded: Staff neglect for not providing appropriate supervision and the Team Leader was cited for not reporting the incident as an incident of abuse or neglect.

(Incident #025)—During a BSDC internal investigation, three separate issues were reported to Human Resources:

1. A direct care staff member had reported another staff member had been sleeping on third shift.
2. A man who resides at BSDC made a suicidal verbalization and a direct care staff member asked to call the psychologist on duty to talk to him. The psychologist replied that he would not talk to the man because the man was being "manipulative."
3. A man who resides at BSDC made a homicidal verbalization. When the direct care staff member called the manager for assistance, the manager told her to "take care of it yourself."

BSDC investigation concluded: Neglect took place regarding the staff member sleeping on third shift, but that there was no neglect in the other two incidences.

(Incident #026)—A man who resides at BSDC pinched another resident. BSDC conducted an internal investigation. The report included the name of the staff member who was assigned to supervise the man. The investigation concluded: Staff member listed to have neglected the man was not at work at the time in question, thus neglect did not take place. The investigator did conclude, however, that the direct care staff member in the man's home did not know who they were supervising and what the supervision requirements were.

(Incident #027)—A man who resides at BSDC was scheduled to have dental work done under general anesthesia. The procedure was explained to his guardian at a team meeting before the procedure was performed. His guardian (mother) was aware that one tooth may have to be pulled and numerous cavities filled. During the procedure, the dentist determined that it would be more beneficial to pull three teeth. The dentist then stopped the procedure to allow the man's social worker to contact his guardian for consent to pull more teeth. When the social worker was unable to contact the guardian, she contacted the guardian's husband (the man's father), whom the social worker believed was a co-guardian. The husband granted consent, however, he was not the co-guardian. The guardian called after the procedure and reported that she would have not given consent to pull three teeth. BSDC investigation concluded: The social worker neglected the man by not obtaining appropriate consent from his guardian.

(Incident #028)—A woman who resides at BSDC injured her hand when she engaged in self-injurious behavior of hitting herself on her head with her hand. She was to receive one-on-one supervision within five to eight feet when the incident happened. BSDC investigation concluded: Shift manager neglected her by not having appropriate safeguards in place.

(Incident #029)—A woman who resides at BSDC injured her back when she was pushed by another resident. A BSDC internal investigation showed that after this incident occurred, the other resident was placed on visual supervision by the Treatment Unit Manager. This manager failed to inform the staff of the change in supervision level, which meant that appropriate safeguards were not in place to prevent future incidences. BSDC investigation concluded: The manager neglected both of these women.

JUNE 2007

(Incident #030)—A woman who resides at BSDC was found walking around outside her work area. The staff member assigned to her had just finished feeding her through her feeding pump. After eating, she lay down for a nap and the staff member went to do paperwork in the office. This woman is ordered not to lie down for 30 minutes after eating via her feeding pump. BSDC investigation concluded: Neglect did not take place due to a shift change and uncertainty of who was assigned to her at the time she eloped.

(Incident #031)—A woman who resides at BSDC was being "buddy lifted" by two staff members from the commode to her bed. While making this transfer, she hit her head on her headboard causing a one-inch red area on her head. BSDC investigation concluded: Neglect due to her requiring the use of a mechanical lift for all transfers.

(Incident #032)—A man who is non-verbal and resides at BSDC had been participating in activities at the Carston Center on the BSDC campus. While in the gym at the Carston Center, he reached for a metal electrical outlet. A staff member responded by pushing the man's arm down with her foot. When he removed his hand from the outlet, it was deeply cut and covered in blood. He required emergency surgery at Bryan LGH-

West in Lincoln to repair a lacerated tendon in his long finger and a laceration on his index finger. At the time BSDC conducted an internal investigation, it was not certain whether he would regain full use of his long finger. BSDC's investigation concluded: Staff member physically abused this man. The investigation further concluded that another staff member neglected him, as she had his supervision card at the time and was not providing him with appropriate supervision.

(Incident #033)—A woman who resides at BSDC was eating a grilled cheese sandwich that was cut up into bite-size pieces per her dietary requirements. While she was eating, she began choking, lost consciousness, and required the use of the Heimlich maneuver. Staff members called 911 and began CPR as they were unable to dislodge the food in her throat. A physician's assistant was able to suction out the food from her throat. BSDC investigation concluded: Neglect did not take place as the food was cut as required and staff responded appropriately to the medical crisis.

(Incident #034)—A man who resides at BSDC had an ileostomy bag that had come open and needed to be changed. None of the staff members on duty were trained to do this task, and the nurse was called. While waiting for the nurse, one staff member assisted the man to a bathroom stall, helped him remove some of his clothing, and left him on the toilet, unsupervised for 30 minutes. When the nurse found him, he had feces all over his body, his clothing, and the bathroom stall. BSDC investigation concluded: Staff members on duty neglected this man in not helping him to clean up even though they could not provide direct assistance with the ileostomy bag.

(Incident #035)—A man who resides at BSDC was discovered unsupervised outside in his wheelchair by a staff member from another area. It is unclear how long he was outside without supervision. The staff member that was assigned to him was required to know where he is at all times, as he likes to leave his home. BSDC investigation concluded: Neglect did take place. The staff decided to give permission for him to use a Wanderguard. This is the fourth time he has left without supervision since January 1, 2007.

(Incident #036)—A man who resides at BSDC was assaulted by a staff member when the staff member was trying to restrict his access to food in the kitchen. The staff member was told to "keep him out of the kitchen" due to a history of his "stealing food." As he attempted to get into the kitchen, the staff member pushed him out of the way causing him to fall back and hit his elbow. BSDC investigation concluded: Staff member physically abused him.

(Incident #037)—A man who resides at BSDC is required to have enhanced supervision for a history of elopement and sexually inappropriate behavior. He left his home and was unsupervised for 15 minutes. Enhanced supervision requires knowing where he is and what he is doing at all times. He had been placed in Mandt holds two times before this for behavioral incidences. BSDC investigation concluded: Staff did not neglect him. The investigator notes that as soon as the staff member realized he was not around, the staff member began looking for him.

(Incident #038)--A woman who resides at BSDC was left in her bed, unsupervised, while all the other residents and staff went to the Carsten Center for activities. A housekeeper came around to clean and discovered that she was left on the unit by herself. When the staff at the Carsten Center realized they had left her on the unit alone about 30 minutes had elapsed. BSDC investigation concluded: Staff was neglectful in failing to supervise. An Acting Team Leader was also found to be neglectful when he did not respond appropriately when it was discovered that this woman with a disability had been left at the unit.

(Incident #039)—A manager from Beatrice Supermarket reported that a staff member flicked a man who resides at BSDC on the head and overheard the staff member tell him to "shut up." BSDC investigation concluded: Staff member verbally abused him, but did not physically abuse him. The staff member provided an "explanation" as to why the manager at the supermarket may have seen what looked like her "flicking" the man's helmet.

(Incident #040)—A woman who resides at BSDC had bruises on her arm after a peer bit her. BSDC investigation concluded: Both women were receiving appropriate supervision and appropriate safeguards were implemented after the incident. No abuse or neglect was found.

(Incident #041)—A man who resides at BSDC was receiving assistance with bathing from a direct care staff member. The staff member realized that she had forgotten the mechanical lift and went to retrieve it, leaving the man unsupervised in the bath. He is required to have one-to-one supervision while bathing because he may "jump or throw himself" while in the bathing device. BSDC investigation concluded: Staff member did not neglect him and that it was not clear in the on-call documentation that he was not allowed to be left unsupervised.

(Incident #042)—A man who resides at BSDC was walking toward a staff member who put her feet up to block his path. The staff member told him to "get away from me" and made physical contact with him with one of her feet. BSDC investigation concluded: Staff member physically and verbally abused him.

(Incident #043 and Incident #044)—Two men who reside at BSDC reported similar incidences during group therapy that staff had elbowed them and were disrespectful. Both incidences included allegations of staff excessively restraining them in some way. BSDC investigations for both incidences concluded: Physical abuse did not take place. However, both investigations did note that a staff member accused of abusing these men had eight allegations of abuse or neglect from five different individuals during his employment at BSDC.

(Incident #045)—A man who resides at BSDC reached out and grabbed and pinched a peer's arm. He was to be provided one-on-one supervision within five feet. He needed this level of supervision because of past incidences of aggression toward others. BSDC investigation concluded: Staff had neglected him because they were not providing the appropriate level of supervision at the time of the incident.

JULY 2007

(Incident #046)—A woman who resides at BSDC was placed in her bed in the early evening while two staff took other residents to an outing. The other staff that stayed behind did not check on her while she was in bed. When she was finally checked almost five hours later, she was found to be soaked in urine (including her clothes, blankets, and mattress). BSDC investigation concluded: Staff neglected her.

(Incident #047)—A direct care staff member reported observing another staff member falling asleep on second shift. The staff member who fell asleep was holding a supervision card for a man and was required to be within five to seven feet because of his aggressive behavior. BSDC investigation concluded: Staff member neglected him and all other people who live in that home. The reporting staff member was also found to have neglected the people she served because she woke the other staff member up about five times before reporting the neglect.

(Incident #048)—BSDC conducted an internal investigation to examine a Team Leader's failure to report an incident of peer-to-peer violence and failure to implement safeguards to prevent further incidences of violence. BSDC investigation concluded: Team Leader neglected the two people involved in the incident in the failed responsibilities of reporting and implementation of safeguards.

(Incident #049)—A direct care staff member was supervising 11 people when an investigator approached the group because of her concern that a man was attempting to harm himself. When the investigator approached the staff member about the situation, the staff member was aggressive and hostile. BSDC investigation concluded: The direct care staff member was not neglecting the people under his supervision and the investigator was reprimanded for approaching the situation like she did.

(Incident #050)—A man who resides at BSDC reported that he injured his back when a staff member pushed him off his bed. BSDC investigation concluded: Staff member did not assault him and the injury took place when he fell off of his bed onto a plastic container. The investigation did note that the staff member has had five allegations of abuse and neglect in the last year. The staff member was found to have verbally abused other people who reside at BSDC and had shown disregard for another person's dignity and respect.

(Incident #051)—A man who resides at BSDC grabbed a gelled cup of tea while out of staff supervision. He was previously placed on one-to-two supervision while in the presence of food and liquid, allowing for staff to immediately intervene. He has a G-tube and is not allowed to have food or liquids. Staff had not passed out supervision cards at the beginning of the shift and only passed them out when this incident took place. BSDC investigation concluded: He was neglected.

(Incident #052)—A direct care staff member reported to her supervisor that she overheard a Social Worker talk to a woman who resides at BSDC in a disrespectful way. The staff member stated that she heard the Social Worker talk in a similar fashion days before. BSDC investigation concluded: The Social Worker did not verbally abuse the woman, as it was clearly stated in her Behavioral Modification Plan to use a stern voice with her. The staff member was reprimanded for not making a report sooner, as she stated she had heard a similar interaction several days before.

(Incident #053)—A woman who resides at BSDC was allowed to go to the beauty shop unsupervised when her supervision level was such that she required someone to go with her. When staff realized that she went without supervision, a direct care staff member went to sit with her and walk her back to her home. BSDC investigation concluded: There was no neglect, as there was a meeting taking place at this time that changed her supervision requirements. This change would allow her to travel independently.

(Incident #054)—A woman who resides at BSDC was placed in mechanical restraints without the authorization of the Qualified Mental Retardation Professional (QMRP). The BSDC staff person made two phone contacts with the QMRP and thought she had authorization to place this woman with a disability in restraints. The BSDC investigation concluded this staff person had abused/neglected her in not receiving appropriate authorization. [47]

(Incident #055)—A woman who resides at BSDC was discovered in the kitchen eating corn chips. She has a G-tube and is not able to have food or liquids. The staff member that was assigned to her care put her to bed, completed his paperwork, and left without letting other staff know that he was leaving. Monitoring devices that were to alert staff to her movements were not in place. BSDC investigation concluded: Staff member assigned to this woman was negligent.

(Incident #056)—A non-verbal woman who resides at BSDC was discovered to have bruising on her left arm. Staff took her to the Beatrice Community Hospital and she received x-rays. It was determined that she had a fracture of the surgical neck of the left humerus and a fragment fracture of the humeral head. Hospital staff described the injury as a "shattered shoulder caused by blunt force trauma." BSDC investigation concluded:

[47] CMS surveyors cited state officials at BSDC in 2006 for misuse of mechanical and chemical restraints. See CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 09-29-2006) (1-413) 301-303, 315-327.

Undetermined cause of injury. BSDC staff was not found to be abusive or neglectful to the non-verbal woman with a disability who could not participate in the investigation.

(Incident #057)—A 76 year old woman who resided at BSDC died while in their care. BSDC staff had assisted her to bed after her evening snack. While eating her snack, she vomited approximately two cups of kool-aid but was able to get up and go to bed. She had a history of reflux and had 12 incidences of reflux from March 2007 to July 2007. After going to bed, staff heard a loud noise coming from her room, and upon entering found her on the floor unresponsive and not breathing. Staff contacted emergency personnel and began performing CPR. When EMS arrived they asked if there was a Do Not Resuscitate (DNR) order. A DNR order was found; however, a new guardian had been appointed in April 2007 and a new DNR had not been signed by the guardian. Life-saving measures were discontinued under an invalid DNR order. BSDC investigation concluded: The Social Worker in charge of the woman's care had neglected her by not having a valid DNR order. An autopsy is being completed at this time.

(Incident #058)—A staff member left for a break which left one staff member to supervise seven people. The women who live in the home require increased supervision levels at times. BSDC's internal investigation concluded that the staff member who left on break neglected the women in her care.

(Incident #059)—BSDC investigation of several people who reside at BSDC found various states of neglect by a third shift staff person. The staff person was found to have neglected these individuals even though he reported that they were all attended to during his shift.

- One person was found to have wet bedding and her brief partially off.
- A second person was found to have dried feces on him and his bedding (top sheet, fitted sheet, and comforter).
- The third person was found wearing a dry brief but his bedding was wet and there were soiled wipes on his bed.
- A fourth person had his brief under him and he was wet.
- A fifth person was found to have a wet spot on his bed that was the size of a basketball.
- A sixth person was found completely soiled in his brief.

(Incident #060)—A woman who resides at BSDC was found in the women's locker room having a seizure. She was on enhanced supervision-visual supervision during waking hours. When another staff member found her in the locker room, she was not being supervised. BSDC investigation concluded: The staff member assigned to her neglected her by not providing appropriate supervision.

AUGUST 2007

(Incident #061)—A woman who is non-verbal and who resides at BSDC went to the BSDC Outpatient Clinic for an examination when a staff member saw a red area in her pubic region. BSDC investigation concluded: Because she had a history of using objects, such as dolls for masturbating, this "may be the cause of injury" and that the staff did not abuse or neglect her. However, because she is non-verbal, she was not able to communicate what happened or how it happened, and thus she could not actively participate in the investigation process.[48]

(Incident #062) August 3, 2007--A man who resides at BSDC was discovered in his bedroom with a toothbrush covered in feces, feces on his tee-shirt, shorts, and bed sheets. He was transported to the Beatrice Community Hospital for an examination. He does not like doctors and the Emergency Room doctor told the staff to take him home as it was too much of a "hassle" to try and examine him. During the BSDC investigation, staff reported that the man has a history of inserting his fingers in his rectum. BSDC investigation concluded: He was not sexually assaulted and that he inserted the toothbrush into his own rectum. BSDC staff was not found to have neglected this man with a disability because supervision was being provided.[49]

(Incident #063)—A staff member reported overhearing another staff member call a man who resides at BSDC a "freak" and said, "fuck you" when the man said he did not want to go to bed. BSDC investigation concluded: Verbal abuse did take place. During the investigation, the reporting staff member stated that she had overheard this same staff member verbally abuse people who receive services at BSDC in the past.

(Incident #064)—A man who resides at BSDC was discovered on the beginning of first shift with dried feces under his fingernails, covering his left hand, outside his briefs, on his sheet, surrounding his penis and scrotum, and matted to his pubic hair. A staff member reported that another staff member who was responsible for his care was "careless." BSDC investigation concluded: The staff member neglected the man in his care. The staff member responsible for him had previously been written up for three other work deficiencies. In these deficiencies, the staff member reported very similar situations of leaving people in soiled briefs.

(Incident #065)—A man who resides at BSDC was not taken to the restroom, checked, or changed for 5 ½ hours during first shift. His clothes were wet with urine and he had feces coming out of his briefs. The staff member in charge of his home that day had just returned from a 5 ½ week suspension due to a finding of substantiated neglect on

[48] Although the facility was previously cited by CMS for its failure to ascertain the cause of the injury and the incident is marked as an "injury of unknown origin" the facility then compounds its initial deficiency by not initiating intervention measures to prevent it or similar injuries from occurring in the future. CMS found this failure to be in violation of federal standards as contained in the regulations. See CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 04-20-2007) (1-192) 2-3. CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 09-29-2006) (1-413) 43-72.

[49] It is logically impossible to claim that" appropriate" supervision of any kind would allow an individual in the care of the facility to insert a toothbrush into his rectum.

another person who receives services at BSDC. BSDC investigation concluded: Staff level of care was neglectful of the man's needs and "did not comply with ICF/MR level of care." Even though this was the staff member's second offense, the discipline involved "informal counseling" and she returned to work ten days later.[50]

(Incident #066) Incident Observed by NAS Case Advocate—A man who resides at BSDC was able to gain access to food when the staff member assigned to him turned around and was not providing appropriate supervision. The man is on a restricted pureed diet. He went to the refrigerator and was able to gain access to a whole pie, an onion, and one other item. The NAS Case Advocate observed two BSDC staff members assisting him to sit by forcibly pushing him down by his head. The NAS Case Advocate reported the staff actions to the BSDC supervisor of investigators. BSDC investigation concluded: Abuse occurred in this incident. One of the staff members who pushed him down by his head was returned to work with the consequence of having "informal counseling and teaching component."[51]

(Incident #067) Incident Observed by NAS Case Advocate—A man who resides at BSDC was talking with a staff member. He called the staff member a jerk and the staff member replied, "no, you're the jerk." The staff member engaged in similar interactions for about 15 to 20 minutes. The same man kissed a female staff person on the cheek and a male staff member told him that he was going to call her boyfriend and have him "kick his butt." The same staff member told the man that he was going to have the female staff's boyfriend "take care of him." The NAS Case Advocate observed the incident and reported the staff actions to the BSDC supervisor of investigators. BSDC investigation concluded: Staff verbally abused this man in both incidences.

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[50] BSDC has averaged nearly 100 vacant positions for months, necessitating significant overtime by existing staff and the shuffling of staff between residential units to cover for vacancies. Consequently, continuity of care in the implementation of individual habilitation plans has been severely compromised. Furthermore, from January 2007 thru August 14, 2007, 165 BSDC staff members were suspended pending investigations of allegations of abuse or neglect. Twenty-three (23) staff members have been suspended multiple times pending investigations. Investigators have substantiated abuse or neglect by 80 direct care staff or almost ½ of those investigations. Of those 80 direct care staff found responsible for abuse or neglect by BSDC's own investigators, ten percent (10%) have been found responsible multiple times. Investigations of abuse or neglect have been substantiated against 12 Team Leaders with two Team Leaders having multiple substantiations. Abuse or neglect has been substantiated against three nurses, the security chief, a treatment unit manager, a treatment team leader, and two social workers. *NAS Analysis of BSDC Staff Suspension from January 2007 to August 14, 2007.* NAS suggests that the chronic staff shortage preventing meaningful habilitation is also impacting on the extent of discipline imposed or not imposed by state officials at BSDC. State officials neither can suspend for long periods of time nor terminate repeat offenders without exacerbating the staff shortage crisis already approaching a meltdown. See N. Hicks, "Beatrice Center Staffing in Crisis", *Lincoln Journal-Star*, May 8, 2007.

[51] The lack of meaningful discipline for a staff member manifesting deliberate indifference, in the presence of the NAS staff, to the dignity of an individual entrusted to his care further illustrates the conundrum of state officials at BSDC due to the staff shortage, lack of adequate training, and a culture embedded with stereotypic and dehumanizing views of the individuals living there. See Osburn, An Overview of Social Role Valorization theory 1(1) The SRV Journal 4, 7-8 (2006); Mason and Menolascino, The Right to Treatment, supra at 135; See Wolfensberger (1976) The Origin and Nature of Our Institutional Models in R. Kugel and A. Shearer, eds., *Changing Patterns in Residential Services for the Mentally Retarded* (Washington, D.C.: President's Committee on Mental Retardation 1969) 63-143.

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(Incident #068)—A man who resides at BSDC was discovered to have eight broken ribs on September 6th when he was being treated for an upper respiratory infection. It was documented that on September 3rd he had fallen out of a Med Care sling while being transferred from his bed to a bath. At the time of the incident, he did not present any bruises or injuries and was seen by a nurse. He has a history of attempting to lunge out of the sling if he becomes highly excitable. BSDC investigation concluded: It was the doctor's opinion that the eight broken ribs were the result of a fall. The investigation reported that pictures were not taken after the fall in violation of BSDC Rules and Regulations. The man is non-verbal and was not able to participate in the investigation.

(Incident #069)—While in the stereo room with six residents, a staff member was found sleeping by another staff member. BSDC investigation concluded: None of the residents were receiving active treatment.

(Incident #070)—A woman who resides at BSDC reported to staff that another staff member raised her voice with her earlier in the day. The reporting staff member observed the other staff member at the elevator after the woman had reported the verbal abuse and questioned her about the woman's allegations. The staff member then raised her voice and told the woman "if you are going to talk about it do it in front of her." The reporting staff member informed the other staff member that her comments were inappropriate. BSDC investigation concluded: The staff member was "stressed due to working massive amounts of overtime."

(Incident #071)—A woman who resides at BSDC was fed via G-tube by a staff member who was not authorized or trained to hook up and administer nourishment through the G-tube. Another staff member observed this and reported the incident. During BSDC's internal investigation, this staff member informed the investigator that he had been allowed to do the same procedure at 207 Kennedy. This information was not confirmed by any other staff members. BSDC investigation concluded: The staff member's actions constituted neglect.

(Incident #072)—A staff member returned from an extended break due to working both first and second shifts on this day. The staff member was supervising five people, and before she left, asked to have another staff member take over their care. The staff member was gone from 1500 to 1615. When she returned, none of the residents had been changed, cleaned up, or readied for supper. A staff member found a woman to be wet with urine that had soaked through her clothes and had a loose bowel movement. A man was wet through his clothes and had to be changed. Another man had dried feces stuck on his bottom. He was also wet with urine and needed his clothes changed. BSDC's internal investigator noted that the three staff assigned at this time did not get along and had actually planned on retaliating against one another. BSDC investigation concluded: Although the residents had been neglected, their toileting assistance was within the established guidelines.

The examples above clearly evidence the continued departure from accepted professional standards of care at BSDC as required by federal regulations. NAS concludes that the chronic and persistent staff shortages are impacting the safety and habilitation needs of the residents. Direct care staff members are working massive amounts of overtime and double shifts. The inevitable consequence is that even basic sanitary needs of the residents at BSDC are being neglected to the detriment of their dignity.[52] The dehumanization of these vulnerable citizens has continued unabated despite promises by state officials to meet federal regulations.[xxi]

FINDING II

Nebraska State Officials Have Failed and Continue to Fail to Provide Active Treatment and Habilitation for Residents with Developmental Disabilities at the Beatrice State Developmental Center in Deprivation of Their Constitutional Rights.

As a result of our ongoing investigation, Nebraska Advocacy Services (NAS) has determined that certain conditions and practices at the Beatrice State Developmental Center (BSDC) violate the constitutional and federal statutory rights of citizens who live at the facility. Specifically, people who live at BSDC have a constitutional right to receive adequate care, training, and habilitation. The level of harm and violence for residents living at BSDC continues to escalate as a consequence of historically chronic staff shortages, inadequately trained staff and lack of professional assistance at the facility. On a weekly average, over 100 direct care staff positions remain unfilled at BSDC. This persistent reality impacts not only the immediate safety issue, but also the ability of state officials to provide active treatment, which requires a continuous process

[52] Repeatedly, individuals at BSDC are being found soaked in urine and covered with feces due to the staff's inability to meet their basic sanitary needs. See: **(Incident Case #064)**—Individual found with dried feces underneath his fingernails, outside of his briefs, on his sheet, and covering his penis and scrotum, and matted in his pubic hair; **(Incident #065)**—Individual found soaked in urine and feces coming out of his briefs because responsible staff let him sit for 5 ½ hours; **(Incident #072)**; **(Incident # 034)**—Individual found smeared with feces after being left unattended on toilet for 30 minutes by staff.

for the development, implementation, monitoring, assessment, and modifying of behavior interventions.

Consequently, people who live at BSDC are neither being properly supervised nor receiving appropriate habilitation.[53] Citizens living at BSDC are denied their right to live in reasonable safety and to receive adequate habilitation to ensure their physical safety, freedom from physical injury, freedom from unreasonable restraint, prevention of regression and assistance in the exercise of their protected liberty interests.[54] In general we find that:

- The facility fails to provide a system of active habilitation that includes adequate assessments; developing, implementing, and monitoring individual programs; or encouraging an individual's choice and self-management.

- Citizens residing at BSDC do not receive consistent, continuous training to acquire behaviors necessary to function with as much self determination and independence as possible and to prevent regression or loss of current optimal levels of functioning.

- In the exercise of BSDC's obligation to teach and develop self-help skills such as eating, bathing, toileting, dressing, and cleaning, the actual practices at BSDC mirror a "convenience for staff" approach rather than meeting the individual needs of those living at BSDC:[55]

    - For many residents there is no selection of food.
    - Plastic utensils for eating are mandatory.
    - Bibs are tied around residents instead of napkins being available.

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[53] Medicare and Medicaid regulations require facilities housing and treating residents with developmental disabilities to protect them from harm, to provide adequate staffing, and to protect them from abuse. 42 C.F.R.§ 483.420 (a) (5) (requiring that the facility "ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment."); 42 C.F.R. § 483.430 (d) (1) (requiring facilities to provide sufficient direct care staff to manage and supervise residents); 42 C.F.R. §483.440 (a) (1) specifies the requirements for an active treatment program.

[54] See, e.g. *Youngberg v. Romeo*, 457 U.S. 307, 322 (1982) (Persons with developmental disabilities residing in State institutions have a constitutional right to "minimally adequate training."). An essential component of habilitative treatment for persons with developmental disabilities is the regular provision of activities designed to help them develop new skills and practice skills already learned. 42 C.F.R. § 483. 420 (6) (requiring that facilities "ensure that clients are provided active treatment to reduce dependency on drugs and physical restraints."). See generally, Title XIX of the Social Security Act, 42 U.S.C. § 1396; 42 C.F.R. § 483 Subpart I (Medicaid Program Provisions).

[55] CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 09-29-2006) (1-413) 223-233; 251-255. The CMS surveyors documented the failure of BSDC to develop programs to address the basic needs of over 20% of residents in sample. Id.

- For many, their food is served on Alladin trays from the central kitchen.[56]
- Those that attend the serving line have their food placed on their trays.
- Personal snacks remain locked and unavailable without staff assistance.
- Laundry facilities remain locked.
- Many incontinent residents do not have toileting programs in their Personal Plan Review/Modification Sheet (PPR/MS).[57]
- Their sanitary and hygienic needs remain unmet.

The Center for Medicare and Medicaid Services (CMS) survey report of October 2006 found that the Beatrice State Developmental Center (BSDC) and state officials had departed from federal regulations in **seven out of eight critical areas** (emphasis supplied) that impacted directly on the lives of all residents living at the facility. Two of those areas are related to the repeated failure of state officials to protect BSDC residents from harm[xxii] while the remaining five are related to the failure of state officials to provide habilitation that met constitutional standards.

1. **Facility Staffing:** BSDC was found in violation of 42 C.F.R. § 483.430. An asterisk (*) by the finding indicates that CMS identified the violation has having the potential to impact all residents living at BSDC. Specifically:

- State officials failed to ensure sufficient numbers of trained and knowledgeable staff to design and carry out the residents' programs and to ensure the health and safety for residents at the facility.*

- State officials failed to ensure that staff was trained and knowledgeable regarding the necessary training and supports for the residents with whom they work.*

- State officials failed to provide sufficient trained direct care staff to manage and supervise residents with their Individualized Program Plans (IPPs).[58] *

[56] In April of 2007, CMS surveyors found that on four of the residences BSDC was not meeting the federal regulations that the facility prepare a palatable, attractive and well-balanced diet. CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 04-20-2007) (1-192) 170-173.

[57] 42 C.F.R. 483.440 (c) (6) (iii) requires that the individual program plan include training for those individuals who lack the personal skills essential for privacy and independence, (including but not limited to toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs) until it has been demonstrated that the client is developmentally incapable of acquiring them. See CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 09-29-2006) (1-413) 223-233; 251-255.

[58] CMS survey October, 2006. Id. 144-145; 162-168; 168-187. CMS surveyors detailed the devastating consequences that the staff shortages at BSDC have for the individuals living there. Safety and health is jeopardized

- Qualified Mental Retardation Professionals (QMRPs) failed to ensure that residents received necessary service and supports.*

- QMRPs failed to ensure appropriate staff participation in the development of IPPs for the residents they serve.*

- QMRPs failed to ensure that residents were integrated into the community and that active treatment programs were developed, implemented and monitored to assure active habilitation for each person.[xxiii] *

- Registered dietician and vocational staff failed to attend annual planning meetings for the residents and necessary nutritional assessments went undone.[xxiv] *

- Residents were denied adequate vocational training to ensure community integration and to ensure overall active treatment.*

- Professional program staff is regularly not available after normal working hours to assist or provide guidance to direct care staff.

- Professional staff (such as vocational specialists and licensed nutritionists) often does not participate in development of program plans for the people living at BSDC.

As a result of a chronic shortage of minimally trained direct care staff coupled with an increasingly greater number of people living at BSDC who require significant behavioral interventions has created a setting in which harm and the risk of harm have risen exponentially.

2. **Active Habilitation:** CMS surveyors also determined that BSDC was in violation of 42 C.F.R. § 483.440 in that state officials failed to provide a program of consistent, continuous, and aggressive training for residents at the facility that potentially affected all BSDC residents. State officials did not and cannot meet the very justification for the continued confinement of individuals at BSDC.[xxv] Specifically, CMS surveyors found that state officials had failed to:

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daily and programs so necessary for habilitation exist either only on paper or are run occasionally and haphazardly. Id. 168-187; 188-215.

- ensure the participation of professionals in the development of individualized plans for residents, impacting on nutritional and health needs;

- ensure that residents attend quarterly mental health treatment program reviews or interdisciplinary team meetings;

- ensure that the Individual Program Plans (IPPs) truly reflect the individual needs of the residents;

- complete functional analyses of maladaptive behaviors to ascertain the causes of aggressive or self-injurious behaviors ; and

- assess restrictions or monitor restrictions on client's freedom of movement within the institution, access to personal items, food, snacks, cleaning, and medications.[xxvi]

3. **Behavior Management:** One consequence of the failure to provide active treatment is that the maladaptive behaviors of the residents escalate, creating a downward spiral into greater chaos and violence within the facility. This downward spiral is evidenced by the unfettered growth of institutional deficiencies and failures to meet accepted professional standards of care in violation of the federal regulations, as documented in the CMS surveys of the facility from 2001 through 2007.[59] CMS found BSDC to be in violation of 42 C.F.R. § 483.450 in that state officials failed to ensure that techniques to manage inappropriate behaviors by residents were an integral part of their individual program plans and were employed with sufficient safeguards to prevent injury to clients. This systemic failure by state officials had an impact on all residents at the facility.[xxvii]

[59] In assessing whether a departure from accepted professional standards of care has occurred, it is appropriate to look to the opinions of experts and, where available, national standards and applicable regulations. Thus, accepted professional standards of care may be found by considering the regulatory standards or requirements such as those found in 42 C.F.R. § 483 Subpart I (Medicaid Program Provisions). Consequently, BSDC's continued failure to meet those standards and be forced to continually develop plans of compliance which later are not fulfilled raises a *prima facie* case of a substantial departure from accepted professional standards of care under the *Youngberg* v.*Romeo* supra, decision.

In addition, CMS surveyors found that state officials did not have policies and practices in place to:

- identify the use of restrictive interventions from the least intrusive to the most intrusive[xxviii] *;

- ensure that physical and mechanical restraints were used with sufficient safeguards so as to prevent injuries to clients. **This egregious failure resulted in a finding of immediate jeopardy**[xxix] *;

- ensure that the use of physical and mechanical restraints and drugs were an integral part of the resident's IPP and intended to lead to less restrictive means of managing behaviors; and

- develop plans to reduce dependence on behavior controlling drugs for significant numbers of residents.[xxx]

Specifically, NAS finds that:

- Crucial behavior management plans (BMPs) are:
  - delayed in development
  - often not followed by direct care staff
  - inappropriately altered by the practice on the living unit, and
  - neither reviewed nor modified when interventions have not been successful. [xxxi]

- Functional analysis of maladaptive behaviors is not contained in treatment plans to ascertain causes of aggressive or self-injurious behaviors.[xxxii]

- Mechanical restraints are regularly and excessively employed against residents with BMPs in contravention of both the BMP and the IPP (Individual Program Plan).

- The facility fails to ensure that restrictive interventions are not used for convenience of the staff.

- Staff is inadequately trained in Mandt techniques to ensure appropriate use of the physical and mechanical restraints so as to protect the individual residents from injury.[60]

[60] 42 C.F.R. § 483.420 (a) (5) requires the facility to ensure that residents are not subjected to physical, verbal, sexual or psychological abuse or punishment. The CMS most recent investigations in 2006 and 2007 have conclusively and unequivocally found that individuals at BSDC have been repeatedly subjected to physical, verbal and sexual abuse. See CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 09-29-2006) (1-413) pgs 89-103; Staff are uncertain as to time durations of Mandt holds. Id. 182, pgs. 106-145; CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 04-20-2007) (1-198) pgs 25-31; 59-105.

Consequently, the facility was found to regularly use restrictive measures as a convenience for the staff[xxxiii].

4. **Medical Services:** BSDC was also found to be in violation of 42 C.F.R. § 483.460 in the ability to provide basic medical, nursing and dental services to the residents who live at the facility. Specifically, state officials failed to:

- provide an emergency level of care beyond the ability of the out-patient clinic;
- provide an annual comprehensive dental examination for some of the residents;
- medically examine residents after allegations of rape or sexual assault pursuant to accepted medical protocols;
- instruct residents in skills leading to self-administration of medications; and
- implement a system to actively prevent possible infection from communicable diseases.[xxxiv]

5. **Nutritional and Dietary Needs:** CMS surveyors also found that BSDC was in violation of 42 CFR § 483.480 in that state officials had failed to:

- consistently follow the physician ordered therapeutic dietary plans;[xxxv]
- consistently provide therapeutic diets to meet each resident's nutritional needs;
- serve food to residents at appropriate temperatures within a reasonable time period;
- ensure each resident received food liquids that were at the consistency that each resident needed and only to the extent required;
- provide residents with adaptive eating equipment and train residents on the use of adaptive eating equipment;
- teach residents commensurate with their functional level eating skills; and
- provide residents an opportunity to participate in family style dining.[xxxvi]

During surveys conducted in April of 2007, CMS surveyors found, as they had six months earlier, that BSDC again failed to meet the requirement of § 1905 (d) of the Social Security Act and substantially departed from the accepted professional standards of care established in federal regulations for intermediate care facilities for the mentally retarded (ICFs/MR). Even though state officials had submitted and CMS had approved a Plan of Correction, the current conditions at BSDC were found to violate federal regulations necessary to meet the constitutional obligations of state officials to provide habilitation to the residents living at BSDC.[xxxvii]

BSDC was found to be in violation of 42 C.F.R. § 483.440, in that state officials again had failed to:

- provide a program of consistent, continuous, and aggressive training for residents at the facility;
- meet the very justification for the continued confinement of citizens at BSDC;[xxxviii]
- ensure that each resident received necessary assessments, program development, and program implementation[xxxix] from staff knowledgeable to provide support and services to each resident;[xl]
- provide residents formalized training in money management, vocational services and self-help or basic personal cares and skills which impeded any opportunity for BSDC residents to transition to a less-restrictive community program;[xli]
- assess the need to restrict residents' access to items in their living units based on a functional analysis of resident behavior, including the need for refrigerators to remain locked on living units;[xlii] and
- develop Individual Program Plans (IPPs) that contained program objectives to meet the needs of the residents.[xliii]

In fact, CMS found that staff was allegedly documenting programs as being followed while the individual residents claimed to be participating were observed sleeping by CMS surveyors.[xliv]

As they had six months earlier, CMS surveyors in April 2007 documented continued deficiencies in the medical and dietary care of BSDC residents including the failure to: provide needed dental services; train residents in self-medication; prepare and serve palatable and well-balanced meals; and consistently provide the therapeutic diets as planned.[xlv]

A majority of residents at BSDC have a history of exhibiting challenging behaviors, such as aggression and self-injury.[61] The CMS survey reports of BSDC for October 2006 and April 2007 clearly document that ineffective behavior management programs (BMPs) for residents at the facility have led to an increase in the use of restraints and injuries to the residents.[xlvi] NAS finds the BMPs for a significant number of people residing at the facility failed to:

- use positive reinforcement and are detrimental because they depart substantially from accepted professional standards of care;
- inform staff how relevant medical, medication, and psychiatric conditions affect the resident; and
- provide specific times and manners for professional and interdisciplinary team review, assessment and modification.[xlvii]

This departure from generally accepted professional standards by state officials in the development, implementation, monitoring, assessment, and review of BMPs was most evident at the following four living units at BSDC: 104 Kennedy[62], 108 Kennedy, 402 State, and 406 State.[63] Moreover, the shortage of five psychologists at BSDC since

[61]Nearly fifty percent (50%) of the individuals at BSDC are receiving medications to control injurious behaviors to themselves or others and over forty percent (40%) have significant behavioral needs requiring behavior program intervention.

[62] CMS surveyors reported that state officials at BSDC recently split 104 Kennedy into two separate units (102 and 104 Kennedy) in an attempt to deal with the significant problems and failures existing at 104 Kennedy. See BSDC Administrative Review of 104 Kennedy (Individual, Home or Day Environment) August 24, 2007.

[63] This conclusion is derived from a detailed review of individual incident reports at the Kennedy residential units by NAS and the NAS Chart of Incidents of Abuse/Neglect From January 2007-August 2007 (hereinafter NAS Chart) which depicts in spreadsheet fashion the monthly occurrence by living residence of the different types of

December of 2006 has had a drastic impact on the facility's ability to meet the habilitation needs of the residents who need BMPs. [64]

CMS surveyors found that state officials failed to develop BMPs that meet accepted professional standards of care. Specifically, state officials had again failed to:

- implement adequate and appropriate BMPs consistently and correctly for residents so as to meet minimum constitutional standards of habilitation;
- develop behavioral programs that adequately meet the needs of residents in a reasonable amount of time;[xlviii]
- provide sufficient numbers of appropriately trained staff to consistently implement the behavior plans;[65] and
- provide staff with adequate competency-based training to correctly and properly implement behavior programs.

As a result, citizens at BSDC are at continued risk of harm by not receiving treatment or habilitation that meets accepted standards of professional care.[66] Many BSDC staff members fail to demonstrate the level of competency necessary for making implementation efforts meaningful and effective.[xlix] The chronic and persistent shortage of trained staff continues to make implementation efforts problematic at best and futile at worst for state officials working to address the problems at BSDC.

Abuse/Neglect/Death incidents for the period of time January 2007 through August of 2007 based on monthly statements of investigations, incident reports and the BSDC Client Abuse, Neglect and Exploitation Log for 2007.

[64] Statement of BSDC Head of Psychological Services on September 28, 2007 when explaining that a client of NAS with significant behavioral needs after six months still did not have the necessary BMPs developed and written.

[65] See: **(Incident #054)** and **(Incident #019)** for examples of BMPs not being implemented.

[66] The lack of functional analysis by state officials for the behaviors of residents at BSDC leads to poor outcomes for those individuals. A "functional analysis" is a professional assessment technique that relies on a detailed analysis of a person's behavior. The main purpose of a functional analysis is to identify which event(s) or antecedent(s) prompt certain behaviors. By obtaining a greater understanding of the causes of challenging behaviors, professionals can attempt to reduce or eliminate these causal factors, and thus reduce or eliminate the challenging behaviors. Without an informed understanding of the cause of behaviors, attempted treatments are arbitrary and, typically, ineffective. For examples see: **(Incident #028)**; **(Incident #029)**; CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 09-29-2006) (1-413) 300-314.

FINDING III

Nebraska Advocacy Services Finds That State Officials Have Deprived Citizens Living At the Beatrice State Developmental Center Of Receiving Services in the Most Integrated Setting and Failed To Pursue the Timely Transition of Residents into the Most Appropriate, Integrated Settings As Required By the Americans with Disabilities Act

Nebraska Advocacy Services (NAS) further finds that the state officials have failed to provide services to a significant number of people living at the Beatrice State Developmental Center (BSDC) in the most integrated setting, as required by the Americans with Disabilities Act (ADA).[67] Specifically, we find that in those residential living units at BSDC that attempt to model family homes (cottages):

- the kitchen areas of each "home" have not been modified to accommodate either preparation of all hot foods or the physical limitations of people who live in the "home", e.g. kitchen sink and counter areas have not been made adaptable for use by residents who use wheelchairs;

- do not provide serving utensils normally found in homes where "family style" meals are served;

- do not have range tops on which residents can learn to prepare food in saucepans and learn safety practices when working with hot surfaces.[1]

Additionally, federal law requires that state officials actively pursue the timely transition of people residing at BSDC into the most integrated and appropriate setting that is consistent with the residents' needs and not opposed by the individual. We find that this is not the case at BSDC:

- The facility fails to provide adequate training and habilitation to prepare a significant number of residents currently living at BSDC for transition to integrated services.[68]

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[67] U.S.C. § 12132 et seq., 28 C.F.R. § 35.130 (d); see also *Olmstead v. L.C.*, 527 U.S. 581 (1999).

[68] See: Executive Order 13217 "Community-Based Alternatives for Individuals with Disabilities" (June 18, 2001). President George W. Bush in Executive Order 13217 emphasized that unjustified isolation or segregation of qualified individuals with disabilities in institutions is a form of prohibited discrimination, that the United States is committed to community-based alternatives for individuals with disabilities, and that the United States seeks to ensure that America's community-based programs effectively foster independence and participation in the community for

- Habilitation programming that does occur at the facility is designed to adjust the resident to long-term life at the institution.

- School-age residents at BSDC are not educated in community schools operated by the Beatrice School District, but remain in segregated settings on the grounds of the facility.

State officials have failed to achieve a more inclusive and integrative education for those residents who are school-age. Consequently, segregation, not integration, remains the educational policy of state officials toward school-age residents at BSDC.[69]

CONCLUSIONS

Nebraska Advocacy Services, Inc. (NAS) concludes that state officials have departed and continue to depart from generally accepted professional standards at the Beatrice State Developmental Center (BSDC). The examples we have identified as a result of our ongoing investigation supplements the findings contained in the Center for Medicare and Medicaid Services (CMS) survey reports from Fall 2006 and Spring 2007. The direct and immediate result of the long-term pattern and practice on the part of Nebraska's state officials has resulted in a significant departure from generally accepted professional standards and the continuing denial of the constitutional and statutory rights of residents living at BSDC to reasonable safety, adequate habilitation to ensure physical

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Americans with disabilities. 66 Fed. Reg. 33155 (June 18, 2001). The executive order directed the Attorney General to fully enforce Title II of the ADA, especially for those that languish unnecessarily so in facilities like BSDC.

[69] CMS surveyors detail the failings of the school at BSDC in their findings concerning the rape of an 18 year old female who reported on 9/14/06 that she was raped in the reading room at the BSDC segregated school by a male 18 year old student whom BSDC knew had a history of violence and sexual predation. CMS surveyors reported, "There seems to be a consensus that supervision of clients in the school area is very minimal and in many instances no specific assignments are made during the school activities…Reports are that several complaints have been made about the situation, but there is no evidence that the issue has been effectively addressed." CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 09-29-2006) (1-413) 91-94.

safety, freedom from physical injury, freedom from unreasonable restraint, prevention of regression, and assistance in the exercise of protected liberty interests.[70]

NAS further concludes that the historical narrative of BSDC reveals that state officials continue to fail in the primary objective of the habilitation of residents with developmental disabilities due to identified and documented conditions that have been well-known and existent for years. Specifically, state officials operate a facility which remains overcrowded. The effects of such overcrowding are compounded especially in light of the growing complexity of the needs of the residents living and entering the facility. The increased complexity of resident's needs, when coupled with the persistent failure to recruit, maintain, and appropriately train sufficient numbers of direct care staff and highly motivated professional staff, creates a vicious cycle. Consequently, state officials at BSDC continue unsuccessfully to even meet the basic sanitary and hygienic needs, as well as failing to prevent the continuation of injuries, and physical and sexual assaults, of residents at the facility under their care and treatment.

We further conclude that the federally mandated requirements of professionally accepted standards for the treatment and habilitation of the residents at BSDC cannot be met by state officials unless significant changes are implemented. The growing complexity of the needs of the citizens at BSDC require sophisticated, effective, data-driven behavioral plans and individual program plans which are promptly and properly prepared based upon adequate functional analyses, implemented by adequately trained

[70] At BSDC there have been **220** internal investigations of abuse and neglect since January 1, 2007, resulting in **86** substantiated cases of abuse and neglect; **22** fractures since January; **209** staff suspensions; **2** Team Leaders with 2 substantiated cases of abuse/neglect; **12** Direct Care staff with 2 or more cases of substantiated abuse/neglect and **1** Direct Care staff person with 4 substantiated cases of abuse/neglect. Furthermore, there have been 10 bone fractures suffered by persons who are non-verbal. Some of those have included a broken finger, broken fibula, fractured right knee, fracture of surgical neck of left humerus and humeral head, spiral fracture of the left distal tibia and the left proximal fibula, fractured left fibula with displacement, fractured right humerus and fractured left foot. *Statistics at BSDC* a report prepared by NAS, October 2007; *Analysis of Fractures with Unknown Causes for Individuals (Non-verbal)* a report prepared by NAS, October 2007.

staff, and monitored and reviewed during implementation for necessary modifications. NAS suggests that the geographical location of the facility, segregated and isolated both physically and symbolically from the treatment community and its professional support and assistance, (1) contributes to the continuation of state officials' failure to employ, train, and then maintain sufficient numbers of highly motivated and well-trained direct care and professional staff essential to habilitate the citizens at BSDC with their demanding complex needs and (2) guarantees the perpetuation of the historical failures at the facility.

NAS concludes that the conditions and practices at BSDC that violate the constitutional rights of the residents living there historically continue to manifest themselves, despite relatively brief and fleeting efforts of remedial reform efforts, and remain imbedded at BSDC. Due to the systemic nature of these conditions and practices at BSDC, the meaningful protection and habilitation of the vulnerable residents living at BSDC requires the enactment and implementation of fundamental changes by the executive and legislative branches of the State of Nebraska to effectuate a meaningful, substantial and lasting resolution. We believe that the evidence contained within the pages of the historical record of BSDC, from its inception in 1885 to the present, establishes that identical problems and failures have manifested themselves throughout the respective periods of the institution's history. To ignore that history is to allow those problems and failures to linger for future generations of vulnerable Nebraskans to endure.

We conclude that state officials must reduce the current population at BSDC, by placement into appropriate community-based settings, to a level consistent with an acknowledgment of the historical reality of the difficulty of maintaining sufficient

numbers of staff. This reduction in the population at BSDC must be accompanied by enhanced financial compensation of professional and direct care staff in order to attract and maintain staff that who are both highly qualified and motivated to meet the habilitation needs of those people who continue to live at BSDC. In addition, state officials must establish an organizational culture at BSDC that is based on an understanding of the historical and social dimensions of the devaluation of people with developmental disabilities.[71] Innovative model programs based upon the principles of consistent positive reinforcement also must be developed and implemented as part of the on-going habilitation of those residents at BSDC with significant behavioral impairments.[72]

NAS also concludes that state officials should develop and implement a meaningful plan to meet and fulfill the "integrative" mandates of federal law, as required by the Americans with Disabilities Act (ADA) and the decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999).[73] The plan must ensure that all school-age children currently living at BSDC receive a "free and appropriate public education" within the schools of the Beatrice School District. State officials in the Department of Health and Human Services and the Nebraska Department of Education must ensure an inclusive and integrative education and eliminate the current *de jure* and *de facto* educational segregation at BSDC. In order to fulfill the integrative mandates of federal law state officials and other interested parties must undertake a re-conceptualization of the current role and function

[71] One possible approach worthy of consideration is Social Role Valorization (SRV) training. SRV is "The application of empirical knowledge to the shaping of the current or potential social roles of a party (i.e., person, group, or class)—primarily by means of enhancement of the party's competencies & image—so that these are, as much as possible, positively valued in the eyes of the perceivers." Wolfensberger, W. & Thomas, *Introductory Social Role Valorization workshop training package*, Training Institute for Human Service Planning, Leadership and Change Agentry Syracuse University: Syracuse, New York (2005).

[72] See, for example, McGee, J & Brown, *A Gentle Teaching Primer* (Michigan: Gentle Teaching International 2007); see also www.gentleteaching.com

[73] See ftnts 66 and 67 supra.

of BSDC along the lines envisioned by state planners in 1985 of supporting and not supplanting community treatment and services for residents with developmental disabilities. State officials should formulate, develop and implement a truly integrative unitary system of services for Nebraska's citizens with developmental disabilities instead of merely continuing the pattern and futile practice of piecemeal patching the ever-deepening cracks in the dual system of institutional and community-based services. Otherwise, the walls of BSDC which have been eroded over time by stagnation and complacency will continue to crumble around the very citizens they were designed to protect and treat.

Finally, we conclude that the Nebraska Legislature must establish a BSDC Oversight Commission comprised of Nebraska's most knowledgeable citizens (private, public and governmental) who are well-versed in both the short-term and long-term habilitation needs of individuals with developmental disabilities, understand the challenges they and their families face, and are informed of new developments and approaches in the habilitation of individuals with developmental disabilities. With the objective of weaving a tapestry of a new integrative unitary system this Commission can provide, as did the Commission in 1968[74], the recommendations for not only an impetus for true reform but a renaissance of the innovative vision that made Nebraska the pathfinder in the nation and the world in services for individuals with developmental disabilities during the 1970s and early 1980s.[75]

[74] The Citizens' Study Committee on Mental Retardation rested on foundational principles that are instructive for any future task force: (1) principles of social role valorization, (2) integrative models with inclusion in the community maximizing family contact, (3) protection of human, legal, and social rights, (4) necessary personal and citizen advocacy. See *Into the Light, supra* p. 5; *Out of the Darkness*, supra at 10.

[75] Id. at 7-52; 138-153; 156-202.

At best, state officials have continued the pattern of the past six years of applying a Band-Aid to a laceration of the carotid artery at BSDC by promising compliance with the mandated constitutional and federal standards, and yet repeatedly failing to meet the accepted professional standards of care because they have never resolved the historically recurrent problems that we have identified. We conclude that only an innovative approach that incorporates solutions addressing all aspects of the long-term, lingering problems previously identified and so often documented at BSDC will succeed.

RECOMMENDATIONS

1. State officials should conduct independent comprehensive evaluations and objective assessments of all individuals at the Beatrice State Developmental Center (BSDC) and prepare a plan with timelines to significantly reduce, by placement into appropriate community settings, the current population to a level consistent with the historical reality of the difficulty of maintaining sufficient numbers of adequately trained and highly motivated staff to meet the habilitation needs of the people living at the facility.

2. State officials should create and utilize effective, data-driven behavioral plans and individual program plans which are promptly and properly prepared based on adequate functional analysis, implemented by appropriately trained staff and monitored and reviewed during implementation for necessary modifications.

3. State officials should provide BSDC staff with adequate competency-based training to properly implement behavior programs and require demonstration of competency in order to make implementation efforts meaningful and effective for the residents.

4. BSDC should develop and implement individualized programs using the principles of consistent, positive reinforcement, such as "Gentle Teaching" to assist in the habilitation of residents at BSDC who have significant behavioral impairments.

5. State officials should establish an organizational culture at BSDC that is based on respect for and valuing of people with developmental disabilities.

6. All state officials, direct care staff, professional staffing, and medical staff at BSDC should participate in Value-Based Training, such as Social Role Valorization (SRV), to increase their competencies in appreciating the respect and value of people with developmental disabilities.

7. State officials should develop and implement a meaningful plan to meet and fulfill the "integrative" mandates of federal law, as required by the Americans with Disabilities Act (ADA) and the decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999) for individuals living at BSDC.

8. State officials should develop and implement policies and procedures to ensure that all school-age children currently living at BSDC receive a "free and appropriate public education" within the facilities operated by the Beatrice School District by the Fall of 2008.

9. State officials should substantially increase levels of compensation and benefit packages for direct care and professional staff at BSDC in order to attract and maintain highly qualified and motivated staff necessary for the habilitation of those residents who continue to live at BSDC.

10. State officials should create, adequately staff, and fund a Section of Civil Rights Enforcement within the Department of Health and Human Services responsible for the protection, investigation and enforcement of the civil rights of persons residing within the State of Nebraska's residential facilities. The Section of Civil Rights should be comprised of individuals with special knowledge and expertise in the law, federal regulations, developmental disabilities, and behavioral health. The Section of Civil Rights should assist state officials in ensuring that residents at BSDC and the other residential facilities are protected from harm, receive appropriate treatment and habilitation, and that the facilities actually meet those standards of generally accepted care by professionals contained within the federal regulations. The Section of Civil Rights would report directly to the Governor's Office and to the Health and Human Services Committee of the Legislature on a periodic basis. The Governor would have the authority to appoint the Section Head subject to confirmation by the Legislature, and the Section Head could be removed only upon a showing of good cause.

11. The Nebraska Legislature should appoint an Oversight Commission that is comprised of Nebraska's most knowledgeable citizens in the private, public and governmental sectors. Such individuals must be knowledgeable of the habilitation needs of people with developmental disabilities and the challenges they and their families face. The Commission should include persons with developmental disabilities, parents and relatives of persons with developmental disabilities, representatives of advocacy groups, professionals and providers, state legislators, and members of the Executive Branch of the State of Nebraska. The Commission should be charged with issuing recommendations to achieve: (1) a unitary integrative system of habilitation services and supports for individuals with developmental disabilities in Nebraska, and (2) the permanent elimination of the deficiencies at the Beatrice State Developmental Center that have historically persisted at the facility.

ENDNOTES

[i]CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 10-26-2001) pgs 1-35.

[ii] CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 04-17-2003) pgs 1-13.

[iii]CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 10-09-2003) pgs 1-6 of 54.

[iv] CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 01-22-2004) pgs 1-24.

[v] CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 03-17-2004) pgs 1-8.

[vi] CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 03-29-2004) pgs 1-3.

[vii]CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 10-04-2004) pgs 1-8.

[viii] CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 05-11-2005) pgs 1-14.

[ix] Id., 10-14.

[x] CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 08-30-2005) pgs 1-7.

[xi] See generally CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 09-29-2006) (1-413) and CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 04-20-2007) (1-192).

[xii] CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 09-29-2006) (1-413) 1-7.

[xiii] Id. 8-9.

[xiv] Id. 9-32.

[xv]Id. 2-3.

[xvi] Id., 10-11.

[xvii] CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 04-20-2007) (1-192) 31-34; 62-98.

[xviii] Id. 35-53.

[xix]Id. 2-3.

[xx] Id. CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 04-20-2007) (1-192); 26-31.

[xxi] See ftnt 43, supra.

[xxii] CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 09-29-2006) (1-413), 35-37.

[xxiii] Id., 144-159.

[xxiv] Id., 159-161.

[xxv] Id., 188-214.

[xxvi] Id., 223-300.

[xxvii] Id., 300.

[xxviii] Id., 301-303.

[xxix] Id., 301; 303-314.

[xxx] Id., 301-302; 315-327.

[xxxi] Id., 300-327.

[xxxii]Id., 223-224; 300-327.

[xxxiii] Id., 314-315.

[xxxiv] Id., 327-385.

[xxxv] Id., 385-413
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[xxxvi] Id., 385-413.

[xxxvii] CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 04-20-2007) (1-192).

[xxxviii] Id., 98-141.

[xxxix] Id., 125-138.

[xl] Id. 99-102.

[xli] Id. 99-107; 107-115.120-125.

[xlii] Id.,107-109.

[xliii] Id., 115-125.

[xliv] Id., 135.

[xlv] Id., 141-192.

[xlvi] CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 09-29-2006) (1-413) 300-314.

[xlvii] Id.

[xlviii] Id.

[xlix] 42 C.F.R. § 483.430 (e).

[l]CMS Statement of Deficiencies and Plan of Correction for the Beatrice State Developmental Center (Survey Completed 04-20-2007) (1-198) pgs 3-5.