IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF NEBRASKA; DAVE HEINEMAN, Governor of the State of Nebraska, in his official capacity only; CHRISTINE PETERSON, Chief Executive Officer, Nebraska Department of Health and Human Services, in her official capacity only; JOHN WYVILL, Director, Division of Developmental Disabilities, Nebraska Department of Health and Human Services, in his official capacity only; RON STEGEMANN, Chief Executive Officer, Beatrice State Developmental Center, in his official capacity only, Defendants.	)	Civ. No. 8:08CV271

SETTLEMENT AGREEMENT

The United States and the State of Nebraska agree to settle this matter on the terms and conditions set forth below in this Settlement Agreement.

I. ***LEGAL FRAMEWORK***

A. This case was instituted by the United States pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997.

B. This Court has jurisdiction over this action pursuant to 28 U.S.C. § 1345.

C. Venue is appropriate pursuant to 28 U.S.C. § 1391(b).

D. The United States is authorized to institute this civil action pursuant to 42 U.S.C. § 1997a and has met all prerequisites for the institution of this civil action prescribed by the statute.

E. The Defendants are the State of Nebraska; the Honorable David Heineman, Governor of the State of Nebraska; Christine Peterson, the Chief Executive Officer of the Nebraska

Department of Health and Human Services; John Wyvill, the Director of the Division of Developmental Disabilities within the Nebraska Department of Health and Human Services; and Ron Stegemann, the Chief Executive Officer of the Beatrice State Developmental Center ("BSDC"). All individual Defendants are officers of the Executive Branch of the State of Nebraska and are sued only in their official capacities. The collective Defendants shall hereinafter be referred to as "the State."

F. BSDC is an institution covered by CRIPA and is owned and operated by the State of Nebraska to provide habilitation and other protections, supports, and services to persons with mental retardation and/or other developmental disabilities. The State has authority and responsibility for the operation of BSDC and is responsible for the implementation of this Settlement Agreement.

G. On May 29, 2007, the Attorney General of the United States, by and through the Assistant Attorney General, Civil Rights Division, notified the Governor of the State of Nebraska, the Attorney General of the State of Nebraska, the Chief Executive Officer of the Nebraska Department of Health and Human Services, and the Acting Chief Executive Officer of BSDC, of his intention to investigate conditions of care and treatment of residents at BSDC pursuant to CRIPA.

H. Following an investigation, including an on-site tour of BSDC from October 15-19, 2007, on March 7, 2008, the Attorney General of the United States, by and through the Acting Assistant Attorney General, Civil Rights Division, informed the Governor of Nebraska, the Nebraska Attorney General, the Chief Executive Officer of the Nebraska Department of Health and Human Services, the Director of the Division of Developmental Disabilities within the Nebraska Department of Health and Human Services, and the Chief Executive Officer of BSDC, that the Attorney General had reasonable cause to believe that BSDC residents were being subjected to conditions that deprived them of their legal rights and of their rights, privileges, and immunities secured by the Constitution of the United States.

I. The parties agree that the care, conditions, and training provided to BSDC residents, including any individual who was a BSDC resident at the time the United States concluded its on-site tour of BSDC on October 19, 2007 (hereinafter "residents"), implicate rights that are secured and protected by the Constitution and laws of the United States. The parties entering into this Settlement Agreement recognize these constitutional and legal interests, and for the purpose of avoiding protracted and adversarial litigation, agree to the provisions set forth below.

J. The purpose of the Settlement Agreement is that the State will achieve and/or maintain desired outcomes for BSDC residents and ensure that they are provided them with the protections, supports, and services they need to ensure that their constitutional and statutory rights are protected. In entering into this Settlement Agreement, however, State officials do not admit any violation of the Constitution or of any law, and this Settlement Agreement may not be used as evidence of liability in any other legal proceeding.

K. This Settlement Agreement is not intended to create any rights in any person or entity not a party to it. Nothing herein is intended to waive any rights or claims with respect to third parties who are not parties to this Settlement Agreement.

L. The provisions of this Settlement Agreement, voluntarily entered into, are a lawful, fair, and appropriate resolution of this case.

M. The parties shall request that this Settlement Agreement be entered by the United States District Court for the District of Nebraska, and be enforceable as an Order of the Court.

N. Once entered by the Court, this Settlement Agreement is legally binding and judicially enforceable by the parties, and it shall be applicable to and binding upon all of the parties, their officers, agents, employees, assigns, and successors.

O. Except where otherwise specified, the State shall implement all provisions of this Settlement Agreement within 90 days of the filing of this Settlement Agreement with the Court.

P. The United States agrees to consult with State officials before seeking judicial enforcement of this Settlement Agreement. Throughout, the United States and the State will coordinate and discuss areas of disagreement and attempt to resolve outstanding differences. It is intended that the parties will pursue a problem-solving approach so that litigation and disagreements can be minimized and the energies of the parties can be focused on the task of meeting the needs of the residents and achieving the outcomes set forth in this Settlement Agreement. The State shall ensure that identified deficiencies, if any, are remedied promptly.

Q. The United States will have full access to residents, persons, employees, residences, facilities, buildings, programs, services, documents, records, and materials that are necessary to assess the State's compliance and/or implementation efforts with this Settlement Agreement. Such access shall include departmental and/or individual resident medical and other records. The United States shall provide reasonable notice of any visit or inspection, although the parties agree no notice shall be required in an emergency situation where the life, immediate health or immediate safety of resident(s) are at issue. Such access shall continue until this case is dismissed.

R. All provisions of this Settlement Agreement will have ongoing effect until the final dismissal of this action.

S. The parties anticipate that the State will have implemented all provisions of the Settlement Agreement within four years of its filing with the Court. The Court shall retain jurisdiction of this action for all purposes until the State has implemented all provisions of this Settlement Agreement and maintained implementation of all provisions for one year and until such time as this action is dismissed. The parties may agree to jointly ask the Court to terminate the Settlement Agreement prior to the end of the four-year term, provided the State has implemented all provisions of the Settlement Agreement and maintained implementation of all

provisions for one year. If the case has not yet been dismissed, the parties agree to ask the Court for a non-evidentiary hearing on the status of compliance on or near this four-year anniversary date. If the parties agree that there is non-compliance, or if there is a dispute about compliance, the parties will so inform the Court, and the Court may set additional hearing dates as appropriate. The parties may agree jointly at any time to allow for additional time to resolve compliance issues.

T. The parties and the Independent Expert agree that any documents produced pursuant to this Settlement Agreement may be shared only with the following: (1) the Court; (2) any expert(s) or consultant(s) selected or retained by the parties pursuant to this Settlement Agreement; (3) all counsel of record in this matter; (4) staff and clerical personnel working with counsel of record in this matter; and (5) United States and other governmental officials, as necessary, in order to carry out law enforcement responsibilities.

U. All parties and the Independent Expert shall be responsible for maintaining the confidentiality of records in their possession. Submissions to the Court that contain identifying information of residents (such as their full name, address, or social security number) shall be filed with the Court using codes or pseudonyms.

V. The State shall promptly notify the United States upon the death of any resident, including the name of the resident, the date of death, and a preliminary cause of death. The State shall promptly forward to the United States copies of any completed incident reports related to deaths, autopsies, and/or death summaries of residents, as well as all final reports of substantiated abuse and/or neglect investigations that involve residents. The United States may require additional written reports from the State regarding the State's compliance with the Settlement Agreement. The State will cooperate and comply with any such requests.

W. The parties reserve the right to withdraw consent to the Settlement Agreement in the event that the Settlement Agreement is not approved by the Court in its entirety.

X. The parties shall bear their own costs, including attorney fees.

II. ***OFFICE OF THE INDEPENDENT EXPERT***

A. ***Selection of the Independent Expert and Consultants***

1. The parties have jointly agreed that John J. McGee, Ph.D., shall be appointed as the Independent Expert to monitor the State's implementation of this Settlement Agreement.

2. In the event that Dr. McGee resigns, or in the event that the parties for any reason jointly agree to discontinue the use of Dr. McGee as Independent Expert, the parties shall meet or confer within 30 days to try to agree upon a replacement person to fulfill the duties of the Independent Expert. The parties shall jointly select a replacement. If the parties are able to agree on a replacement, they shall notify the Court of their joint selection. If the parties are

unable to agree on a replacement within 30 days of their first meeting or conference, they shall jointly petition the Court to make the selection. In this petition, each party will be permitted to propose the names of three alternate candidates for the position, from which the Court shall select the new Independent Expert. The parties shall submit the candidates' *curricula vitae,* along with other pertinent information regarding the proposed candidates at the time of the submission of the names of the candidates. The procedure described in this paragraph, if necessary, shall apply to the selection of all successor Independent Experts.

3. The parties agree that Dr. McGee may use consultants to assist in completing the duties of the Independent Expert. In collaboration with the Independent Expert, the parties shall meet or otherwise confer whenever necessary to agree upon which particular consultant(s) Dr. McGee shall use to assist in completing the duties of the Independent Expert.

4. Neither the Independent Expert, nor any consultant (person or entity) retained by the Independent Expert to assist in completing the duties of the Independent Expert, shall be liable for any claim, lawsuit, or demand arising out of the monitoring of this Settlement Agreement. This paragraph does not apply to any proceeding before this Court for enforcement of payment of contracts or subcontracts for monitoring this Settlement Agreement. The selection of the Independent Expert shall be conducted solely pursuant to the procedures set forth in this agreement, and will not be governed by any formal or legal procurement requirements.

B. ***Budget of the Independent Expert***

5. The parties and Dr. McGee have agreed upon the annual budget for Dr. McGee's work as Independent Expert. The agreed-upon budget is attached.

C. ***Reimbursement and Payment Provisions***

6. The cost of the Independent Expert, including the cost of any consultant to assist the Independent Expert, shall be borne by the State in this action. All reasonable expenses incurred by the Independent Expert or any consultant, in the course of the performance of the duties of the Independent Expert, pursuant to the attached budget of the Independent Expert, shall be reimbursed by the State. The State shall provide the office of the Independent Expert with access to clerical assistance, office space, and office supplies as necessary. The United States will bear its own expenses in this matter.

7. The State shall deposit $100,000.00 into the Registry of the Court as interim payment of costs incurred by the Independent Expert. This deposit and all other deposits pursuant to this Order shall be held in the Court Registry Investment System and shall be subject to the standard registry fee imposed on depositors.

8. The Independent Expert shall submit monthly statements to the Court, with copies to the parties, detailing all expenses the Independent Expert incurred during the prior month. These statements shall include daily records of time spent and expenses incurred, and shall include

copies of any supporting documentation, including receipts. The parties shall have seven business days from the receipt of the Independent Expert's monthly statements to submit to the Court any comments on or objections to the statements. The Court will then review the statements and any party's comments or objections and order the clerk to make the appropriate payments to the Independent Expert. The clerk shall then make those payments within 10 days of the entry of the Order authorizing payment. Within 45 days of the entry of each Order authorizing payment, the Defendants shall replenish the fund with the full amount paid by the clerk in order to restore the fund's total to $100,000.00.

D. ***Responsibilities and Authority of the Independent Expert***

9. The Independent Expert shall have the responsibility and authority to independently observe, assess, review, and report on the State's implementation of and compliance with the provisions of this Settlement Agreement. The Independent Expert shall regularly review the protections, services, and supports provided to residents in their residential settings and day programs or other programs to determine the State's implementation of and compliance with this Settlement Agreement. The Independent Expert's evaluation shall include: regular on-site inspection of the residences and programs of residents, interviews with administrators, professional and direct care staff, contractors, and residents, and detailed review of pertinent documents and resident records. The Independent Expert shall conduct on-site inspections at least every quarter. The Independent Expert shall devote such time as is necessary to fulfill the duties and responsibilities of the Independent Expert pursuant to this Settlement Agreement.

10. Within 30 days of appointment, the Independent Expert shall consult with the parties and shall submit a written plan with regard to the methodologies to be used by the Independent Expert to assess the State's compliance with and implementation of the Settlement Agreement.

11. The Independent Expert will have full access to residents, persons, employees, residences, facilities, buildings, programs, services, documents, records, and materials that are necessary to assess the State's compliance and/or implementation efforts with this Settlement Agreement. Such access shall include departmental and/or individual resident medical and other records. Such access shall continue until this case is dismissed.

12. The Independent Expert may have *ex parte* communications with the parties at any time.

13. The Independent Expert shall confer regularly and informally with the parties on matters relating to compliance, and the parties envision that the Independent Expert may provide specific recommendations with regard to steps to be taken to come into compliance with the Settlement Agreement. However, the State retains the discretion to achieve compliance by any legal means available, and may choose to utilize methods other than those that may be proposed by the Independent Expert. The Independent Expert shall not be empowered to direct the State or any of its subordinates to take, or to refrain from taking, any specific action to achieve compliance with the Settlement Agreement. Conversely, no party or any employee or agent of any party shall have any supervisory authority over the Independent Expert's activities, reports, findings,

or recommendations. The parties do not intend for the Independent Expert to have the role of a "Special Master."

14. At least every quarter, the Independent Expert shall submit to the parties a draft written report with regard to the State's implementation efforts and compliance with the Settlement Agreement. The parties shall have 15 business days to submit a response to the report to the Independent Expert. The Independent Expert shall consider the parties' comments and within 10 days of receipt of the comments shall submit a final report to the parties, making whatever modifications the Independent Expert deems appropriate in light of the parties' comments. While the parties are reviewing the draft report and submitting comments, the State will take timely action to remedy any deficiencies cited by the Independent Expert. Only where conditions or practices pose an immediate and serious threat to the life, health or safety of a resident or residents, may the United States use the Independent Expert's draft report in a compliance action before the Court prior to the completion of the review and submission period set forth above.

15. So as to review issues related to this Agreement, the State shall promptly notify the Independent Expert upon the death of any resident, including the name of the resident, the date of death, and a preliminary cause of death. The State shall promptly forward to the Independent Expert copies of any completed incident reports related to deaths, as well as autopsies, and/or death summaries of residents. The State shall promptly notify the Independent Expert of serious incidents, including but not limited to allegations of abuse and/or neglect, incidents producing a serious injury, incidents involving prolonged physical and/or mechanical restraint, and incidents involving law enforcement personnel. The State shall promptly forward to the Independent Expert copies of all final reports of investigations that involve residents. The State shall provide advance notice to the Independent Expert, along with copies of discharge plans, for residents to be transitioned to the community or any other setting. The Independent Expert may require additional written reports from the State regarding the State's compliance with the Settlement Agreement. The State will cooperate and comply with any such reasonable requests.

16. It is intended that the Independent Expert will pursue a problem-solving approach so that disagreements can be minimized and the energies of the parties and the Independent Expert can be focused on the task of meeting the needs of the residents and achieving the outcomes set forth in this Settlement Agreement.

III. *REMEDIAL MEASURES*

A. **REASONABLE SAFETY, PROTECTION FROM HARM**

Principal Requirement

1. The State has declared that the most important concern of the State Department of Health and Human Services is the safety and quality of life of its clients with developmental disabilities. To this end, the State agrees to provide residents with a reasonably safe and humane living environment which includes that the State shall: (1) protect residents from abuse and neglect; and (2) take effective steps to minimize or eliminate resident injuries and other significant incidents that may negatively impact their health, safety, and welfare.

Zero-Tolerance for Abuse and Neglect

2. The State shall take effective steps to ensure that residents are free from abuse and neglect. The State has announced, and shall maintain, a policy of "zero-tolerance" for abuse (including verbal, mental, sexual, or physical abuse) and neglect, whether from other residents or from staff.

3. The State shall provide effective, ongoing competency-based training to staff on recognizing and reporting potential signs and symptoms of abuse and/or neglect, and on the prevention of abuse and neglect of residents by staff. Such training shall include providing staff with an explanation of the definitions of resident abuse and neglect, explaining to staff that abuse and neglect are prohibited, explaining to staff the requirement to promptly report any suspected abuse or neglect, and advising staff of the potential consequences if they commit abuse or neglect or fail to promptly report witnessed or suspected abuse or neglect.

Adequate Staffing

4. The State shall maintain sufficient numbers of adequately trained professional and direct care staff on each shift to provide adequate protections, supports, and services to residents at all times.

5. On or before November 1, 2008, the State shall maintain sufficient staff in direct care positions so as to minimize or eliminate the use of overtime to meet resident needs. The State may address staffing issues by hiring additional staff and/or by reducing the resident census at BSDC. In order to address staff fatigue, the use of mandatory overtime and requiring that staff work double shifts (two consecutive eight-hour shifts) is disfavored. In order to increase continuity of care and the familiarity of staff with particular residents and their needs, the State shall minimize or eliminate the use of part-time "on-call" staff and "pulled" staff who are unfamiliar with the residents on a unit.

6. The State shall ensure that residents receive all protections, supports, and services from staff who are properly trained on how to meet their individualized needs. The State shall place a heightened focus on ensuring that part-time "on-call" staff and staff pulled from other units are properly trained on individualized resident needs before assignment to any particular unit.

7. The State shall adequately supervise and monitor staff and residents at all times to ensure that staff are continually working to address resident needs.

8. The State shall conduct a regular review of all resident injuries and "significant" incidents to determine if staffing concerns are a contributing factor; wherever this is the case, the State shall develop and implement prompt and effective measures to address the staffing concerns in order to provide adequate and sufficient staff to care for and supervise residents and to prevent otherwise avoidable injuries and incidents. "Significant" resident incidents include all instances of: alleged, suspected, and/or substantiated abuse and/or neglect; serious injury, including those of unknown origin; actual or attempted elopement from the facility; and death.

9. Before permitting any staff person to work with residents, the State shall investigate the criminal history and other relevant background factors regarding that staff person, whether full-time, part-time, temporary, or permanent, including regularly-scheduled volunteer staff with direct resident contact. The State shall screen and take appropriate action to protect residents if the investigation indicates that the person would pose a risk of harm to the residents.

Resident Incidents

10. The State shall take effective steps to minimize incidents that may adversely impact the health, safety, and welfare of residents. This includes all "significant" resident incidents, especially those incidents that result in serious injury to residents.

11. Whenever a significant incident (other than death) occurs, the State shall immediately take appropriate measures to protect the safety and well-being of the resident(s) involved, including procuring any necessary basic care and/or health care treatment.

12. An interdisciplinary team on each BSDC living unit shall meet to identify, discuss, and address individual and systemic issues that have arisen since the last unit team meeting, as well as any individual and systemic issues that may arise before the next unit team meeting. The team's conclusions and action steps shall be conveyed across shifts to ensure continuity and consistency with regard to implementation efforts.

13. On or before January 1, 2009, the State shall develop and implement across all settings and shifts an integrated and coordinated incident management system. All resident incidents, including incidents that result in injury, shall be accurately and consistently documented. Documentation of each injury shall be kept in the resident's file and in a central location, and all incidents and injuries shall be entered into a central database, which is capable of capturing the following information: the type of incident, the time the incident occurred, the location of the

incident, the resident(s) and/or staff involved in the incident, and the nature and severity of the injury, if any. The State shall develop and implement, within 90 days, a policy mandating that staff report all incidents in a timely manner.

Quality Assurance

14. The State shall develop and implement a comprehensive quality assurance program to track and analyze patterns and trends of incidents and injuries, including incidents and injuries of unknown origin. The State shall develop and implement prompt and effective measures to address patterns and trends that impact the health, safety, and welfare of residents, so as to minimize or eliminate their occurrence in the future.

15. The State shall place an emphasis on identifying and analyzing resident-to-resident interactions that create risk of harm and/or actual harm, and then develop and implement measures to address these risk factors to prevent residents from harming themselves or others. The State shall identify vulnerable residents who are at higher risk of harm, and develop and implement measures to minimize or eliminate potential risk factors. The State shall identify aggressor residents and develop and implement measures, in conjunction with behavioral and other interventions, to minimize or eliminate potential triggers for aggression.

Investigation of Significant Incidents

16. The State shall investigate all "significant" resident incidents. As referenced above, "significant" resident incidents include all instances of: alleged, suspected, and/or substantiated abuse and/or neglect; serious injury, including those of unknown origin; actual or attempted elopement from the facility; and death.

17. The investigation of each significant incident shall be accurate, thorough, and complete. Investigations are to commence at least by the next working day of the incident being reported, and shall be concluded within 30 days of the incident being reported, or, when material evidence is unavailable to the investigator, as soon as is practicable so as to eliminate any undue delay. Other than with regard to matters involving a criminal investigation conducted by law enforcement authorities, investigators shall conduct interviews of all necessary witnesses in a timely manner. Each investigation will result in a written report. Each investigation report shall include: a summary of the incident and investigation, a chronology of events, a summary of interviews with all relevant staff and residents who may have information about the incident, findings with a detailed discussion of the bases for the findings (including a reasoned analysis of witness statements, documents, and other evidence considered), and recommendations for corrective action, when necessary, with timeframes for completion. The State shall ensure that investigators are competent, experienced, and well-trained in conducting investigations of significant incidents.

18. The State shall develop and implement prompt and effective remedial measures to address the individual and systemic issues and recommendations associated with these

investigation reports. The State shall track the implementation of the remedial measures on an ongoing basis to ensure that outstanding issues are addressed and appropriate resident outcomes are achieved in each instance.

19. The State shall require staff, including supervisory personnel, to safeguard evidence associated with the significant incident.

20. The State shall require that all potential criminal matters are referred promptly to appropriate law enforcement authorities. When law enforcement authorities indicate an intent to proceed with a criminal investigation, any compelled interviews of State employees shall be delayed until those authorities issue a written declination to proceed with a criminal investigation.

21. The State shall immediately remove any staff member suspected of staff-on-resident abuse or neglect from direct resident contact until the conclusion of the investigation and submission of the written investigation report about the incident.

22. The State shall impose appropriate disciplinary and/or corrective personnel action where a staff person is determined to have caused or been responsible for abuse and/or neglect, and against any staff person who fails to report a significant incident to supervisory or other appropriate personnel in a timely or accurate manner.

B. PLACEMENT IN THE MOST INTEGRATED SETTING

Principal Requirement

23. In accordance with Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132, and implementing regulation 28 C.F.R. § 35.130(d), the State shall ensure that each BSDC resident is served in the most integrated setting appropriate to meet each person's individualized needs. To this end, the State shall actively pursue the appropriate discharge of BSDC residents from BSDC and provide them with adequate and appropriate protections, supports, and services, consistent with each person's individualized needs, in the most integrated setting in which they can be reasonably accommodated, and where the individual does not object.

Appropriateness for Placement

24. It is the State's determination that all residents of BSDC meet the essential eligibility requirements for placement and habilitation in integrated community settings. All residents can be served in integrated community settings when adequate protections, supports, and other necessary resources are identified as available by service coordination. The State shall ensure that this is clearly set forth in each resident's written interdisciplinary team recommendation contained within each individual's BSDC Personal Plan, or equivalent.

Resident Involvement and Choice

25. Throughout, each resident shall be involved in the team evaluation, decision-making, and planning process to the maximum extent practicable, using whatever communication method he or she prefers.

26. To foster each resident's self-determination and independence, the State shall use person-centered planning principles at every stage of the process. This shall facilitate the identification of the resident's specific interests, goals, likes and dislikes, abilities and strengths, as well as deficits and support needs.

27. Each resident shall be given the opportunity to express a choice regarding placement. The State shall provide residents with choice counseling to help each resident make an informed choice; the State will provide enhanced counseling to those residents who have lived at BSDC for many years.

28. If any resident opposes placement, the State will document the steps taken to ensure that any individual objection is an informed one. The State shall set forth and implement individualized strategies to address concerns and objections to placement.

29. Throughout the process, the State shall regularly educate residents about the community and the various community options open to them. Any written materials or presentations shall be easy for residents to understand.

30. The State shall provide each resident with several viable placement alternatives to consider whenever possible. The State shall provide field trips to these viable community sites and facilitate overnight stays at certain of the community residences, where appropriate.

31. Where family members and/or guardians have reservations about community placement, the State shall provide ongoing educational opportunities to such family members and/or guardians with regard to placement and programming alternatives and options. These educational opportunities shall include information about how the individual may have viable options other than living with the family members and/or guardians once discharged from BSDC. The State shall identify and address the concerns of family members and/or guardians with regard to community placement. The State shall encourage family members and/or guardians to participate, whenever possible, in residents' on-site, community home field trips.

Transition Plans

32. The State shall set forth in reasonable detail a written transition plan specifying the particular protections, supports, and services that each individual resident will or may need in order to safely and successfully transition to and live in the community. Such a transition plan shall be prepared on or before January 1, 2009, for each resident regardless of whether or not a suitable community placement is currently available.

33. Each transition plan shall be developed using person-centered planning principles. Each transition plan shall specify with particularity the individualized protections, supports, and services needed to meet the needs and preferences of the resident in the alternative community setting, including their scope, frequency, and duration. Each transition plan shall include all individually-necessary protections, supports, and services, including but not limited to: housing and residential services; transportation; staffing; health care and other professional services; specialty health care services; therapy services; psychological, behavioral, and psychiatric services; communication and mobility supports; programming, vocational, and employment supports; and assistance with activities of daily living. Each plan shall include specific details about which particular community providers, including residential, health care, and program providers, can furnish needed protections, services, and supports.

34. The State will continue to[1] emphasize the placement of residents into smaller community homes.

35. In developing these plans, the State will avoid placing residents into nursing homes or other institutional settings whenever possible. The parties recognize that nursing homes are often not well-suited to provide needed habilitation to persons with developmental disabilities. The State will develop and implement a systemic plan to develop, through the Home and Community-Based Waiver or otherwise, integrated community alternatives to nursing homes for all residents with unique or more intense and complex health care needs.

36. Each transition plan shall identify the date the transition can occur, as well as timeframes for completion of needed steps to effect the transition. Each transition plan shall include the name of the person or entity responsible for: commencing transition planning; identifying community providers and other protections, supports, and services; connecting the resident with community providers; and assisting in transition activities as necessary. The responsible person or entity shall be experienced and capable of performing these functions.

37. Each transition plan shall be developed sufficiently prior to potential discharge so as to enable the careful development and implementation of needed actions to occur before, during,

[1] The United States does not concede that the words "continue to" or "maintain" throughout this Settlement Agreement mean or imply that the State has already been meeting residents' needs in each area.

and after the transition. This shall include identifying and overcoming, whenever possible, any barriers to transition. The State shall work closely with pertinent community agencies so that the protections, supports, and services that the resident needs are developed and in place at the alternate site prior to the resident's discharge.

38. The State shall update the transition plans as needed throughout the planning and transition process based on new information and/or developments.

39. In developing the transition plans, the State shall attempt to locate community alternatives in regions based upon the presence of persons significant to the resident, including parents, siblings, other relatives, or close friends, where such efforts are consistent with the individual's desires.

40. The State agrees to provide as many individual on-site and overnight visits to various proposed residential placement sites in the community as are appropriate and needed to ensure that the placement ultimately selected is, and will be, adequate and appropriate to meet the needs of each resident. The State shall modify the transition plans, as needed, based on these community visits.

41. Each individual transition plan shall establish a schedule for monitoring visits to the new residence to assess whether the ongoing needs of the individual are being met. Each plan shall specify more regular visits in the days and weeks after any initial placement.

Implementation of Transition Plans

42. For those residents who do not oppose community placement, the State shall implement, in an expeditious manner, the transition plans that can be reasonably accommodated, by transferring each resident to an adequate and appropriate alternative community setting pursuant to the details set forth in each transition plan.

Developing and Expanding Community Capacity

43. The State shall take effective steps to support and expand service and provider capacity in the community so as to better serve residents placed and to be placed in the community. This shall include, but not be limited to, developing community capacity with regard to: housing and residential services; health care and other professional services; specialty health care services; therapy services; communication and mobility supports; and psychological, behavioral, and psychiatric services.

44. Based on data and information gleaned, in part, from the State's Outreach Treatment Services ("OTS") and Intensive Treatment Services ("ITS") programs, the State shall develop and implement a plan with effective steps to expand and improve expert health care and expert psychological, behavioral, and mental health services in the community for community residents with complex health care needs, and/or behavior problems and/or mental illness. The intent of

the plan shall be to better meet residents' health care, behavioral, and mental health needs in the community, avoid crises marked by the escalation of health care and/or behavior problems, and to minimize or eliminate failed or troubled community placements due to poorly addressed resident behaviors and, thus, minimize or eliminate re-institutionalization.

45. To assist in this process, the State will develop and implement a plan on or before March 1, 2009, to utilize and/or expand the State's existing electronic information system/tele-health network to better meet the needs of persons with developmental disabilities, especially those living in more rural areas of the State. The plan shall address how to provide more immediate and better access to records and expert professionals, transmit lab results and radiological reports between health care and other professionals, better track quality of care, improve communication with local hospitals and specialists, and generally provide better proactive care and treatment through a more seamless continuum of care to enhance resident outcomes. The plan shall address how to conduct video-conferences among various health care providers at scattered locations to save time and the expense of travel, and to encourage, wherever appropriate, the use of video-consults/clinics between local physicians and other professionals with specialists at distant locations. The plan shall also address how to incorporate timely tele-trauma services for residents in crisis. In developing and implementing this plan, the State shall ensure that the security and privacy of resident information is safeguarded.

46. The State shall significantly expand its OTS program to address unmet needs in the community that place individuals at risk of short-term or long-term institutionalization at BSDC. The OTS program shall continue to support positive behavioral change to keep individuals as independent as possible, and in familiar surroundings in their homes in the community, and away from more restrictive placements such as hospitals, nursing homes, psychiatric facilities, and institutions.

47. The State shall continue to support its ITS program, but shall strengthen its focus on returning individuals back to appropriate community homes promptly after a short-term stay. The State shall maintain more restrictive criteria for admitting a person long-term to a congregate or institutional setting after a stay in the ITS.

Monitoring of Community Placements and Quality Assurance Measures

48. The State shall develop and implement a system, including service coordination services, to effectively monitor community-based placements and programs to ensure that they are developed in accordance with the individualized transition plans set forth above, and that the individuals placed are provided with the protections, services, and supports they need. These and other monitoring and oversight mechanisms shall serve to help protect individuals from abuse, neglect, and mistreatment in their community residential and other programs. The State's oversight shall include regular inspections of community residential and program sites; regular face-to-face meetings with residents and staff; and in-depth reviews of treatment records, incident/injury data, key-indicator performance data, and other provider records.

49. BSDC residents who are placed in the community shall be served by an adequate number of service coordinators to meet residents' needs. The State's service coordination program shall provide for various levels of follow-up and intervention, including more intensive service coordination for those residents leaving BSDC with more complex needs. To encourage frequent individual contact, residents leaving BSDC will be served by service coordinators that carry a caseload of no more than 25 individuals at a time. Service coordinators involved with individuals from BSDC with more complex and intensive needs will carry a caseload of no more than 20 individuals at a time. All service coordinators shall receive appropriate and adequate supervision and competency-based training.

50. The State shall provide prompt and effective support and intervention services post-placement to residents who present adjustment problems related to the transition process such that each resident may stay in his or her community residence when appropriate, or be placed in a different, adequate, and appropriate community setting as soon as possible. These services may include, but not be limited to: providing heightened and enhanced service coordination to the resident/home; providing professional consultation, expert assistance, training, or other technical assistance to the resident/home; providing short-term supplemental staffing and/or other assistance at the home as long as the problem exists; and developing and implementing other community residential alternative solutions for the resident.

51. The State commits to maintaining discharged residents in the most integrated community setting appropriate for their needs. Any admission or re-admission to BSDC will be considered short-term. If a resident is re-admitted to BSDC, the State shall document the basis for the re-admission and then conduct a prompt assessment to identify and resolve any factors necessitating the re-admission.

52. The State shall regularly collect, aggregate, and analyze data related to discharge and placement efforts, including but not limited to information related to both successful and unsuccessful placements, as well as the problems or barriers to placing and/or keeping residents in the most integrated and appropriate setting. On or before January 1, 2009, the State shall also collect, aggregate, and analyze community data for at least the past five years from its OTS program and its ITS program, which may reveal systemic problems or barriers to meeting individual consumer needs in the community. Such problems or barriers may include, but not be limited to insufficient or inadequate: housing, community resources, health care, behavior management and services, and meaningful day activities including supported employment. The State shall review this information on a regular basis and develop and implement prompt and effective strategies to overcome the problems and barriers identified.

53. The State shall regularly review various community providers and programs to identify gaps and weaknesses, as well as areas of highest demand, to provide information for comprehensive planning, administration, resource-targeting, and implementing needed remedies. The State shall develop and implement effective strategies to any gaps or weaknesses or issues identified.

C. TRAINING AND BEHAVIORAL SERVICES, RESTRAINTS, AND PSYCHIATRIC CARE

Training and Behavioral Services

Principal Requirement

54. The State shall provide adequate psychological and behavioral services, including skills training and positive behavioral support plans, to meet the individualized needs of each resident, especially those with challenging behaviors. These services shall be developed and implemented to ensure and protect residents' right to training sufficient to provide each resident a reasonable opportunity to enhance functioning, to grow and develop, to attain self-help and social skills needed to exercise as much autonomy or independence as possible, to prevent or decelerate both physical and psychological regression, loss of skills and functional status, and to ensure their reasonable safety, security and freedom from undue bodily restraint. To this end:

Individualized Assessments

55. The State has begun and will continue the process of conducting a new interdisciplinary evaluation of each resident to determine the specific areas in which each resident needs training. These interdisciplinary evaluations shall be completed for all residents on or before January 1, 2009, and shall be repeated for all residents at annual intervals, unless required more frequently by each resident's needs; residents with challenging behaviors will likely require interdisciplinary evaluations much more frequently than once a year.

56. This interdisciplinary evaluation shall include adequate behavioral assessments (including an individualized, formal functional analysis whenever appropriate) based on the input from the psychologists and an interdisciplinary team. A functional analysis is an assessment of an individual's behavior that includes: (1) a description of the behaviors(s); (2) the collection of empirical data; (3) an assessment of the behavioral intensity, frequency, duration, and severity; (4) an evaluation of the antecedents, consequences and function of the behavior(s); (5) an assessment of any medical, nursing, mental health or other conditions related to the behavior(s) so as to determine the medical, behavioral, mental health, environmental and/or other factors that may be causing each resident's challenging behaviors; and (6) the development of skills training, behavior support, and other procedures based upon the analysis. The psychologist's assessment and functional analysis shall be based on a first-hand, in-depth, observational analysis of each resident's behavior, and not primarily from data provided pursuant to a screening tool.

Skills Training and Habilitation

57. Based on this evaluation, the State shall develop and implement a professionally-based, individualized skills training and habilitation support plan for each resident and provide each resident with a minimum of five hours per day of off-residence skills training, in the community

whenever appropriate, derived from the resident's skills training and habilitation support plan, to meet the individualized needs of each resident. The skills training and habilitation support plans shall include real-life variables, in the community whenever appropriate, with outcome measures that will be meaningful to residents with an emphasis on providing training in functional contexts. Plans shall be developed and implemented with a focus on proactive skills building and an emphasis on reducing the use of restrictive interventions. Residents' needs for meaningful training shall be continually met.

58. In developing and implementing the skills training and habilitation support plans, the State shall provide residents with these services in the most integrated setting appropriate for each individual resident. The State shall emphasize involvement in and with the community, away from the BSDC campus, as much as possible and appropriate, according to each resident's individualized needs.

59. The State shall develop and implement an initiative to significantly increase community integration activities and opportunities for residents day-to-day, including: (a) community supported employment; (b) community day programming; (c) community volunteer activities; and (d) community business and recreational outings, including but not limited to grocery stores, pharmacies, restaurants, theaters, and places of religious expression. This initiative shall ensure that staffing, transportation, and other resources are adequate to meet the residents' needs for community integration activities and opportunities.

60. The State shall develop and implement an initiative to better engage residents in meaningful training and activity throughout each day, according to their individualized needs, when the residents are on-campus and/or on their living units. This initiative shall make better use of on-campus recreational facilities, such as at the Carstens Center.

Positive Behavioral Support Plans

61. For residents with behaviors, the State shall ensure that psychologists develop and implement positive behavioral support plans that include: (1) a detailed definition and identification of the specific, measurable, and objective behavior(s) to increase and/or decrease; (2) a description and incorporation of the individualized functional analysis; (3) a comprehensive discussion of how medical and/or psychiatric disorders impact behavioral problems; (4) the procedures for staff to follow to decrease the occurrence of the problem behaviors; (5) the skills and positive, adaptive behaviors (to include replacement behaviors) that will be taught and the procedures for teaching them; (6) environmental changes to promote the development of positive, adaptive behaviors; (7) individualized reinforcers and/or preferences as determined in accordance with the needs of each resident; (8) an individualized schedule of active treatment activities as documented in the resident's individualized plan that corresponds to the resident's treatment needs; and (9) an adequate data collection system that includes appropriate data collection procedures which, for residents with positive behavioral support plans, shall measure information about maladaptive and adaptive behaviors and the conditions under which they

occur, including, where appropriate, the frequency, intensity, severity, and duration of the behaviors.

62. In developing and implementing these positive behavioral support plans, the psychologists shall adequately document their clinical findings and the treatment hypotheses to be tested, and set forth how treatments are derived. The psychologists shall also document their rationale for using specific behavioral interventions.

63. The State shall ensure that psychologists write concise and simple-to-use positive behavioral support plans at a level that can be easily understood and implemented by direct care staff.

64. The State shall improve implementation of behavioral plans at the direct care staff level. As part of this initiative, in conjunction with outside consultants, as appropriate, the State shall provide regular and ongoing competency-based training to direct care and supervisory staff on how to properly redirect residents' behaviors pursuant to each resident's plan, without resorting to the undue use of planned or unplanned mechanical, physical, or chemical restraints.

65. Both skills training and positive behavioral supports shall be developed and implemented as part of a resident's overall individualized plan. The State shall ensure that there is effective coordination and integration of services and treatment modalities, including psychology, psychiatry, neurology, nursing, medical and health care, and other needed services.

66. On or before January 1, 2009, the State shall maintain an effective Behavior Intervention Committee review process for the development and implementation of positive behavioral support plans, with an emphasis on stringent review and approval of restrictive interventions.

Monitoring and Follow-Up

67. The State shall develop and implement an effective system to regularly monitor each resident's skills training and positive behavioral support plans. The monitoring of the skills training and positive behavioral support plans shall produce prompt and effective follow-up action to ensure that: (a) the direct care staff are effectively implementing the skills training and behavior support plans, (b) the skills training and behavior support plans are effective and producing training and treatment outcomes specified in each resident's plan, and (c) where the residents are not making progress, the skills training and behavior support plans are modified appropriately and whenever necessary, and implemented promptly thereafter.

68. This monitoring system shall include tracking of systemic and individual outcome measures, with variables including, but not limited to: the incidence of resident behaviors, the use of restraints, the use of emergency procedures, and the implementation and monitoring of behavior plans. The State shall promptly and effectively address any systemic or individual problems identified through monitoring.

Priority Group

69. Based on the assessments and the monitoring, the State shall create a list of behavioral priority residents for heightened and enhanced attention and focus. This priority group shall consist, at least, of those residents who have already had a planned or unplanned mechanical, physical, or chemical restraint, those residents with a dual diagnosis of mental illness, those residents with significant or challenging behavior problems, as well as those residents who sustain or cause frequent injuries or are at risk of serious harm due to their behaviors.

70. In close consultation with outside consultants, as appropriate, the State shall prioritize these residents for the development and implementation of alternative and/or more tailored and intensive protections, supports, and services, where appropriate, through augmented and enhanced skills training and habilitation, positive behavioral supports, mental health care, and other interventions and treatment modalities, including an increased emphasis on community living and/or more structured, meaningful, and integrated habilitative activities in the community. These protections, supports, and services shall meet the resident's individualized needs without relying on the use of restraints. The intent here is to minimize or eliminate the triggers for behaviors, minimize or eliminate the behaviors themselves, and minimize or eliminate the use of restraints.

71. The steps necessary to achieve such positive outcomes for the residents in this priority group may include: daily interdisciplinary team meetings, regular contact with outside consultants, as appropriate, close observation of the residents and their staff, daily competency-based training of staff with regard to how to properly implement needed interventions, regular revision of plans and approaches, changes in the living environment, more frequent contact with people in the community in normal settings, and more meaningful and engaging day activities in the community.

Restraints

72. The State shall ensure that all residents are free from unreasonable restraint. The State shall develop and implement effective measures to minimize significantly or eliminate entirely the use of mechanical, physical, and chemical restraints on BSDC residents. The State shall ensure that restraints are not used as punishment, in lieu of habilitation, skills training and behavior support plans, or for the convenience of staff. Any restraint used will be the least restrictive form of restraint.

73. Restraints shall not be a part of any positive behavioral support plan and restraints shall not be used as a learning-based contingency to reduce the frequency of a behavior. Restraints may only be used for medical reasons or when there is immediate risk of harm to self or others (*i.e.*, to interrupt or terminate a seriously dangerous situation where injury could result). The State shall revise its policy definition of immediate risk of harm to self or others to ensure that the justified use of restraints is minimized. The State shall ensure that restraints labeled as

"medical" restraints are not, in fact, used for behavioral purposes or control. The State shall continue to prohibit the use of all prone physical and mechanical restraints.

74. In order to minimize or eliminate the use of restraints generally, the State shall ensure that the staff are adequately and appropriately implementing all aspects of each resident's overall individualized plan, including aspects related to positive behavioral supports, skills training and habilitation, mental health care, and integrated community living and activities. The State shall ensure that the supervisory and professional staff are regularly monitoring the individualized plans and their implementation to ensure that the plans and their implementation are effective and producing the desired reduction or elimination in the use of restraints. Where plan modifications are needed to address a resident's restraint usage, the State shall ensure that appropriate plan revisions are promptly developed and implemented.

75. The resident's psychologist shall begin the regular practice of reviewing, by the next working day, each use of mechanical, physical, or chemical restraint (excluding planned medical restraints), so as to ascertain the circumstances under which such restraint was used. The psychologist will conduct an analysis of what antecedents or circumstances may have prompted the behavioral escalation that led to the use of restraint. The psychologist shall analyze at least these variables: whether the behavior plan as written and/or implemented is effective in addressing the resident's behaviors; whether the living environment is overly restrictive and segregated; whether the living environment is overly crowded and/or fosters conflict with too much exposure to other residents prone to behaviors; whether there is adequate skills training, habilitation, and/or meaningful community activities throughout the day; and whether the resident is receiving adequate and appropriate treatment for his or her mental illness. The psychologist will then promptly develop, and the staff will implement, individualized measures to minimize or eliminate such antecedents or circumstances.

76. If any resident is subjected to three or more restraints within a 30-day period, the State will convene a meeting of the resident's interdisciplinary team, including the psychologist, to conduct a comprehensive review of the effectiveness and appropriateness of the resident's existing protections, supports, and services. This team meeting shall take place on the first working day following the third restraint. The team meeting shall include the input and analysis of outside consultants whenever possible. The team shall promptly develop, whenever necessary, alternative and/or more tailored and intensive protections, supports, and services that meet the resident's individualized needs, but that do not rely on the use of restraints. The team shall make specific recommendations and shall document these recommendations in the resident's record, making changes in the resident's individualized plan whenever necessary. These recommendations in the revised plan shall be implemented promptly and properly to meet the resident's plan.

77. The parties anticipate that the use of mechanical, physical, and chemical restraints at BSDC will become a very rare occurrence. When utilized, however, staff shall take the following steps and precautions:

a. provide immediate notification to an on-site supervisor upon the use of any restraints;

b. provide notification to and obtain the approval of a psychologist and/or nurse if any restraint is applied for longer than one hour, and upon each hour thereafter;

c. ensure that a nurse provides a timely assessment that the restraint is being safely applied and is reasonably tailored to the resident's behavior;

d. provide continuous monitoring of the resident while restrained to ensure safety; ensure that a nurse or senior supervisor monitors and documents the residents' vital signs, respiration, circulation, and mental status at least every hour the resident is restrained; release every restrained limb from restraint, examine it for bruising and skin tears, and allow exercise of the limb at least ten minutes every hour; provide the restrained resident with an opportunity to eat, drink fluids, and toilet, as needed; provide every resident in restraint with continuous one-to-one supervision; and

e. release every restrained resident from restraint as soon as the resident is determined not to pose an immediate risk of harm to self or others.

78. The State shall ensure that staff are adequately trained on the proper use of restraints.

79. The State shall document each use of mechanical, physical, and chemical restraint, including the date and time of use, the events leading to the restraint, the exact type of restraint or procedure used, as well as the length of time it was used. Documentation of each use of restraint shall be kept in the resident's file and in a central location.

80. The State shall ensure that chemical restraints meet appropriate levels of approval and oversight by a psychiatrist, psychologist, and physician prior to their administration. Staff shall collect adequate data on the effects, as well as adverse side effects, of each individual administration of such medications. The psychiatrist, psychologist, and physician shall consider the data collected when making future clinical intervention decisions. The State shall prohibit the use of standing PRN or "stat" orders for chemical restraints.

Psychiatric Care

81. The State shall provide adequate and appropriate routine and emergency psychiatric and mental health services to meet the individualized needs of each resident. These services shall be developed to ensure and protect residents' rights.

Adequate Psychiatry Hours

82. On or before October 1, 2008, the State shall procure additional psychiatry hours to meet the mental health needs of the residents. The psychiatrist(s) shall be well-respected with a demonstrated history of effectively meeting the needs of persons with developmental disabilities

and a dual diagnosis of mental illness. The State shall provide residents with enough psychiatry hours to enable the psychiatrist(s) to conduct thorough and complete evaluations, develop carefully considered differential diagnoses, order appropriately tailored treatments, and provide regular and sufficient follow-up monitoring to determine whether ordered treatments are, in fact, working to address the residents' underlying mental illness. If such treatments are not working, the psychiatrist(s) shall have enough time to conduct new evaluations, pursue alternative diagnoses and treatments, and monitor and follow-up again. The psychiatrist(s) shall have enough time to engage in this ongoing practice for all residents, including those residents with challenging behaviors associated with their mental illness. The psychiatrist(s) shall have sufficient time to see all residents frequently enough such that they are receiving effective treatment for their mental illness. The psychiatrist(s) shall have sufficient time such that no primary care physician, physician's assistant, or registered nurse is primarily responsible for providing psychiatric follow-up care.

Psychiatric Assessments and Diagnoses, and Mental Health Treatment

83. The State shall ensure that annually, or more often as needed, the psychiatrist(s) conducts a comprehensive assessment of each resident receiving psychotropic medication and each resident who has or may have a diagnosis of mental illness. The State shall ensure that for each resident assessed as having mental illness, the psychiatrist(s) documents a clinically justifiable, differential diagnosis consistent with DSM-IV-TR criteria. No resident shall have a current mental health diagnosis that is not clinically justified in the record.

84. The State shall ensure that the psychiatrist(s) develops and implements an overall mental health treatment plan for each resident with a diagnosis of mental illness, and provides ongoing monitoring and revision of the treatment plan. Any treatment must comport with the mental health diagnosis. The psychiatrist(s) shall ensure that there is proper coordination and integration of psychiatric services with other services and treatment modalities, including those in psychology, neurology, nursing, medical and health care, and other ancillary services.

Psychotropic Medication

85. On or before January 1, 2009, the State shall implement and maintain the following requirements with regard to the use of psychotropic medication:

a. Prior to developing and implementing an appropriate treatment plan, the psychiatrist(s) shall review the current medication regimen of each resident to determine whether the type and dosage of the medication is appropriate and necessary, and then, if necessary, make any changes in the medication regimen.

b. The psychiatrist(s) shall use psychotropic medication only as an integral part of the resident's individualized skills training and positive behavioral support plans.

c. The psychiatrist(s) shall carefully review the medication regimen of residents where current doses are above the generally accepted effective dose for any particular medication.

d. The psychiatrist(s) shall consult with the assigned psychologist and interdisciplinary team to determine whether the existing skills training and behavioral support plans are appropriate and whether different programs or interventions should be developed to address the resident's index behaviors and symptoms so as to reduce or eliminate the need for psychotropic medications.

e. The psychiatrist(s) shall consult with the resident's primary care physician, nurse, or other appropriate members of the resident's interdisciplinary team, to determine whether the harmful effects of the resident's mental illness clearly outweigh the possible harmful side effects of the psychotropic medication and whether reasonable alternate treatment strategies are likely to be less effective or potentially more dangerous than the medication.

f. The psychiatrist(s) shall ensure that the decision-making process for titrating medications up or down is clearly and fully set forth in each resident's record.

g. The psychiatrist(s) shall ensure that there is a clear and full justification for the use of any typical or "first-generation" anti-psychotic medications.

h. The psychiatrist(s) shall take care to reduce or discontinue benzodiazepines and anticholinergic medications that have been used for longer periods of time than are justified by the resident's psychiatric diagnosis.

i. The use of intra-class polypharmacy shall be minimized, and whenever it is used, the psychiatrist(s) shall fully justify its use in that resident's treatment plan.

86. The State shall better educate guardians about proper mental health care and address their concerns when medication changes are needed to meet residents' needs.

Monitoring and Follow-Up

87. The State shall develop and implement an effective system to ensure that the psychiatrist(s) regularly monitors the residents with mental illness whenever needed, and make changes, when warranted, in the residents' treatment plans. For those residents who receive psychotropic medication, this monitoring shall be face-to-face, and shall be conducted quarterly by the psychiatrist(s), or more often as necessary based on the residents' current status and/or changing mental health needs. The monitoring review shall include a review of any current psychotropic medication provided, as well as a review of the pertinent behavioral and other data. Whenever necessary, the psychiatrist(s) shall provide a psychiatric re-assessment and revision to the treatment plan, as appropriate, for each resident who: i) presents a significant adverse

change in symptoms/index behaviors; ii) an increase in significant injuries or incidents related to symptoms/index behaviors; or iii) is subjected to an increase in repeated restraint due to a significant adverse change in symptoms/index behaviors.

88. The State shall maintain an adequate system for detecting, reporting, responding to, and documenting any drug-induced side effects of psychotropic medication. The State shall provide effective competency-based training for staff that complete side effects monitoring forms.

Chemical Restraint

89. Consistent with the restraint section above, when psychotropic medication is used on an emergency basis, a supervisor shall be notified immediately, there shall be continuous monitoring of the resident after administration of the medication, and a physician shall observe the effect of the medication by personally visiting the resident or directing supervision by a registered nurse. A psychiatrist shall review the use within 24 hours of the order being written if there are multiple administrations of the medication or if more than one order is written for different medications. The psychiatrist shall develop and implement measures to help prevent the emergency use of psychotropic medication in the future.

D. **HEALTH CARE AND RELATED SERVICES**

Principal Requirement

90. The State shall provide residents with adequate, appropriate and timely preventive, routine, acute, and emergency health care, including neurological care, to meet the individualized needs of the residents. The State shall develop and implement policies to guide the delivery of general and preventative medical care to meet the needs of the residents and require appropriate physician participation in the interdisciplinary provision of services and the creation of residents' individualized plans.

Adequate Health Care Staffing

91. The State shall maintain sufficient numbers of adequately trained health care staff, including physicians and nurses, on each shift to provide adequate protections, supports, and services to residents at all times. The State shall take effective steps to reduce reliance on temporary or floating health care staff, who may not be as familiar with the particular needs of individual residents. The State shall place a heightened focus on ensuring that new and temporary floating health care staff are properly trained on individualized resident needs before assignment to any particular unit.

Medical Care

Health Care Assessments, Diagnoses, Treatments, and Follow-Up Monitoring

92. The State shall have a physician conduct comprehensive health care evaluations of all residents, and repeat at annual intervals unless required more frequently by each resident's condition. The assessments shall be sufficient to enable the physician to reach a reliable diagnosis, if applicable, for each resident. The State shall develop and implement a system to ensure that referrals and testing procedures are completed and results are placed in the residents' medical record in a timely manner. For each resident assessed as having a health care concern or concerns, a physician shall document a clinically justifiable health care diagnosis for each of the resident's conditions. Based on the comprehensive medical assessment, the State shall ensure that a physician develops for each resident an integrated health care plan to address any health care conditions revealed through the assessment process. The State shall ensure that each resident's health care plan is implemented properly, day-to-day, to meet each resident's individualized health care needs.

93. To assist implementation efforts, the State shall take effective steps to improve communication among disciplines and departments at BSDC to eliminate confusion and fragmentation of care. To assist with this, the State shall continue to require medical staff members, including physicians and nurses, to participate in interdisciplinary team meetings. In addition, the State shall take effective steps to simplify and streamline charting, documentation, and record-keeping, with a goal of enhancing interdisciplinary communication and coordination to enhance timely service-delivery and continuity of care.

94. The State shall have a physician determine what specialized health care services, including neurological services, are required for each resident and ensure that each resident receives such specialized health care services in a timely manner whenever necessary to evaluate or treat each resident's health care problems.

95. The State shall develop and implement an effective system to regularly monitor each resident's health status and progress and develop and implement changes, whenever warranted, in each resident's health care plan. The State shall establish a health care quality assurance program that actively collects data relating to the quality of health care services, assesses these data for trends, initiates inquiries regarding problematic trends and individual issues, identifies and triggers corrective action, and provides ongoing monitoring to ensure that appropriate remedies are achieved.

96. The State shall develop and implement a plan to conduct regular internal chart audits with regard to the delivery of effective health care to residents. If any problems or concerns are identified as a result of any audit, the State shall promptly develop and implement corrective measures, both for individual and systemic issues.

Priority Group

97. Based on the assessments and the monitoring, the State shall create a list of health care priority residents for heightened and enhanced attention and focus. This priority group shall consist, at least, of those residents who have had a seizure or have a seizure disorder, have developed or are at risk of developing a bowel impaction or bowel obstruction, have aspirated or are at risk of aspirating, have developed a decubitus ulcer or skin breakdown or are at risk of developing a decubitus ulcer or skin breakdown, and have suffered a fracture or are at risk of suffering a fracture, including those residents with osteoporosis. The State shall include in this priority group any other resident who is in an at-risk group or is at-risk of suffering an incident that would adversely impact his or her health.

98. In close consultation with outside consultants, as appropriate, the State shall prioritize these residents for the development and implementation of alternative and/or more tailored and intensive protections, supports, and services, where appropriate, that meet the residents' individualized needs. The intent is that the State will develop and implement strategies to provide proactive health care such that resident seizures, bowel impactions and obstructions, aspiration and aspiration pneumonia, decubitus ulcers and skin breakdown, fractures, and the adverse consequences of other at-risk conditions will be minimized or eliminated.

99. The steps necessary to achieve such positive outcomes for the residents in this priority group may include daily interdisciplinary team meetings, regular contact with outside consultants, as appropriate, close observation of the residents and their staff, daily competency-based training of staff with regard to how to properly implement needed interventions, regular revision of plans and approaches, and changes in the living environment.

Seizure Disorders

100. The neurologist(s) shall identify all residents currently receiving anticonvulsant medication, residents with an existing diagnosis of epilepsy, and residents who have had at least one seizure in the past two years, and provide them with a comprehensive evaluation using a detailed diagnostic work-up conducted by a neurologist, at least annually, or more frequently as required by each resident's condition.

101. The neurologist(s) shall ensure that those residents with refractory seizures, i.e., those having more than 10 seizures in one year, receive appropriate and effective neurological interventions.

102. The neurologist(s) shall document the rationale and need for anticonvulsant medication in all cases, with a special emphasis on those residents receiving anticonvulsant polypharmacy, and document whether the potential harmful effects of the anticonvulsant medication on a resident's quality of life outweigh the potential benefits of the use of the medication. The neurologist(s) shall ensure that it is still appropriate for each resident currently receiving anticonvulsant medication, but who has remained seizure-free for the past two years, to continue

to receive the anticonvulsant medication. For each resident receiving medications for both seizures and a mental health disorder, the psychiatrist(s), the neurologist(s), and the interdisciplinary team shall coordinate the appropriate and continued use of such medications. The use of intra-class polypharmacy shall be minimized, and whenever it is used, the neurologist(s)/psychiatrist(s) shall fully justify its use in that resident's treatment plan.

103. The State shall develop and implement a system that ensures the accurate and timely recording of seizures for each resident including the following information: the date and time of the onset of the seizure; the duration of the seizure; a description of the seizure; an indication as to whether or not the resident is conscious or unconscious; if unconscious, the onset of the unconsciousness and the duration of the period(s) of unconsciousness; any medical or other steps taken to control the seizure; and the resident's response to the intervention. All staff, including nursing and direct care staff, shall be provided with competency-based training in recognizing a seizure, describing the seizure and length of time it lasts, and recording that information in the resident's record.

104. The State shall develop and implement an emergency protocol for the proper treatment of status epilepticus and provide competency-based training to the staff on how to implement it.

Peer Review

105. On or before January 1, 2009, the State shall create a peer review system with regard to the provision of health care services to residents. The peer reviewers shall be independent and external to BSDC and shall include individuals who are not employees of the State Department of Health and Human Services. The peer reviewers shall be well-respected health care consultants who have a demonstrated history of effectively meeting the health care needs of persons with developmental disabilities. Peer review of the provision of health care shall take place at least once a year. The peer reviewers will review a limited sample of plans from each physician or other primary health care provider. The review will include a targeted review of plans for residents in the health care priority group. Promptly after each peer review, the State will develop and implement measures to address all individual and systemic issues identified in the peer review process.

Mortality Review

106. On or before November 1, 2008, the State shall create an independent and external mortality review committee, comprised of well-respected health care consultants who have a demonstrated history of effectively meeting the health care needs of persons with developmental disabilities. The members of the mortality review committee shall be independent and external to BSDC, and shall not be employees of the State Department of Health and Human Services. The consultants who serve on the mortality review committee may also serve on the health care peer review committee. The purpose of the mortality reviews is to identify and promptly resolve any preventable causes of illness and death so that other similarly situated residents will not suffer preventable illness or death.

107. The mortality review committee shall meet promptly after each resident death to address individual and systemic issues related to each death. The committee shall have full and complete access to pertinent health care records and other documents, physicians and primary health care providers, and staff. The committee shall conduct appropriate interviews, and review and discuss any necessary supporting documentation related to the course of care leading up to each death, including: the death incident report, the completed death investigation, documents from the resident's chart, any autopsies that may have been performed, and reviews from all pertinent disciplines.

108. The committee shall identify preventable causes of illness and/or death, if any, in each individual case. The committee shall make written recommendations for remedial action, whenever appropriate, with regard to individual and systemic issues related to the death. The State shall ensure the prompt and effective implementation of all of the committee's recommendations. The mortality review committee shall continue to monitor all recommendations for remedial action until they are implemented.

National Health Care Organizations

109. The State shall take effective steps to encourage health care staff to become more actively involved in national health care organizations, especially those that focus on providing proactive health care to persons with developmental disabilities. The intent of this provision is that more involvement and engagement with national health care organizations may lead to better health care for residents.

Nursing Care

110. The State shall provide residents with adequate, appropriate and timely nursing care to meet the individualized needs of the residents. Nurses shall perform their responsibilities by adequately identifying and assessing health care problems, developing and implementing appropriate interventions, monitoring and intervening to ameliorate such problems, evaluating the appropriate outcome for the problems, and keeping appropriate records of residents' health care status.

111. The State shall develop and implement policies to guide the delivery of nursing care to meet the residents' needs with regard to conducting assessments, frequency of follow-up, and documentation for changes in residents' health status. The State shall develop and implement policies that require nursing participation in the interdisciplinary provision of services and the creation of individualized nursing care plans as part of residents' individualized plans. Nurses shall participate as core members of the interdisciplinary team. These policies shall include a formal communication system to alert all team members and health care providers to changes in a resident's health status, and documentation of reasons for the discontinuation of any team recommendations.

112. Nursing interventions shall be developed and implemented whenever needed, and especially for the following situations: (a) when a resident sustains an injury; (b) when a resident is restrained; (c) when medications are administered; (d) for the ongoing care of a resident's tracheotomy tube; (e) when a resident has a skin care and/or positioning and/or nutritional and physical management plan; (f) when a resident has or is at risk of developing a decubitus ulcer; (g) when a resident is at risk of a bowel impaction or obstruction; (h) when a resident presents any other risk factor; (i) when a resident suffers a significant weight loss/gain or is at risk of significant weight loss/gain; and (j) when a resident is enterally fed.

113. The State shall develop and implement an effective system to regularly monitor the residents' health care outcomes and make and implement changes in the residents' nursing care plans and interventions whenever warranted given the residents' needs.

114. The State shall provide nursing staff with ongoing competency-based training with regard to the following: (a) appropriate documentation and description of a resident's status when the resident leaves the facility and upon the resident's return; (b) role of the nurse in the interdisciplinary team process; (c) functional programming and habilitation; (d) proper development and implementation of the nursing care plans; (e) proper documentation and treatment of decubitus ulcers, including the description and the stage of the ulcer; and (f) proper documentation and treatment of significant events.

115. The State shall develop and implement a nursing Performance Management Process to monitor nursing assessments and documentation. Where problematic trends are identified, the State shall timely develop, implement and monitor a corrective action plan given the residents' needs.

116. The State shall administer medications to residents safely and effectively. When a medication error occurs, the State shall investigate the error, document it and take appropriate corrective action, including supervision and training.

117. The State shall ensure that nurses and other health care and direct care staff observe proper infection control procedures.

118. The State shall develop and implement a policy on the proper procedure for emergency tracheotomy care and replacement that includes competency-based staff training. The State shall provide an adequate and appropriate replacement tube of correct size and length which is easily accessible to each resident with a tracheotomy.

119. The State shall develop and implement a protocol for documentation of caloric, protein, water, and/or fluid intake requirements to ensure that residents, including those who are enterally fed, are receiving the prescribed nutrition and fluid intake to meet their individualized needs.

Nutritional and Physical Supports/Therapeutic Interventions

120. The State shall provide each resident with effective, appropriate, and timely nutritional and physical supports to meet the individualized health care needs of each resident.

Interdisciplinary Nutritional and Physical Support Team

121. The State shall ensure that an interdisciplinary team qualified to address nutritional and physical support issues addresses residents' global nutritional and physical support needs. The State shall ensure that the team meets on a regular basis, and includes representation from various disciplines as required to meet the individualized needs of the residents including, nursing, a physician, nutrition, psychology, occupational therapy, speech therapy including a specialist in dysphagia, respiratory therapy, and physical therapy, as well as certain direct care workers from the particular resident's unit, and any other necessary specialists.

122. The team shall identify each resident who has a nutritional and physical support need, or nutritional support problem, including all residents who are at risk of choking and/or aspirating, have dysphagia, difficulty swallowing, chewing, or retaining, food or liquids, have had aspiration pneumonia or other recurrent pneumonias, all residents who cannot feed themselves, any resident who currently receives or is a candidate to receive a feeding tube, and any resident with other medical or health care problems related to nutritional and physical support.

123. After the team members contribute comprehensive assessment(s) of the resident's individualized needs to identify the causes for the nutritional and physical support problem(s), the team shall provide an analysis of the assessment(s) in a written comprehensive, coordinated nutritional and physical support action plan (hereinafter called "action plan") to meet the individualized needs of the residents and that adequately addresses the resident's positioning and nutritional support needs throughout the day. The analysis and action plan shall describe antecedents and interrelationships of the occurrence of physical and nutritional health risk indicators. The action plan shall be implemented for each resident and shall address proper mealtime/eating techniques and positioning of the residents during meals (including snacks), drinking, tooth brushing, dental exams, medication administration, bathing, nighttime/bedtime, and other routine activities that are likely to provoke nutritional and physical support problems. The plan shall include support strategies to anticipate, minimize, or remediate these concerns with written documentation of measurable, functional outcomes to be achieved.

High Risk Criteria, Oversight

124. The State shall develop and implement criteria by which residents at the highest nutritional and physical risk are identified and assessed by the interdisciplinary nutritional and physical support team with regard to nutritional and physical support needs on an ongoing basis. The State shall prioritize these residents for the development and implementation of alternative and/or more tailored and intensive protections, supports, and services, where appropriate, that meet the residents' individualized needs.

125. The State shall develop and implement a system to provide review and oversight of at-risk residents so that those identified as at highest risk may benefit promptly from comprehensive nutritional and physical supports. The system shall clearly define and document the oversight role with regard to ensuring the effectiveness of implementation strategies. The system shall develop and implement a methodology and clearly defined policies and procedures related to follow-up and documentation to ensure that individualized outcomes are achieved.

Meals, Eating, Drinking, Plan Monitoring

126. The State shall develop and implement a system to ensure that staff do not engage residents in any mealtime/eating practice that poses an undue risk of harm to any resident, including assisting a resident to eat or drink who is improperly positioned or aligned, assisting a resident to eat or drink while the resident is coughing or exhibiting distress, assisting a resident to eat or drink with bites that are too large and/or faster than he or she can safely chew or swallow food and/or liquids. The State shall ensure that non-ambulatory residents shall be kept in proper alignment and shall not be laid flat on their backs during or after a meal until sufficient time has passed to allow digestion of food and/or liquids.

127. The State shall systematically and routinely monitor the implementation of the plans to ensure that the direct care staff safely and appropriately assist residents to eat and position the residents, especially for those residents who are at risk of aspirating, and to ensure that residents' nutritional and physical support plans are working effectively to meet the individualized needs of the residents to ameliorate the residents' physical and nutritional difficulties. The State shall ensure that all staff follow the instructions for each resident contained on the resident's nutritional and physical support plans.

128. The State shall develop and implement a system to ensure that staff assist residents with proper head alignment and other techniques during tooth-brushing, dental exams, and medication administration to minimize aspiration risk. The State shall ensure that there is proper coordination with dental and nursing personnel to accomplish this, and ensure that staff use proper infection control techniques during tooth-brushing to minimize risks of cross-contamination.

129. The State shall ensure that residents who use a feeding tube are fed through the tube only when medically necessary. The State shall evaluate and document the continued appropriateness of the tubes on a regular basis, and, where appropriate, develop and implement plans to return residents to oral eating and drinking. The State shall ensure that residents who take nutrition through a tube are provided with proper postural alignment and with adequate supervision to intervene whenever needed, especially if the resident is coughing during a tube feeding.

Therapy and Related Services

130. The State shall provide each resident with adequate, appropriate and timely occupational therapy, physical therapy, speech therapy, assistive technology support and physical assistance

support services to meet the individualized needs of the residents, to enhance the capacity of the residents to function, and to help the residents live safely and as independently as possible.

Assessments

131. The State shall identify and provide a comprehensive assessment of all residents who are in need of occupational therapy, physical therapy, speech therapy, assistive technology and physical assistance supports. Such assessments shall address: diagnoses and/or description of significant health care issues; health risk indicators; orthopedic concerns; musculoskeletal status, posture' functional mobility; functional performance of activities of daily living; communication; impact of health care issues on performance and therapeutic intervention; description of current therapeutic supports, which include mealtime, positioning and alignment, and assistive technology; and shall include baseline measurements where appropriate. Comprehensive assessments shall include analysis of findings to provide a rationale for recommendation and intervention strategies.

132. The State shall conduct a comprehensive assessment of all residents who use mobility, alternative/ therapeutic positioning, or other assistive technology supports (hereinafter, in this section, called "supports"). These assessments shall be completed in an interdisciplinary manner, including appropriate therapy staff and other appropriate staff, as well as direct care staff persons who know the resident well. Such assessments shall occur as frequently as needed to meet the individualized needs of the residents.

Implementation

133. The State shall develop and implement occupational therapy, physical therapy, speech therapy, assistive technology and physical assistance supports for all residents in need of such services as an integral part of the residents' individualized service plans. These supports shall have functional outcome goals and expectations that are measurable and which shall be implemented so as to document observable changes in a resident's function as a result of therapy intervention. The State shall conduct a comprehensive review of any existing occupational therapy, physical therapy, speech therapy, assistive technology or physical assistance supports for residents and determine whether these supports adequately meet the needs of the residents and are working as intended. The State shall develop and implement new or modified individualized service plans to meet the individualized needs of each resident identified in the assessments.

134. The State shall develop and implement the supports based on the comprehensive assessments so as to ensure that the supports and positioning are promoting good body alignment and functional health status. The State shall ensure that for residents with physical and nutritional problems, the supports mitigate the occurrence of aspiration and support other therapy goals for each resident based on the individualized needs of each resident. Proper supports and positioning are to be integrated into the resident's activities throughout the day.

Monitoring, Quality Assurance

135. The State shall systematically and routinely monitor the implementation of all of the aforementioned direct and indirect therapy supports to ensure that they are working effectively to achieve specific, measurable outcomes. The State shall develop and implement changes, whenever warranted, in the residents' supports and interventions to meet the individualized needs of the residents. The State shall adequately document direct therapy supports and interventions to justify initiation, continuation or discontinuation of such services to determine a resident's progress and the efficacy of treatment interventions. Direct therapy supports and interventions shall be documented and a monthly summary should identify the resident's status, progress and a comparative analysis of progress over time. Implementation of indirect therapy supports shall be documented at least quarterly per the individualized service plan.

Assistive Technology and Supports

136. The State shall develop and implement a quality assurance system for speech, occupational and physical therapy supports and services to self-monitor for quality improvement so as to achieve functional outcomes for residents.

137. Residents shall be provided with necessary identified assistive technology supports such as: (a) individualized, properly fitted seating systems that provide support and alignment for function that is optimal for that resident; (b) appropriate footwear while in such seating systems unless there is clear justification documented in the resident's record; and (c) seatbelts on wheelchairs and other mobility devices are appropriately positioned and adequately secured whenever appropriate to meet the needs of the residents. All supports shall be maintained in good working order and shall be repaired whenever necessary.

Alternate Positioning, Lifts and Transfers

138. The State shall develop and implement effective alternative positioning options for residents.

139. The State shall develop and implement a system to ensure that staff utilize appropriate lifting and transfer techniques.

Speech Therapy and Communication

140. With regard to speech therapy and communication, the State shall ensure that, on or before March 1, 2009, a qualified speech language pathologist with expertise in augmentative and alternative communication conducts comprehensive assessments of residents who need speech therapy and/or communication supports, develops and implements plans based on these assessments and monitors the implementation of the plans on an ongoing basis to ensure that they meet the individualized needs of the residents. The State shall ensure that such plans are reviewed and revised, as needed, but at least annually. The State shall develop and implement a

screening and evaluation tool and process designed to identify residents who would benefit from the use of alternative and/or augmentative communication devices or systems.

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I, on behalf of the undersigned parties, hereby execute and consent to the entry of this Consent Judgment.

Respectfully submitted,

UNITED STATES OF AMERICA, Plaintiff

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Date: June 27, 2008

And: */s/ Dave Heineman*
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State of Nebraska

Date: June 27, 2008

And: */s/ Christine Peterson*
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Date: June 30, 2008

And: */s/ John Wyvill*
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WHEREFORE, the parties to this action having agreed to the provisions in the Consent Judgment set forth above, and the Court being advised in the premises, this Consent Judgment is hereby entered as the Order and Judgment of this Court.

It is so ordered, this 2nd day of July, 2008, at Lincoln, Nebraska.

/s/ Richard G. Kopf
HON. RICHARD G. KOPF
United States District Judge