PLAINTIFFS'
EXHIBIT

PPI 1281

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, by his next friend	§	
and mother, Lilian Minor, *et al.*,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	
	§	
	§	
CHARLES SMITH, Governor, *et al.*,	§	
	§	
Defendants.	§	
	§	CIV. NO. 5:10-CV-1025-OG
	§	
THE UNITED STATES OF AMERICA,	§	
	§	
Plaintiff-Intervenor,	§	
	§	
v.	§	
	§	
THE STATE OF TEXAS,	§	
	§	
Defendants.	§	

PLANTIFFS AND THE UNITED STATES' EXPERT DISCLOSURE AND DECLARATION FOR BARBARA T. PILARCIK

I declare under the pains and penalties of perjury under the laws of the United States and in compliance with Fed. R. Civ. P. 26(a)(2)(B) that the foregoing is true and correct and that I am submitting this disclosure regarding my work as an expert consultant in the above case:

1. My rebuttal report describes the facts, data and other information I considered in forming my opinions.
2. There are no exhibits prepared at this time to be used as a summary of or support for my opinions.

3. My curriculum vitae, which was attached to my initial report, states my qualifications and lists all publications I have authored within the past ten years.

4. Within the last four (4) years, I have not testified as an expert, either in a deposition or at trial, except in this case during the preliminary injunction hearing.

5. I have been retained by the Plaintiffs and the United States as a joint expert in the Steward v. Smith litigation. My compensation in this litigation is $150.00 per hour or $1,200 per day for my review, preparation of reports and statements, and for deposition or testimony, plus expenses. My compensation is not dependent on the outcome of this litigation.

Signed and dated: April 30, 2018

Barbara T. Pilarcik

Barbara T. Pilarcik

CERTIFICATE OF SERVICE

I certify that on this 30th day of April, 2018, a true and correct copy of the foregoing Plaintiffs' and the United States' Expert Disclosure and Declaration for Barbara T. Pilarcik was delivered via electronic mail to the attorneys for defendants at the addresses below:

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

Eric Steward, by his next friend and
Mother, Lillian Minor, et al.,

Civil No. 5:10-cv-1025-OLG

Plaintiffs,

v.
Charles Smith, Executive Commissioner,
Texas Health and Human Services
Commission, et al.,

Defendants.

The United States of America,

Plaintiff-Intervenor,
v.

The State of Texas,

Defendant.

EXPERT REBUTTAL REPORT OF BARBARA PILARCIK

1. PURPOSE

I was asked by counsel for Plaintiffs and the United States to review the findings and opinions concerning the eleven named plaintiffs that are set forth in the expert reports of Eleanor Shea-Delaney and Kathy A. Bruni. For reasons not stated, neither reviewed one named plaintiff, Melvin Oatman. I conducted my own review of the needs, strengths, preferences, and services provided to all twelve of the named plaintiffs. Based upon this review, I have found numerous incorrect and misleading statements made by Bruni and Shea-Delaney about the named plaintiffs, as well as numerous omissions in their findings and conclusions. In addition, I determined that there were significant issues with the methodology they used to reach these conclusions. This limited methodology and these problematic findings were then used by Bruni and Shea-Delaney – who appear to have no recent clinical experience in evaluating individuals with IDD in nursing facilities – to make erroneous statements and unsubstantiated opinions about the overall performance of Texas' PASRR and transition programs. This report describes my findings and opinions concerning those statements.

In reaching these findings I have reviewed a variety of documents, as provided by counsel for Plaintiffs and the United States – all of which are set forth in Attachment B to my March 30 report or in Attachment A to this report.

2. QUALIFICATIONS

My training, experience, and professional qualifications were described in detail in my initial expert disclosure and report, and attached curriculum vitae, dated March 30, 2018.

3. METHODOLOGY

For this abbreviated rebuttal review, I reviewed nursing facility and LIDDA records for each of the twelve named plaintiffs primarily for the two years prior to September 1, 2017, or the two years prior to their transition to the community. Given the limited time available, I focused my review on the same types of records that I used in my prior review, because in my opinion those records are most relevant to assessing whether habilitative needs are assessed and provided for; whether LIDDA service coordinators are monitoring and ensuring the provision of needed specialized services and community options; whether there are appropriate transition plans in place; whether an individual would benefit from community placement; and whether an individual has made an informed choice to remain in a nursing facility. I focused on PASRR forms, specialized and rehabilitative services records including Medicare-funded services wherever I could find them, ISP, IPC, IDP, hospitalizations, incident reports, admission and discharge records, transition plans, any other assessment documents such as psychological or psychiatric reviews, MDS, and nursing care plans. I did not read but noted nursing facility assessments such as skin, pain and similar evaluations. I did not typically review nursing facility doctor's orders, nursing flow sheets or progress notes, daily flow sheets or logs, or medical administration records unless it appeared pertinent.

As part of my review I interviewed, by telephone, each individual and their guardian, Legally Authorized Representative (LAR), or another individual who knew them well including provider staff if the named plaintiff was in a community placement. For one woman who died prior to my review, I spoke to her mother and reviewed her records. Given the time constraints of this review, I was unable to meet face to face with the individual, or interview the relevant service coordinator and key nursing facility staff, as I did in my initial review. Despite the limitations of this methodology, which is substantially less rigorous and not as reliable as what I employed in my review of the randomly-selected individuals, I believe that this approach allowed me to make basic findings – and certainly rebut the far less informed opinions of Bruni and Shea-Delaney – concerning the situations of the named plaintiffs.

I conducted this review using the same questions and considerations from my initial review, both because they are the most appropriate frame for this type of clinical evaluation and to ensure some measure of consistency with my prior review. However, given the time and other limitations of this process, I was unable to make all findings for all individuals.

My review focused on information about events that occurred on or before September 1, 2017. Obtaining accurate information through telephone interviews about the historical thoughts, feelings, and experiences of individuals with IDD is challenging and limited my ability to make definitive findings. However, through these telephone interviews I was able to gain a direct sense of the person, their abilities and/or their guardian's experiences and preferences. I did not consider information about events that occurred after September 1, 2017 when making my findings.

When possible given the limited scope of this review, I made the following six findings: 1) whether the individual received a comprehensive functional assessment of all habilitative areas that accurately identified all of the individual's strengths, needs and preferences; (2) whether the individual is receiving all needed specialized services with the appropriate intensity, frequency, and duration to address all need areas; (3) whether the individual is receiving active treatment; (4) whether the individual has a professionally-appropriate Individual Service Plan that was developed based upon a comprehensive person-centered assessment and that includes all needed services and supports to successfully transition to the community; (5) whether the individual would benefit from living in an integrated setting with appropriate community services and supports; and (6) whether the individual or their guardian has made an informed and meaningful choice to remain in a segregated nursing facility.

My initial review of a randomly selected sample of individuals was significantly more comprehensive and detailed. It presents, for each person, a more reliable and complete understanding and assessment of the individuals' strengths, needs, and preferences and a more accurate picture of Texas's service system for people with Intellectual or Developmental Disabilities. Even so, the review I conducted of the named plaintiffs was more comprehensive and more consistent with professional standards for evaluating individuals with IDD than the limited reviews conducted by Bruni and Shea-Delaney.

4. GENERAL FINDINGS

A. Methodology

The sole source of information cited by Bruni or Shea-Delaney appears to be the records for each named plaintiff. Neither Bruni nor Shea-Delaney indicated that they spoke to the individual named plaintiffs themselves, anyone who personally knows or has ever met the individual plaintiffs, provides services to the individual plaintiffs, is familiar with the needs or preferences of the individual plaintiffs, or has direct knowledge of the nursing facility or community residential program where the individual lives. They did not conduct any type of in person or telephonic interviews with the individuals, their LAR/guardian, family members, service coordinators, nursing facility staff, or other involved persons. This method of evaluating the adequacy or appropriateness of the environment where individuals live, the services they receive, or the preferences they might have is inconsistent with professional standards for evaluating individuals with IDD and forming clinical opinions about their needs, preferences, and services. Despite this fundamental deficiency in their review, both Bruni and Shea-Delaney have made definitive statements and rendered clinical opinions about the choices and preferences of individuals, determinations of necessary specialized services, and their ability to be served in the community.

Shea-Delaney relied on discussions with HHSC staff to inform her findings about the named plaintiffs – none of whom appear to be service providers or who have personal knowledge or direct contact with the individuals reviewed. In fact, it appears that Shea-Delaney largely ignored the named plaintiffs' records and simply relied on short synopses written by the LIDDAS as requested by HHSC. It is not clear whether Bruni even spoke with state officials about the named plaintiffs. She nevertheless makes statements about individuals receiving all specialized services identified in their PE, even though it does not appear that she reviewed this information for individuals who transitioned to the community before 2015. In my previous review, I often found that statements in the ISP did not reflect what the individuals wanted when I spoke with them directly. Bruni and Shea-Delaney's methodology that relies primarily on a paper review is not an adequate substitute for actual communication and conversation with the individual with I/DD or their guardian, Legally Authorized Representative (LAR), or another individual who knows them well.

In my professional experience, the methodology used by Bruni and Shea-Delaney, taken together with their lack of clinical experience in conducting such reviews, renders their opinions unreliable and of little value in drawing broader conclusions about the effectiveness of Texas' PASRR and transition programs.

B. Unique Circumstances

I strongly disagree with the summary conclusion of Shea-Delaney that the transition of certain named plaintiffs to the community demonstrates that Texas has an effective transition process. In fact, what is blatantly obvious from their records, and quite apparent from the timing, circumstances, and unique conditions of their transitions is that HHSC's efforts toward transition occurred only after the individual joined this litigation. Further, it appears in most cases that even given their elevated status, transition may not have occurred or would have been significantly delayed without the relentless individual advocacy these individuals received from Disability Rights Texas (DRTx). Efforts around transition were remarkably different from the limited, if any, transition planning that occurred for most of the twenty, randomly selected individuals with IDD in nursing facilities that I reviewed for my earlier report, and for most of the other thirty-four randomly selected individuals that other experts reviewed at the same time. The named plaintiffs received more services; had more exposure to the community and more opportunities to gain skills and prevent loss; were more intensively engaged in transition planning; and were provided more independent advocacy than virtually any of the 20 people I saw. Their records often included notes concerning requests from HHSC for frequent updates about their conditions and special efforts to ensure the provision of needed specialized services.

Although the initial situations and levels of need of the named plaintiffs mirrored those of individuals from the random sample, their outcomes were dramatically different. It appears that their status as named plaintiffs, in combination with direct individual advocacy from DRTx provided these individuals with far more attention, services, engagement, opportunities, service coordination, and state oversight not offered to those from the random sample. Moreover, and most significantly, it is my understanding that this special attention, services, and opportunities were not evident *prior to* their joining this litigation as named plaintiffs. Based upon the information available to me, it does not appear that these individuals received LIDDA specialized services or almost any nursing facility specialized services prior to their becoming a named plaintiff.

For Bruni and Shea-Delaney to ignore these unique circumstances – in fact, to fail to investigate their status before and after their becoming a named plaintiff – renders their generalizations about the State's PASRR and transition programs highly suspect. To the contrary, what the unique outcomes of these individual named plaintiffs demonstrate is the necessity and efficacy of individualized exploration of community options supported by a comprehensive program of active treatment. It is apparent that lives of these individuals improved dramatically when they became named plaintiffs in this case, and when HHSC and its agents began making assertive efforts to engage them – something I did not see in my initial review. As a result of their unique status, and these resultant efforts, the named plaintiffs gained skills, participated in more activities, explored community options, and many began living full lives in the community.

C. Aggregate Findings

In order to provide as much consistency as possible with my prior review, I focused my review on the six questions that I explored, and that the other client review experts explored, to assess the adequacy of services offered to the fifty-four randomly selected individuals in our earlier review.

Even with the increased services and supports afforded to these individuals as named plaintiffs and through strong advocacy from DRTx the histories of the named plaintiffs are full of low expectations, missed opportunities for growth and self-determination, and unnecessary institutionalization. They do not represent a "successful and compliant PASRR program that meets the three goals of PASRR," as Bruni states. Nor do they serve as evidence that transition is working, as reported by Shea-Delaney.

1. Comprehensive Functional Assessment:

None of the 12 named plaintiffs received a Comprehensive Functional Assessment (CFA) while residing in a nursing facility. Without a CFA there is no basis for planning and delivering necessary specialized services. The result is a service plan that often fails to address basic habilitative needs and fails to identify needed services. It also results in a plan that has low expectations, lack of clear direction, fragmentation, and lost opportunities for maintenance or growth of skills in independent living and self-determination. This is repeatedly evident in the experiences of the named plaintiffs, whose needs were often overlooked or mistakenly evaluated.

Bruni does not appear to have considered whether the individuals had received a comprehensive functional assessment. Bruni does not address the issue of the adequacy of the assessments for each individual or mention whether any person received a comprehensive functional assessment. A professionally acceptable program for individuals with IDD begins with a CFA. It is unclear to me how Bruni concluded that Texas provides individuals with necessary services and supports without considering the adequacy of assessments needed to determine necessary services.

2. Specialized Services:

While no individuals were receiving all needed specialized services before their status as named plaintiffs and representation by DRTx, it appears that one individual, Tommy Johnson, may have finally received all needed specialized services in the months before September 1, 2017. Every individual reviewed was denied opportunities to increase skills, avoid deterioration, and maximize independence and self-determination. Specialized services are a core component of active treatment.

I disagree strongly with the summary conclusion of Bruni that all named plaintiffs were receiving the specialized services recommended in their PE and her implication that they were receiving all necessary specialized services. For instance, Patricia Ferrer did not receive behavior supports, physical therapy, or day habilitation prior to her community placement. It was only when she left the nursing facility that she received these services. Zackowitz Morgan did not receive physical therapy, occupational therapy, or day habilitation while he was in the nursing facility and his sister stated that he lost transfer and standing skills. He only began receiving habilitative PT after he requested a HCS slot. And Johnny Kent was not receiving behavioral supports;

Vanisone Thongphanh was not receiving OT, PT, or ST; and Maria Hernandez was not receiving independent living skills, OT, PT, or ST.

3. Active Treatment:

None of the 12 named plaintiffs received active treatment while in the nursing facility. Without active treatment, none of the 12 individuals were receiving a program that meets the federally-mandated standard of care and that is directed toward the acquisition of behaviors necessary for the individual to function with as much self-determination and independence as possible.

4. Individual Service Plan (ISP)

5 of the 12 named plaintiffs had a professionally appropriate ISP, although for two individuals, this only occurred after transition planning was initiated and the focus shifted to moving to the community. This is in contrast to my previous review where I found only one ISP of the 20 that I reviewed was appropriate, and even that one was for a person who was on palliative care. Of the individuals initially reviewed by each of the other experts only 0 of 34 had an appropriate ISP.

In this review, it is clear that the involvement of DRTx and the status as named plaintiffs resulted in this positive finding for many individuals. For several, the service planning teams were composed of the relevant professionals, including clinicians. For some, outcomes were based on the strengths, needs, and preferences of the individual and the plan contained a lot of specific information about the individual. For many, perhaps due to intensive HHSC oversight, the information was updated over time and the plan was changed correspondingly. There was no ISP in the records for one individual.

5. Community Living

I believe all twelve of the named plaintiffs would benefit from community living and were able to be safely served in the community. For Ms. Hernandez, it is clear that she could have been served in the community for the majority of her time in the nursing facility. Since her health began decline in late 2016, it's likely that at some point between that time and September 1, 2017, it would have become inappropriate for her to transition to the community. However, I have served individuals in both group homes and host homes who have very similar medical challenges as Maria had, who have avoided nursing facility placement for the entirety of their lives.

I strongly disagree with Shea-Delaney's statement that 3 individuals are too medically compromised to live in the community. Having many years of experience serving individuals with I/DD including those with complex medical needs, I know that individuals with similar medical needs are served in and benefit from the community.

6. Choice

All but one of the named plaintiffs and their guardians have clearly chosen to leave the nursing facility. The remaining individual, Tommy Johnson, suffered decades of physical, psychological, and economic abuse when he was confined to living in an uninhabitable old school house with other men and made to do excruciating work for long hours and virtually no pay on a turkey farm in Iowa that became the subject of state and federal investigations. Since his transfer to a nursing facility, it does not appear that significant efforts have been made to address barriers to transition, including Mr. Johnson's trauma history, understandable fears of certain living situations, and lack of recent exposure to new possibilities for community integration.

There is no evidence that Shea-Delaney or Bruni considered Mr. Johnson's unique history and abilities when making findings about his decision and did not even mention these critical facts in their reports. Without an in-person review and further information, I cannot definitively determine whether Mr. Johnson made an informed choice to stay in the nursing facility. Additionally, there is evidence in older records that he previously was interested in leaving the nursing facility. Given his history of institutionalization and abuse, and demonstrated need to learn through exposure, it seems unlikely he has made a truly informed choice to remain in the segregated setting.

Additionally, and directly contrary to Shea-Delaney's and Bruni's report that Johnny Kent has chosen to remain in the nursing facility, Mr. Kent actually decided to leave the nursing facility, requested a waiver slot on August 31, 2017, and was informed that he was being placed on a wait list as one was not currently available. This also contradicts Bruni's statement that the state offered waiver slots to all those who chose to transition to the community.

I strongly disagree with Shea-Delaney's statement that two individuals have chosen to remain in a segregated nursing facility. The records directly contradict this statement for one individual who requested a waiver slot – Mr. Kent. The other individual has likely not made an informed choice due to his thirty years of institutionalization, ongoing segregation in an abusive living and working situation, and the lack of appropriate behavior supports to address his trauma.

Eric Steward

Eric Steward is a 52-year-old gentleman who, as of September 1, 2017, was living at Windcrest Nursing facility in San Antonio. He was determined to be eligible for PASRR services on September 1, 2011. At that time he lived at Buena Vida Nursing and Rehab where he resided from 1999 until his discharge to a four bed HCS group home in 2013. He remained there until he was hospitalized in January 8, 2017 for dehydration, acute renal failure, and underlying rhabdomyolysis (muscle destruction), dialysis, urinary tract infection, acute pancreatitis, gall bladder surgery, and a fractured ankle. He was discharged from the hospital on January 30, 2017 and was sent to his current nursing facility placement. He had two additional hospitalizations in 2017, in June for kidney stones and in July for Dilantin toxicity. He was also hospitalized in 2016 for increased seizures due to a medication omission error of not receiving his anti-convulsant medications.

Mr. Steward has diagnoses of congenital cerebral cysts, unspecified convulsions, hyperlipidemia, mental disorders due to known physiological condition, hypertension, hypothyroidism, cerebral palsy and other constipation. Throughout his life, his seizures have been difficult to control and he had split brain surgery. He also had multiple surgeries on his hips and legs to correct contractures. Eric is described as very social, has many friends, and enjoys outings, arts and crafts, music, and playing video games. He uses a wheelchair for ambulation and is verbal and was able to respond to all of my questions during my interview with him and his sister. His mother was a strong advocate for him until her death in January 2014, and now his sister is a strong advocate and consistent presence in his life.

Mr. Steward did not receive a comprehensive functional assessment during his nursing facility stays. His most recent PASRR Level 1 was done on January 30, 2017 and a PASRR Evaluation (PE) done on February 10, 2017 which recommended LIDDA specialized services of alternate placement, service coordination, independent living skills (ILS), and behavioral support as well as nursing facility specialized services of occupational therapy (OT), physical therapy (PT), and durable medical equipment (DME). He had physical therapy and occupational therapy assessments done after admission to the nursing facility as well as various medical/nursing assessments done which assess long term care concerns such as skin breakdown, fall risk, restraints and similar. He did not have assessments for affective development, speech and language development, auditory functioning, social development, and adaptive behaviors.

Eric is receiving many, but not all necessary specialized services. Beginning in January 2017, after he was hospitalized and subsequently admitted to Windcrest, Eric did not receive day habilitation (DH) services from January 2017 through September 1, 2017. Previously Eric had attended DH consistently in 2015 and 2016. The barrier to Eric receiving DH services after his admission to Windcrest in January 2017 was transportation. Via Trans, San Antonio's public transit agency, does not serve Windcrest or the surrounding area and transportation was not provided by the LIDDA or nursing facility. He had an interruption in his PT and OT therapies in 2017 due to a denial of PASRR services on March 27, 2017 because the Center for Health Care Services incorrectly determined Mr. Steward was not eligible for specialized services because he did not have IDD.

Previously he had consistently received PT and OT. In 2017 some of his OT and PT services were rehabilitative as was appropriate because of his serious medical issues and subsequent hospitalization. There was a delay in ST. He requested an evaluation for ST at his SPT meeting of May 19, 2017 due to problems with memory, possibly due to his illness and hospitalization. The ST assessment did not occur until June 21, 2017, and services began shortly thereafter and continued until the end of August 2017.

At his request he was referred for employment services in September 2015 and took the DARS employment test which he "failed". He then decided he was not interested in employment but would like a different DH program. He has received his CMWC and a powered wheelchair. He had a recommendation for behavioral supports but the SPT determined that those supports were not needed. I disagree with Bruni's statement that Eric received all appropriate specialized services and all services identified in his PE. Mr. Steward did not receive a program of active treatment, continuously implemented.

Eric has a person-centered professionally appropriate Individual Service Plan (ISP). His ISP has information regarding his strengths, preferences and needs. Section 9 phase II is completed and includes information about the supported and services needed in the community. The SPT consists of clinicians, provider representatives, his sister, an attorney from Disability Rights Texas (DRTx), and Eric. The meetings are held regularly and in collaboration with the nursing facility. There are five outcomes in his ISP: to attend activities with music; activities with arts and crafts; to watch movies; to attend day habilitation, and to live in the community. These are outcomes that either reflect his preferences or will help increase his independence.

Eric continues to request community placement and his SPT agrees that he is appropriate and is capable of returning to the community with supports. He left his previous nursing facility and entered a group home in 2013. The placement was described as very good for the first two years and problematic for the last two years. First there was a medication error that caused Eric to be hospitalized for seizures, and second, there were difficulties primarily with certain of residents who had significant behavioral issues. Both residents subsequently moved out. During this time, Eric was offered assistance with moving to another residential setting but declined. The HCS placement ended upon his admission to the hospital for severe dehydration and acute renal failure. The response from the LIDAA was that Eric should work out his problems with his housemates - an unreasonable expectation given his immobility and other medical concerns. His SPT team continues to work toward community placement with the appropriate provider.

It is unfortunate and of significant concern that he experienced a series of illnesses in 2017, some of which may have possibly been preventable such as his fractured leg and severe dehydration and subsequent acute kidney failure. Eric experienced problems with seizures and dehydration, two of the well-known "fatal four" that lead to increased morbidity and mortality for individuals with IDD: dehydration, seizures, constipation, and aspiration.

Mr. Steward has not made an informed choice to remain in the segregated nursing facility. He has been supported in the past with a community placement and his SPT team continues to work with him toward that goal. I strongly disagree with Shea-Delaney's assertion that Eric is too medically compromised to live in the community. The medical diagnoses that he has can be and are supported in the community with appropriate supports including on-going nursing monitoring and coordination. Adequate, well trained direct support staff, under the direction of nursing and medical specialists can provide the daily, consistent oversight that his diagnoses of seizures, cerebral palsy, and immobility require.

It is clear that his status as a named plaintiff and the involvement of DRTx has had a major impact on the services that Mr. Steward receives. They became his attorneys in January 2010. In my previous reviews, individuals rarely had more than three people at a SPT meeting and the service coordinator did not necessarily speak with involved family members. The ISP's had very few outcomes and those listed did not provide for increased independence or self-determination. Rarely were clinical staff present. DRTx was very active in researching appropriate providers and arranging visits; a task usually done by service coordination in all other states I have reviewed. DRTx has supported the active involvement of his family, a major asset for Eric. They have attended every SPT meeting and followed up whenever there was a problem with denial of services. DRTx has had a major impact on the quality of life for Eric Steward.

Linda Arizpe

Linda Arizpe is a 49-year-old woman who, as of September 1, 2017, lived with her family in Bulverde. Linda returned to her family home in February 2013 from a nursing facility where she had resided since January 30, 2008. She lived in two other nursing facilities from 2005 to 2008. Ms. Arizpe was discharged from the last nursing facility after her parents learned she had been sexually assaulted. Prior to that she had lived with her family in their home. Ms. Arizpe was determined to have developmental delays as a young child, but her disabilities became much more serious after she suffered a cardiac arrest in 2005 which left her with anoxic brain damage, unable to walk and speak. She requires total care but is responsive to others.

In order to bring her home from the nursing facility, her parents modified their home with an addition including an accessible bathroom. They also added a lift system to the family pool so that she could go swimming. She has a large family and she enjoys being around them and part of the activities. She uses a wheelchair for mobility and has lost eyesight in both eyes. She has a baclofen pump for her spasticity and it has helped to reduce her stiffness and made her care easier and reduced her pain and screaming. She no longer has a g-tube or an indwelling urinary catheter. She has diagnoses of anxiety, profound ID, anoxic brain damage, convulsions, asthma, anemia, and dysphasia, oral phase. Ms. Arizpe has staff support in the home 24/7; she has weekly visits from a nurse through a home health agency and her mother is also her care giver. Her father, who was a very strong advocate for her, passed away in December 2015. In addition to being in the swimming pool, Linda loves music, being shown a special photo album, being outside, and being read to.

From the limited records regarding assessments from her nursing facility stay from 2008 until 2013, it does not appear that she had a comprehensive functional assessment. She had a PASRR Screening form done on April 28, 2011 which affirms that she is positive for a related condition, epilepsy. The assessment appears to have elements of an MDS. She had multiple MDS's in 2011 and 2013. She had Rehabilitative Therapy Screenings on a quarterly basis in 2011 and 2012. She had an occupational therapy (OT) evaluation on October 2011 and in February 2008. She had three speech therapy (ST) evaluations on 3/19/11, 11/14/11, and 12/9/11 in 2011 as well as modified bedside swallow studies on 1/27/2011 and 12/9/11. The swallow studies were done to see if her diet could be upgraded to a less restrictive diet. It was difficult to read the hand-written progress note, but it appears that the therapist did not recommend the upgrade. She had a PT evaluation in May 2012. She had a Determination of Intellectual Disability (DID) assessment done on 11/9/12 which is thorough and an ICPAP done on 10/10/12 as part of her transition process. These assessments were done over a widely varying time period and not done in collaboration to provide a picture of Ms. Arizpe needed to form the basis of active treatment.

Linda Arizpe did not receive all necessary specialized services while she was in the nursing facility. She may have received rehabilitative PT for eight weeks in May-July of 2012. She had an OT evaluation on 10/16/11 and it was determined that she did not need skilled therapy. The multiple Rehabilitation Therapy Screens that she received quarterly all determined that there had been no change and therefore she did not need therapy. It appears there was no consideration given to habilitative therapy which would have helped to maintain her skills and prevent regression. The only specialized service she received while in the nursing facility was service coordination.

Without the necessary services, Ms. Arizpe's physical condition declined significantly during her stay in the nursing facility. She was unnecessarily confined to her bed and developed pressure sores. Her mother stated that she got "crabs". Her parents paid for additional staffing to provide 1:1 support for Linda during her time in the nursing facility. Even with the relentless advocacy of the Arizpes and Disability Rights Texas (DRTx), she never received needed services while residing in the nursing facility. Once she was transferred to her parents' home she began receiving PT on a weekly basis in addition to the passive range of motion done weekly by the home health agency nurse. She requires specialized medical equipment (DME) to assist in her care needs including an electric bed, lifting systems, shower gurney and other supplies. There were significant delays with the bed, shower gurney, and lifting systems. Her mother reports that the service coordinator and DRTx were very helpful in trying to work out the problems with the lengthy delay.

While in the nursing facility, it appears from the limited records available that Linda did not receive a program of active treatment continuously implemented. She did not receive a comprehensive functional assessment. She did not receive the necessary specialized services that would have prevented regression of her skills. She was finally offered an HCS slot in 9/18/12 as a result of DRTx's advocacy and was discharged to her family's home in February 2013.

I cannot determine whether or not Ms. Arizpe had a person-centered professionally appropriate individual service plan (ISP) as one was not in the records I reviewed. Linda has benefitted from community placement in her parents' home. Linda likely would have benefited and was appropriate for the community, 8 years earlier, in 2005. She has received PT twice a week for several years. She has the necessary medical equipment to enable her to be outside her family home. She is able to go swimming in the family pool. She has consistent care givers and nursing through her support agencies. There is less screaming and she is able to enjoy family activities. Her mother states that she is a lot happier. She no longer has a g-tube for feeding or an indwelling urinary catheter. In the nursing facility she had bedsores; she has not had any since she has been home.

Ms. Arizpe's guardian, her mother, reasonably decided that Linda should return to the community. Her mother, reported that they have always wanted Linda to come home, since she was first admitted to a nursing facility in 2005. Even with relentless advocacy from the Arizpes and DRTx it took 7 years for Linda to receive a HCS waiver slot. Almost 8 years passed before Linda received the necessary supports to leave the segregated nursing facility and return home to her community and family. Her parents were consistent in stating that the primary outcome they wanted for Linda was to bring her home. Her mother reported that the nursing facility did not agree with her coming home with supports and felt that her health was too precarious to be managed in the community, though that clearly has not proven to be the case. In April of 2012, Mr. Arizpe asked the service coordinator to "Please assist with bringing Linda home." The Arizpe's disappointment, frustration, and confusion with the system is evident throughout out service coordinator's notes. In 2012, it was noted that the Arizpes had been personally paying for transportation for Linda to visit them in their home, but were considering ending the visits because it was too heartbreaking to watch Linda cry every time she was returned to the nursing facility.

DRTx worked directly with the nursing facility, the service coordinator and community providers to help the Arizpe's ultimately achieve their goal of bringing Linda home. They participated in all of her planning meetings and helped to find a provider in their area. DRTx also worked to get the DME through the lengthy approval process. It is clear that her status as a named plaintiff, the persistence of her family, and the support of DRTx, is what made the difference in her leaving the nursing facility and living at home for the past three years.

Patricia Ferrer

Patricia Ferrer is a 54-year-old woman who, as of September 1, 2017, had resided in a group home in Dallas since 11/16/12. Prior to living in the group home she resided at a nursing facility in Dallas for four years. She was placed in the nursing facility on September 25, 2008 by her parents when they felt they could no longer care for her due to her seizures. After extensive advocacy by Disability Rights Texas (DRTx) beginning in 2011, she was offered a waiver slot and moved to the group home from the nursing facility.

Ms. Ferrer is described as having a kind spirit, a good sense of humor, and helping others. She enjoys arts and crafts, especially coloring, television novellas, movies, and quiet. She does not like loud noises and had been verbally abusive and physically aggressive to other individuals in the nursing facility. She is ambulatory although she has an unsteady gait and uses a wheelchair for distances. She is articulate and responsive to questions. She has diagnoses of seizures, schizoaffective disorder, unsteady gait, GERD, and moderate intellectual disability.

Ms. Ferrer did not have a comprehensive functional assessment at any time while she was in the nursing facility. A May 25, 2011 PASRR Screen affirming IDD with no organic condition states that there was a previous PASRR screen on 10/27/08. However, her July 2012 MDS (there were at least two other MDS forms completed in 2009 and 2010 in her records) indicates that as of that date, no PASRR Evaluation had been completed and service coordinator notes from an August 9, 2012 diversion meeting indicate that there was no confirmation of IDD in Patricia's records, almost four years after she was admitted to the nursing facility. She had a physical therapy (PT) evaluation on 10/28/10. On November 9, 2010, DADS denied a request for physical therapy (PT) as a PASRR specialized service, the only request in Patricia's records for a PASRR specialized service, stating that DADS did not have a copy of Patricia's PASRR. The inconsistencies between the MDS and PASRR denials do not clarify whether a PASRR evaluation was ever completed before the May 25, 2011 PASRR screen. There are no discharge plans to return to the community.

While in the nursing facility, Ms. Ferrer had a nursing facility care plan and various long-term assessments for medical/nursing concerns such as skin, pain, and fall risk. She did not have a complete assessment of her sensorimotor development, auditory functioning, adaptive behaviors, nutritional status, vocational skills, or development in the areas of speech and language, affective, cognitive, and social.

Ms. Ferrer did not receive all needed specialized services while in the nursing facility. Patricia had PT from 10/8/10 for approximately three months for her unsteady gait. Based on the denial of PASRR PT in November 2010, together with notes in the PT records and the short duration of the PT, it appears that this 3 months of PT for Patricia was provided as a rehabilitative service and not as a habilitative service pursuant to PASRR. It also appears to be the only IDD-related therapeutic service she received while in the nursing facility. Because of her unsteady gait, Patricia would have benefitted from continuous habilitative PT to maintain or increase her strength, balance, and coordination as well as habilitative OT to maintain or increase upper body strength, balance, coordination and assist in maintaining her abilities for self-care and transfers. Since she was only 44 years old when admitted to the nursing facility, she would have benefitted from day habilitation (DH) services and a vocational assessment. She also would have benefitted from an assessment for and provision of behavioral supports.

My review of the records shows that Ms. Ferrer began receiving service coordination around 9/7/10, although I could not find records of monthly visits to nursing facility. It appears that she may have at first refused services although it is not clear that she understood what services were being offered to her. Patricia Ferrer did not receive a program of active treatment continuously implemented. She did not have a comprehensive functional assessment providing information regarding her strengths, needs, and preferences. She did not receive the necessary specialized services, in fact, it appears that the only specialized service Ms. Ferrer received was service coordination. The service coordinator writes in her notes of 8/9/12 that "since admittance in 2008 several of her activities of daily living skills have decreased." The services of the PASRR program would have helped her to maintain these skills and increase her abilities for independence and self-determination. After DRTx become involved on behalf of Ms. Ferrer an introduction meeting was held on 8/8/12 at the nursing facility where she lived. In attendance were Patricia, her mother, DRTx, nursing facility staff, and the service coordinator. The records of this meeting are the first documentation that community placement was discussed. Prior to this meeting, all records I reviewed relating to community living options are nursing facility records that reflect a determination that discharge to the community was not feasible, but there is no indication in the record that Patricia's service coordinator had any discussions about community options or the availability of services to promote independence with Ms. Ferrer. At this first meeting to discuss community living in August 2012, Patricia told the team that she was very interested in a community placement and possibly a part-time job.

When she was transferred to the group home, she received assessments, including for her psychiatric diagnosis of schizoaffective disorder. In the group home, she also received behavior supports, PT, day habilitation, psychiatric services, and consistent service coordination. In the nursing facility she was physically aggressive to another resident just prior to her transfer to the group home. Her records after the transfer reflect no such behavioral incidents.

From my review of the records, I was unable to find a person-centered professionally appropriate individual service plan (ISP) for the time Patricia was in the nursing facility. She has had a Person Centered Plan (PCP) while she has lived at the group home, which is person-centered, contains relevant information regarding her strengths, needs, and preferences and has appropriate outcomes. Her outcomes have included having aides to assist in personal hygiene, good oral health, a safe and secure environment, fun and stimulating day activities, maintenance of good health, and to stop maladaptive behaviors.

Ms. Ferrer has benefitted from living in the community. As of September 1, 2017, she had lived in her group home for nearly five years. The LIDDA service coordination notes consistently show that she is pleased with her group home and enjoys going to day habilitation. She goes on outings, including to the movies and out to eat. She likes her private room and the fact that she can find a place of quiet in her home. She has had only one seizure since her admission to the group home. She has received PT and behavior supports. She has regular visits with her psychiatrist to monitor her medications and her psychiatric diagnosis. She receives regular dental care and nursing monitoring. She has consistently received service coordination.

When I spoke with her, Patricia said she likes to take a bath, to color, and likes the people she lives with, especially Melba. She also likes her bedroom and the food, especially chicken nuggets. She does have some maladaptive behaviors of verbal abusiveness to other individuals, but staff are able to redirect her and I did not see documentation of any incident involving Patricia being physically aggressive.

Apparently as a result of DRTx advocacy, Ms. Ferrer was provided with an opportunity for an overnight visit on 10/9/12 and a weekend visit on 10/19/12-10/21/12. Patricia decided to accept an HCS slot and transfer to a group home based on concrete information upon which to base her decision. Her SPT, including Patricia and DRTx, developed a plan of supports she would need for a successful placement in the community.

Her status as a named plaintiff and the involvement of DRTx has made a significant difference in Patricia's life. Without DRTx's advocacy, it is not clear that she would have ever been given information about her options for living in the community. Based on available records, she could have continued indefinitely in the nursing facility, without appropriate assessments and PASRR services, lined up in a chair in front of the nursing station or in her small, semi-private room, continuing to regress in her skills and unable to manage her abusive behaviors.

Zakowitz Morgan

Zakowitz (Zak) Morgan is a 47-year-old gentleman who, as of September 1, 2017, resided in an HCS group home in Houston, Texas, operated by NG&B Enterprise. He has lived in HCS group homes operated by NG&B since March 28, 2013. Prior to being in an HCS group home setting, he lived at a nursing facility for nearly four years.

As described by his guardian, Mr. Morgan was placed into a State Supported Living Center as a four-year-old. When he became a teenager, he left the State Supported Living Center to live in a six-bed Intermediate Care Facility for a number of years. On January 25, 2008, he was transferred by the ICF provider to a nursing facility. On July 14, 2009, at the request of the guardian, he was transferred to another nursing facility because the guardian was dissatisfied with the quality of medical care he was receiving.

Mr. Morgan uses a wheelchair for primary ambulation but is able to stand and transfer. He has diagnoses of diabetes mellitus, hypothyroidism, glaucoma, cerebral palsy, hypertension, obesity, congestive heart failure, and mild IDD. He is described as a very friendly, pleasant person who enjoys being active. He likes Bingo, music, going to the library, searching the internet, and going out to eat. He enjoys performing office-related tasks such as shredding and filing. His guardian is very active in his life.

From my review of limited records from the second nursing facility, it appears that Mr. Morgan did not have a comprehensive functional assessment during that time. He had therapy screens in 2009, 2010, and 2011. He had a Determination of Intellectual Disability on September 4, 2012, an ICAP on January 7, 2013, and an Intellectual Disability and Related Conditions Assessment on 3/12/2013. He had physical therapy (PT) and occupational therapy (OT) assessments in 2009, 2010, 2012, and 2013. He had various nursing facility assessments done which assess his medical/nursing concerns. While these various assessments were thorough and evaluated his development in the areas of sensorimotor, affective, cognitive, physical development and health, nutritional status, social development, and adaptive behaviors, they were done over a widely varying period of time and the majority of them were done once he was allocated an HCS slot in 2012 that resulted in his eventual transition in 2013.

Mr. Morgan did not receive all necessary specialized services while he was in the nursing facility. He received rehabilitative PT and OT at the end of 2009 and for parts of 2010 and 2011. He was on a Restorative Nursing Program for much of this time, with assessments by the PT/OT clinicians stating that he did not need PT/OT because there was no change in his condition. It appears from the record and from his guardian, that during his nursing facility placement, his skill level regressed and he lost transfer and standing skills. He previously could walk a short distance, but later spent nearly all of his time in a wheelchair and lost his ability to walk. He did not participate in day habilitation (DH), vocational training, or community activities, despite enjoying going on outings and liking to do office related work. He would have benefitted from Independent Living Skills. He finally began receiving habilitative PT in July 2012, just after he had requested an HCS slot, which was approved on 9/14/12.

Once he was transferred to his group home, he began going to DH and received OT and PT several times a week, and limited speech therapy (ST) to help him with his stuttering. He has consistently received service coordination.

While at the nursing facility Mr. Morgan did not receive a program of active treatment, continuously implemented. He did not receive a comprehensive functional assessment until he decided to transfer to the community. He did not receive the necessary specialized services that would have prevented his regression in the skill areas of ambulation, personal care, socialization, and adaptive behaviors. He relied solely upon a wheelchair for mobility and gained over 80 pounds in a three-year period, dangerous for a person with diabetes. He required insulin daily to control his diabetes. When he was transferred to the group home he lost weight and no longer requires insulin and daily finger sticks.

The individual service plan (ISP) of 3/12/13, done at the nursing facility, is a person-centered plan and is professionally appropriate. However, this plan was done after he had decided to transfer to the community, appears to be a transition plan, and is most likely not reflective of nursing facility plans that would have been done prior to his identification for an HCS slot in 2012. This plan and others done in the community, unlike most I have seen done prior to the decision to move to the community, have the necessary relevant information about Zak's s strengths, needs, and preferences. The service planning team (SPT) consists of all his clinicians and other professionals involved in his services. He and his guardian participate in the planning process. The SPT team usually numbers around 8 people. He has 7 outcomes: to live in a group home, to have assistance with finances, to go to DH, to increase socialization, to improve health status, and to freely exercise his rights. These outcomes have specific measurable goals and the responsible person is identified. Goals are time bound.

Mr. Morgan has benefitted from living in the community. He has lived with the same provider since his discharge in early 2013. Since that time, he has increased his standing and transfer skills, he can once again ambulate short distances, and he can transfer to a regular car. He has lost weight and been able to stop his daily insulin injections and control his diabetes through oral medication. He no longer needs daily finger sticks but checks his diabetes control through quarterly blood studies.

His guardian described a particularly sad comparison between the nursing facility and the group home. When Mr. Morgan was in the nursing facility, he was unable to get his wheelchair through the bathroom door. The staff told him to have his bowel movement in his underwear and they would come and clean him up after. The group home was modified so that his wheelchair fits through the bathroom door and he is able to go into the bathroom by himself.

Zak attends DH consistently, five days a week. He goes out frequently and has more friends. He has received PT and ST to help him regain skills. He is slowly getting his serious dental problems fixed and is nearly finished with the dental treatments. They have gone more slowly than he would like because of the annual cap on dental costs. Mr. Morgan told me that he is much happier, he likes living in the group home much better than the nursing facility, they give him the help he needs, the food is good, and he feels much better with less weight. He is in need of another CMWC; they have begun the process to apply for a new wheelchair. He has consistently received service coordination and that has been helpful.

Mr. Morgan has a legal guardian and she made the decision to have him transfer to the community. Zak also participated in the decision and continues to make his wishes known to his guardian and the provider. Mr. Morgan has been assisted by DRTx since 2008 and that advocacy, plus his status as a named plaintiff, has made an important difference in his life. DRTx helped locate appropriate providers and attended all of his SPT meetings. His transition plan was thorough and comprehensive. It is likely that without their help, he would still be residing in a nursing facility, unable to walk or care for his personal needs, obese, and receiving daily insulin injections.

Maria Hernandez

Maria Hernandez was a 28-year-old woman who resided in a nursing facility in San Antonio for the past eleven years. As of September 1, 2017, she was residing in the nursing facility. She died on January 8, 2018 while hospitalized at an acute hospital for an infection. I spoke with her mother and reviewed her records.

Ms. Hernandez was born with a cleft palate and cleft lip that was repaired at 5 months. She had several more surgeries while young and started pre-school at age 3. She could feed herself, spoke a few words, and walked using a walker. At age five, she got rheumatoid arthritis and was no longer able to walk. At age 9 or 10 she was no longer eating and had a peg tube placement. She also had a baclofen pump implanted to control her stiff and spastic muscles. She had ER visits due to dehydration and infections. At around age 14 she was placed in the nursing facility where she resided until her death. Her family remained very involved with her throughout her life and her mother was her legal guardian. Maria has diagnoses of hyponatremia, rheumatoid arthritis, hypertension, cerebral palsy, quadriplegia, seizures, anxiety, asthma, baclofen pump placement, and g-tube placement. She has had several episodes of septicemia, placement of a colostomy, Harrington rods placement for her severe dextroscoliosis, and a port-a-cath for blood draws. She has been on oxygen and had intravenous antibiotic treatment multiple times.

Despite all of her medical challenges, her mother states that she would smile and coo at her family, loved to be around them, and enjoyed their stimulation. She liked music and also enjoyed quiet time. She would respond to people, especially those familiar to her although she could no longer speak. According to her ISP, Maria was able to communicate "through smiling, chuckles, physical gestures, and some vocalizations." Maria waved at people when they were leaving. She liked to watch activities around her and be out of bed.

Maria Hernandez did not receive a comprehensive functional assessment. She had a PASRR Level 1 done in November 2016 and PASRR Evaluations done in June, July, and November 2016. They are positive for intellectual and developmental disabilities. The PASRR Specialized Services forms dated August and November 2016 recommend no nursing facility specialized services and the only recommended LIDDA specialized service is service coordination. She had many MDS assessments throughout 2016.

Ms. Hernandez had Therapy Screens at the nursing facility on June 22, 2015, September 24, 2015, October 29, 2015, and January 4, 2016 none of which recommended therapies. On October 29, 2015 a therapy screening was done to determine whether Maria needed OT, it was determined that "therapy was not indicated" and that she only needed restorative nursing care. Five days later, she received an OT evaluation. The evaluation recommended that Maria receive restorative OT to address her contractures, decreased range of motion, and decreased neuromotor control. She also received an OT evaluation in January 2016. The evaluation recommended Restorative Nursing Program (RNP) of passive range of motion (PROM) to her extremities and splinting of her lower arms. The records indicate that these were carried out. Nursing facility records indicate that she had a ST screening on 10/29/15 but it was determined that ST was not indicated. She also had a ST evaluation on January 24, 2016 and no ST was recommended because she was not able to track or follow directions. She had a speech therapy (ST) evaluation on January 24, 2016 that did not recommend ST. She had physical therapy (PT) evaluations done on June 22, 2015, March 3, 2016, and December 15, 2016. She had an occupational therapy evaluation done on January 6, 2016. She had a nursing care plan and evaluations for long-term care nursing issues such as pain, fall risk, skin breakdown, and similar. None of these evaluations were done in a collaborative manner, and few were done within the same period of time. These were not part of a comprehensive functional assessment. She did not have assessments in the areas of affective development, auditory functioning, cognitive development, social development, or adaptive behaviors.

Maria Hernandez did not receive all the necessary specialized services. In addition, Bruni is incorrect that Ms. Hernandez was receiving the specialized services that were recommended in her PE. Her July 2016 PE recommends LIDAA specialized services of service coordination, alternate placement, and independent living skills (ILS) and nursing facility specialized services of OT, PT, ST, and durable medical equipment (DME). Maria received short-term rehabilitative PT for one month in June, 2015 and for one month in December 2016. She received habilitative PT for one month in March 2016 to assist her in adjusting to her new wheelchair.

From the records, it appears that there was a disagreement between members of the service planning team (SPT) including her mother, and the Director of Rehabilitation at the nursing facility regarding the benefit of PT, OT, and ST for Maria. The team consistently recommended therapies and the nursing facility Director of Rehabilitation resisted, stating that Maria had reached maximum potential. The director repeatedly refused to provide therapies other than for the two months, over two years, listed above, despite the requests for these services by Maria's mother and her LIDDA service coordinator. In 2016, a new director arrived and agreed to provide therapies; unfortunately, by this time Maria had begun having multiple hospitalizations and was not capable of participating in therapies. She had a recommendation for ILS, which was never implemented due to her medical challenges. After an almost six-month delay, she did receive a Customized Manual Wheelchair (CMWC). Multiple attempts were made to provide an alternate placement, detailed below. She received service coordination and the service coordinator visited frequently, was in frequent contact with both her mother and the nursing facility. From my review of the records I agree with the assessment of the SPT, including her mother, that PT, OT, and ST were necessary to assist Maria in maintaining her muscle strength, balance, mobility, and to assist in the performance of her personal care. She could have participated in these therapies in the years prior to her eventual decline in health which would have enabled her to lead a more independent and functional life.

Ms. Hernandez did not receive a program of active treatment that was continuously and aggressively implemented. She did not receive a comprehensive functional assessment (CFA) at any point during her nursing facility stay. Instead, she received a variety of assessments, conducted over a lengthy period of time that did not encompass all the elements of a CFA. Because her strengths, needs, and preferences were not adequately assessed, she did not receive the specialized services that would have enabled her to maintain her strength and mobility. The dispute between the first director of rehabilitation and the rest of the SPT was never resolved, so as a result, the director of rehabilitation's decision to deny Maria specialized therapies became the *de-facto* decision. By the time the new director of rehabilitation became part of the SPT in 2016, it was too late for Maria to benefit, because her medical condition had deteriorated to the point that she could no longer participate.

Maria did not have a person centered individual service plan that was appropriate to her developmental strengths, preferences, needs, and age. The continued disagreement between the first director of rehabilitation and the SPT team resulted in Maria not having her needs met for specialized services. She had one outcome in her ISP, for placement in the community, which was appropriate but she should have also had outcomes to maintain her muscle strength, flexibility, and balance. She should have also had an outcome relative to the recommendation for the specialized service of independent living skills. Her ISP indicated that she was “at risk for isolation due to her medical condition.” The provision of independent living skills would have helped to reduce this risk. She did have an appropriately constituted SPT, and they met frequently and according to required time lines. The service coordinator provided detailed and timely information regarding Maria and maintained frequent contact with her legal guardian and the nursing facility. Maria’s mother stated that there was a lack of communication with the nursing facility in the last several years.

Ms. Hernandez would have benefitted from living in the community during those years, prior to 2016, when her health was relatively stable. Individuals with conditions such as Maria are capable of living in the community. I have served individuals in both group homes and host homes who have very similar medical challenges as Maria. Alternate placement was her single outcome listed in her ISP; the service coordinator, her mother, and Disability Rights Texas (DRTx) put much effort into finding a suitable community living setting for her. They identified Day Break, Tried and True, Every Child, Inc., and Permieant as potential providers for Maria. Homes were identified and toured. Nevertheless, there were a number of unresolved barriers that prevented Maria from being able to transition to the community with one of these providers. Several of the homes were ruled out due to not being accessible to accommodate Maria’s large wheelchair. There were also disagreements about the amount of nursing hours Maria required and some providers indicated that they could not meet her nursing needs. Maria had a consultative review by the University of Texas Health Science Center in the spring of 2015. They determined that she could be served in the community. She also had a consultation review by DADS, dated February 21, 2016 that recommended nursing care 24/7 and determined that this care could be provided in a less restrictive environment. Additionally, on multiple occasions, community providers filled openings at the homes that Maria’s mother/guardian identified and selected before Maria’s discharge planning was complete. At least one provider was reluctant to serve Maria because they were concerned that the State would not pay for the level of nursing services that Maria needed. In what became the last year of her life, her health declined to the extent that discharge planning was on hold until she became healthier. Unfortunately, time ran out for Maria and she was never able to transition to a community setting, despite all the efforts and her mother’s desire.

Ms. Hernandez’s legal guardian appropriately decided to have Maria reside in a community setting. When the discharge planning was placed on hold, for medical reasons particularly for much of 2016 and 2017, it was a decision made by her legal guardian. Her mother stated to me in my interview that she felt supported in finding her a community placement, especially by DRTx. She also poignantly said that “an earlier HCS would have helped her.” Although Bruni stated that she “was left with the impression that [Maria’s] guardian was conflicted about community services versus nursing facility services,” she failed to speak with Ms. Hernandez to find out more about her decisions for Maria or barriers to achieving her chosen outcomes for Maria, including community placement. Had she done so, Bruni would have realized this statement is plainly not true.

It is clear that Maria Hernandez received much more aggressive planning around alternate placement than the individuals in the random sample I reviewed in 2017, probably as a result of her status as a named plaintiff and the ongoing advocacy from DRTx. Multiple providers were identified, two consultations were provided to resolve the amount and type of nursing supports she would need, and the discharge planning went on throughout her health challenges with the hope that she would recover from her multiple hospitalizations. Her SPT team consisted of a variety of professionals and potential providers, not usually seen in my other reviews. There was collaboration between the nursing facility and the service coordinator and the service coordinator kept in very frequent contact with her mother, unlike several of the individuals I reviewed in 2017 whose service coordinator never spoke with involved family members. Unfortunately, the number of serious infections she experienced in the last two years of her life, including surgical removal of the infected rods in her back, meant that time ran out for Maria before she was able to benefit from all the effort to bring her out of the nursing facility and into the community.

Vanisone Thongphanh

Vanisone Thongphanh is a 40-year-old gentleman who, as of September 1, 2017, resided at a nursing facility in Arlington. He was admitted to this nursing facility on April 6, 2016 from an acute care hospital where he was hospitalized for nearly a month for pancreatitis, diverticulitis, and a urinary tract infection. He was admitted to the hospital from a group home where he lived for nearly two years. I focused my review on the records from Vanisone's 4/6/16 admission to a nursing facility through September 1, 2017.

Mr. Thongphanh has a tracheostomy, a g-j-tube for feedings, a wheelchair for mobility, and requires total assistance for care. He also has diagnoses of cerebral palsy, anemia, Type 2 Diabetes, seizures, and GERD. He responds to people and, reportedly, has a beautiful smile. He enjoys watching activities but is unable to participate. He had a corporate guardian, GSI, until his sister found him through an internet search. She became his guardian in the spring of 2017. She is a nurse and is very involved in his life.

Mr. Thongphanh did not have a comprehensive functional assessment. He had a PASRR Level 1 screening done on 4/6/16 which was positive for mental illness, intellectual disability, and developmental disability. He does not have any diagnoses of mental illness. He had a PASRR Evaluation (PE) done on 5/9/16 which states that he has only a developmental disability, cerebral palsy. The PE recommends specialized services including service coordination, physical therapy (PT), occupational therapy (OT), and speech therapy (ST). He had a PT evaluation on 4/21/16, and OT evaluation on 4/22/16, and a ST evaluation on 4/26/16. He had various nursing assessments which assess his medical/nursing concerns such as skin integrity, fall risk, and similar. He did not have assessments of his developmental skills in the areas of affective, cognitive, social, or adaptive behaviors.

Vanisone Thongphanh has not received all necessary specialized services. He received rehabilitative OT and PT shortly after admission to the nursing facility for two months, April-June 2016. This was appropriate as he required rehabilitation after his lengthy hospitalization. He then received habilitative PT from March 2017 until May 2017 and again in July and August of 2017. He received habilitative OT from October 2016 until January 2017. He received habilitative ST from April through June 2016 and again from October 2016 until February 2017. It is not clear from the records I reviewed why these habilitative services were terminated. The SPT requested therapies on an ongoing basis from the nursing facility, but the nursing facility did not agree that he needed therapies. There were no apparent medical reasons to stop these therapies, particularly since he showed improvement and was making progress. This directly contradicts Bruni's statement the Vanisone received the services recommended in his PE. He had a customized manual wheelchair (CMWC) and an air mattress. His team continued to recommend alternate placement which has not occurred.

Mr. Thongphanh did not receive a program of active treatment continuously implemented. He did not receive a comprehensive functional assessment to form the basis for the provision of specialized services. He did not receive the necessary specialized services with the frequency, intensity, and duration required by his conditions of immobility and cerebral palsy. He had significant periods of time when he was not receiving OT, PT, and ST. Given his immobility and cerebral palsy he would have benefitted from maintenance and prevention of regression of his skills. He spent much of his time at the nursing facility in bed. His guardian had to specifically request that they reposition him every two hours, standard care for someone who is immobile. He developed a decubitus on his heel. He was hospitalized in February 2017 for respiratory distress and a bowel obstruction. His sister said that the bowel obstruction was from fecal impaction. Fecal impaction, which is a result of constipation, is one of the "fatal four" known in the field of developmental disabilities to lead to increased morbidity and mortality. It is usually prevented by meticulous daily attention to hydration and monitoring of bowel movements.

The individual service plan (ISP) dated 9/22/16 is a person-centered, professionally appropriate ISP. It contains relevant information regarding Vanisone's strengths, preferences, and needs. It contains helpful historical information and a thorough picture of medical concerns and treatments. Although he only has two outcomes, they have been agreed upon by the SPT. They are to live in a safe environment in the community and to go to day habilitation (DH). The SPT consists of his clinicians, his guardian, Disability Rights Texas (DRTx), and LIDAA staff. They meet regularly. Section 9 on community placement is complete with all three phases containing information relevant to his anticipated community placement. One concern expressed by his sister is that she does not believe that he has diabetes mellitus, as is stated under the diagnoses. She stated that it is a carry-over from his hospitalization when he was so ill and showed elevated blood sugars due to steroid treatment.

Mr. Thongphanh is appropriate for and would benefit from community placement. He lived in the community for at least two other periods of time, most recently from May 1, 2014 until April 6, 2016. From the review of the record, he did well during that period and attended day habilitation. Although I cannot be definite, it appears he had his tracheostomy and g-tube during that period and his medical conditions were very similar to his current state. His SPT continued to work on community placement.

However, there was a serious disagreement with the nursing facility staff who did not believe he should return to the community. The disagreement centered on whether or not he needed tracheal suctioning and whether or not that could be performed in the community by non-nursing staff. From my review of the record and interview with his sister, it appears that the nursing facility gave conflicting information as to whether or not he was being suctioned. The nurse at the SPT meeting of June 30, 2016 said he had been suctioned on all three shifts. However, during visits to the nursing facility, nurses caring for him would state that they had not suctioned him. The corporate guardian refused to allow discharge unless the group home had 24-hour nursing. These arguments continued through all of 2016 and until at least July of 2017. When his sister became his guardian, she asked the nursing facility for documentation of his recent suctioning history; they did not provide it. She also told me that she asked them what they were doing to help him reduce and/or manage his secretions and they could not provide any answer. DRTx attempted to get this information and was also unsuccessful. The SPT continued to meet and develop transition plans and a CLDP was written on 8/16/17. As of 8/22/17, the SPT was still planning for his return to the community and the nursing facility continues to remain opposed. I disagree with Bruni's assertion that Vanisone's medical condition makes community placement "an extraordinary challenge." Not only was he successfully served in an HCS program in the past, in my experience, individuals with similar medical needs are being served successfully in appropriate community settings in other locations as well.

When finally offered appropriate alternatives, Mr. Thongphanh's guardian decided that Vanisone should return to the community. DRTx appears to have made a significant difference in Vanisone's life, as does his status as a named plaintiff. The ISP, the SPT, and the provision of specialized services is at a higher level than the individuals I visited in my previous reviews. Despite the lack of success in obtaining necessary specialized services, the SPT was persistent in requesting them from the nursing facility and he finally did get some therapies in 2017. The presence of DRTx and his sister/guardian ensures that the

SPT will continue to work toward community placement. Vanisone is a clear example of an individual, who could be served in the community, and is currently residing in a nursing facility against the expressed wishes of his guardian. This undermines Shea-Delaney's statement that Mr. Thongphanh serves as evidence that the transition process in Texas is working.

Melvin Oatman

Melvin Oatman is a 54-year-old gentleman who, as of September 1, 2017, resided by himself in his own apartment in Richardson Texas. He moved to this apartment in (June 28) 2016. Previously he resided in a nursing facility, for almost 9 years, almost all without any specialized services or rehabilitative services. He was admitted to that nursing facility in 2007 after experiencing a stroke. Prior to the nursing facility he lived with family and experienced periods of homelessness. He has multiple, serious chronic medical conditions, including HIV, TB currently not active, Hepatitis C-chronic, Cytomegalovirus (CMV), peripheral neuropathy, encephalopathy-HIV related, retinopathy-HIV-related, movement disorder, degenerative disc disease, and Bell's palsy, several of which apparently were present before age 22.

When I spoke with Mr. Oatman he was able to communicate his preferences and expressed pleasure in living in his own apartment and working. He enjoys making money and uses it to purchase decorations for his home, shopping, and to go to the movies. He is able to walk to the movies and Walmart from his apartment. He uses public transportation to get to and from work and works five days a week. He obtained his apartment through a housing voucher, but it took about nine months for the voucher to be approved. He is on the Star-Plus waiver and receives attendant services for 3-4 hours five days a week with no services on the weekend. The attendant comes in around 4 pm when he gets home from work, helps him set up his dinner, makes sure he has his lunch for the next day, and sets up breakfast. The attendant also sets up his multiple medications, which are very extensive given his serious chronic diseases. The attendant also does some light housework and some laundry.

Melvin did not receive a comprehensive functional assessment. A service coordinator note from November 11, 2013 – six years after he moved to the nursing facility -- indicate that Mr. Oatman had a PASRR Evaluation (PE) -- that is positive for mental illness and developmental disability and negative for intellectual disability. Five days previously, he had a DADS Eligibility Assessment on November 5, 2013 which determined that he had a full scale IQ of 74 and that he did not meet the eligibility requirements for PASRR services. A referral to the Department of Assistive and Rehabilitative Services (DARS) was made to follow up for a vocational assessment. A DARS assessment was done on 10/21/2014 and he was working at Goodwill by March 25, 2014. He had a Quantitative Functional Capacity Evaluation on October 21, 2014 which determined that he did not meet the lifting and carrying requirements and that he has deficits in bending, sitting, reaching, and his gait. The recommended options were to discharge from work or do rehabilitation therapy.

Six months later, he had an MDS on April 22, 2015 that lists diagnoses of intellectual disability and mental illness and identifies psychosis NOS as his primary diagnosis. He had another MDS on July 30, 2015 which does not identify intellectual disability, mental illness, or developmental disability as diagnoses and lists his primary diagnosis as convulsions. He had a further MDS on May 3, 2016 which includes a diagnosis of mental illness and does not identify diagnoses of intellectual disabilities and developmental disabilities. The primary diagnosis in this nursing facility assessment is convulsions. The record indicates that he had a new PASRR Level 1 done on May 5, 2016 that is negative for mental illness, developmental disability, and intellectual disability. The conclusion on this assessment appears to have been in error, since a prior confirmed developmental disability on his PASRR Evaluation and another one on the nursing facility MDS should have at least triggered an indication of developmental disability on this subsequent PASRR Level 1. He had an ICAP evaluation on May 23, 2016 as part of the transition process, which is partially filled out and not scored. From my review of the records, I could not find any assessments for sensorimotor, affective development, or adaptive behavior. The assessments were not done within a circumscribed time period of thirty days, in fact, they were done over several years. It is surprising that he did not have OT, PT, or ST (sensorimotor) evaluations since he had a gait disturbance and peripheral neuropathy.

Mr. Oatman did not receive all necessary specialized services. Despite his gait disturbance and his movement disorder, he did not receive OT, PT, or ST while he was a resident of the nursing facility. During his nursing facility stay of nearly nine years, he would have benefitted from independent living skills (ILS) to expose him to the community. He also would have benefitted from alternate placement planning prior to 2016 when alternate placement planning began.

Melvin did not receive a program of active treatment continuously implemented. He did not receive a comprehensive functional assessment (CFA) at any point in his stay at the nursing facility. Instead, he received a variety of assessments, conducted over a lengthy period of time that did not encompass all the elements of a CFA. Because his strengths, needs, and preferences were not adequately assessed, he did not receive the necessary specialized services that would have enabled him to gain strength and mobility in his gait disturbance and movement disorder. Despite a PE done in 2013 which identifies that he wants to work and that he could live in the community with support, he was not offered employment until 2014 and a community placement until 2016. During my interview he repeated that working is very important to him and he enjoys living on his own in his apartment.

Mr. Oatman did not have a person-centered individual (ISP) that is appropriate to his developmental strengths, preferences, needs and age. After multiple assessments spanning nine years that found that Melvin had either IDD, mental illness, or a related condition, it appears that DADS then determined that he does not meet the eligibility criteria for a related condition and concluded he was no longer eligible for PASRR services, just before his transition to the community.

Melvin has benefitted from his existing community placement as evident from his enthusiastic expressions of satisfaction with his apartment, his job that generates extra money, and his social and recreational activities - all of which are a result of his ability to live independently, with some supports. In fact, the PE of 2013 reportedly indicates that he could live in the community with supports and yet it was another three years of segregated living that he endured before his discharge planning meeting was held on June 22, 2016. Planning for his discharge was done without any assistance from the LIDDA and was done exclusively with the nursing facility and Disability Rights Texas (DRTx). They assisted him in obtaining a housing voucher, food stamps, and a Star Plus waiver slot. He had a CLASS waiver slot, which was withdrawn when he was encouraged to sign a form that he was ineligible. He moved to his apartment on June 28, 2016 with the initial support of nursing once weekly for three months and 20 hours a week of attendant services. Currently he only receives 20 hours a week of attendant services.

With the assistance of DRTx, Melvin made a decision and successfully transitioned to the community. While in the nursing facility for nine years he consistently stated that he wanted to work and once he began working in 2014, realized that he enjoyed going out into to the community and making extra money. Prior to his stroke, hospitalization and subsequent placement in the nursing facility, he was homeless and, therefore, had little understanding of the types of supports that could be provided for him to help him be successful at living and working in the community. Once he experienced these supports, he understood that he could be successful in the community.

Melvin Oatman is fortunate that he is a named plaintiff and has been represented by DRTx. Without their continued advocacy, it appears he would have been forgotten by the system and would still be living in a segregated nursing facility, not working, not living in his own apartment, managing his complex medication routine, walking to Walmart, and seeing movies. His challenging chronic diseases are held in check through his adherence to his doctor's protocols and his consistent compliance. An ordinary life in many ways, but not a forgotten one.

Richard Krause

Richard Krause is a 37-year-old gentleman who, as of September 1, 2017, had resided in a group home in Victoria since July 21, 2014. Prior to that he was admitted on September 18, 2011 to a nursing facility in San Antonio. After a normal childhood, he sustained a traumatic brain injury at age 20. After his lengthy hospitalization and rehabilitation, he lived at home with his father and step-mother. He had one additional nursing facility placement prior to the 2011 placement. He has diagnoses of hepatic encephalopathy, chronic liver disease, traumatic brain injury, general muscle weakness and seizures. He uses a customized power wheelchair and can assist with transfers. He is able to use a walker for short distances. Prior to his head injury, he graduated from high school and had begun electrical trade school. He is very social and enjoys working at his day habilitation (DH) program. He enjoys sports, particularly football and baseball. He loves to eat and go out to dances. He enjoys hunting and fishing. His family is very involved and his father is his legal guardian.

From my review of limited records from the nursing facility for the time period of admission on 9/18/11 until his discharge on 7/21/14, Richard did not have a comprehensive functional assessment done soon after admission. He had his PASRR Level 1 done on 4/13/13 – two years after his admission -- which is positive for IDD. He had a PASRR Evaluation (PE) done on 7/15/13 which confirms that he has a developmental disability and recommends specialized services of service coordination, alternate placement, physical therapy (PT), occupational therapy (OT), speech therapy (ST), and a determination of intellectual disability (ID). He had the DID and an ICAP done in September 2013, as part of the transition process. At that time, he was assessed in the developmental areas of affective, cognitive, social, and adaptive behaviors. Previously, he had OT and PT assessments as part of rehabilitative therapy on 10/12/11 and 10/10/11, respectively. He had a ST assessment as part of rehabilitative therapy on 10/10/11. He had various nursing facility medical/nursing assessments. Although his assessments for therapy occurred at the same time and shortly after he was admitted to the nursing facility, his other assessments were not done within a circumscribed time period and not in collaboration among the professionals. The majority of the assessments were not done until after he was identified for a HCS slot in 2013.

Mr. Krause did not receive all necessary specialized services while he was in the nursing facility. He received rehabilitative PT, OT, and ST from October 2011 through to mid-March in 2012. This occurred after a qualifying hospital stay from 9/27/11-10/07/11 for hepatic coma and uncontrolled seizures. This illness profoundly affected his functional abilities as he was able to ambulate, with assistance, transfer and do most of his personal care needs prior to the illness. Subsequently, he was unable to walk and needed assistance with all care needs. He used a wheelchair at all times for mobility. He received a customized manual wheelchair (CMWC), which he could propel short distances with his one foot. He eventually received habilitative PT, OT, and ST in August through November 2013 once a HCS slot had been identified and as part of his transition.

The SPT disagreed on recommending a customized power wheelchair (CPWC) with the nursing facility refusing to recommend the CPWC because they thought Richard could not properly use it. The SPT team wanted Richard to obtain the CPWC prior to his transition but decided not to delay the scheduled transfer to his community program. He was evaluated by two different therapy services and eventually the CPWC was recommended. Due to this disagreement and the change in the payer source, he did not receive the CPWC until March 10, 2015, eight months after he moved to the group home. Despite his history of working and his age, he did not receive day habilitation services (DH) until he left the nursing facility. He never received independent living skills training (ILS) which would have increased his socialization and community skills. He did receive consistent service coordination. While Richard did receive the specialized services recommended in his PE, the PE did not occur until he had already been living in the nursing facility for two years and did not recommend a number of needed services. In addition, I strongly disagree with Bruni's conclusion that Richard's situation "would appear to support the successes of the Texas PASRR program."

While in the nursing facility, Mr. Krause did not receive a program of active treatment that was consistently implemented across settings. He did not receive a comprehensive functional assessment until he decided to transfer to the community. He did not receive all the necessary specialized services that would have helped him to regain his ambulation, self-care, and speech skills. The nursing facility did not prevent regression of his skills, as acknowledged in the PT assessment of 10/16/13 where the therapist states that there is documentation of a steady decline in functional status since his admission in 9/18/11.

Mr. Krause's Individual Service Plan of 7/31/13 is person centered and professionally appropriate. However, this plan was developed only after a HCS slot had been approved for him and includes his selected provider. Most likely it is not reflective of plans that would have been done prior to his identification for an HCS slot. This transition plan identifies his needs, strengths, and preferences. The planning team consists of clinicians, his family, Richard, and other relevant staff from the nursing facility. It identifies specialized services of OT, PT, ST, alternate placement, DH, behavior support, and service coordination. It has several outcomes related to increased ability to ambulate, increased self-care skills, health maintenance and monitoring, socialization, oral health and increased communication skills. These outcomes have measurable goals, are time bound, and identify the responsible person.

Richard Krause has benefitted from living in the community. He transitioned to his chosen group home, in the same town as his family, on July 21, 2014 and has stayed with the same provider. His needs for continued specialized rehabilitation for his TBI were identified and he had a five month stay at the Transitional Learning Facility in Galveston. He returned with the ability to ambulate short distances and use a walker, increased transfer abilities, improved self-care skills, and improved speech. His father states that it had a "big impact on his abilities." He attends DH consistently five times a week and has a job through the DH that enables him to earn some spending money. He frequently goes on outings including to football and baseball games and out to eat with his family. He loves to go dancing. He has received PT three times a week since the beginning of his transfer. His father states that he is much less sedated than he was in the nursing facility, where he was on 16 different medications. He has his CPWC which he is able to use despite the nursing facility belief that he could not use one.

Once appropriate options were made available, Mr. Krause's guardian decided that Richard should transfer to the community. His guardian originally did not have a meaningful and appropriate alternative for Richard. However, once a concrete proposal was provided to him, he quickly moved to select a provider. Nevertheless, the transition was reported to be difficult with the nursing facility not providing information or access to paperwork, refusing to authorize the CPWC, and generally not cooperating. Mr. Krause has benefited immensely from the relentless individual advocacy provided by DRTx, and together with his status as a named plaintiff, has made a significant difference in his outcomes. DRTx has been involved in all of his SPT meetings, visited him while he was at the nursing facility, followed up on the refusal of the nursing facility to authorize the CPWC, and assisted in locating a provider near Richard's family. Without their involvement, it is most likely that Richard would still be totally non-ambulatory, confined day after day to the nursing facility, on 16 different medications and living over two hours away from his family. Richard Krause is a young man who now has the opportunity to achieve the one goal he wants to achieve -- to walk again, even for short distances.

Leonard Barefield

Leonard Barefield is a 73-year-old gentleman who, as of September 1, 2017, resided in a group home in Lubbock. Prior to living in the group home he resided in a nursing facility in Midland until his discharge on September 1, 2015. He entered the nursing facility on December 9, 2008 after an investigation into the abusive living and working conditions at Henry's Turkey Farm where he worked in Iowa. Leonard had worked and lived there for a number of years. He and six other men from the Turkey Farm were transferred to the nursing facility in Midland, where the administrator was the nephew of the owners of the Turkey Farm, Leonard knew the administrator for many years, and used to give him rides on a tractor when the administrator was a young boy.

Leonard has diagnoses of Diabetes Mellitus, requiring daily insulin, hypertension, hypercholesterolemia, and hearing impairment. He is described as very pleasant and outgoing, enjoys being well dressed, and likes to wear cowboy boots and multiple rings when he goes out. He is fairly independent in his personal care, although his speech can be difficult to understand. He likes going to the park and fishing. When he was at the nursing facility, he would either be in his bedroom watching television or sitting outside smoking.

Mr. Barefield did not have a comprehensive functional assessment of his strengths, needs, and preferences during his stay in the nursing facility. He had a PASRR Level 1 completed in February of 2013 – five years after his admission – which found he had ID and MI. The form indicated that Leonard was admitted through an exempted hospital discharge requiring less than 30 days of care – but he spent 7 years living in a segregated nursing facility. He had a PASRR Evaluation (PE) completed six months later, in August 2013, which was positive for ID. No nursing facility specialized services were recommended and the only LIDDA specialized service recommended was service condition, even though he had been working at a processing plant for years before his admission to the nursing facility. The assessment also inaccurately indicated a primary diagnosis of dementia and stated that Leonard's care needs were likely greater than support available in the community. He had multiple MDS assessments on 11/22/14, 1/20/15, 4/30/2015, 5/30/15, 6/2/15, and 8/18/2015. He had nursing care plans, dated 11/7/14, 1/28/15 and 7/28/15 which assess various medical/nursing concerns related to his medical diagnoses. He had an occupational therapy (OT) evaluation in January 2015 and a speech therapy (ST) evaluation in 5/12 and again in 7/13 and 5/15. These assessments were not done within the circumscribed period of time, thirty days, and not part of a collaborative process by a team of clinicians. He did not have a complete assessment of his sensorimotor development, nutritional status, affective development, cognitive development, social development, or adaptive behaviors. When he was discharged to the community provider, he finally was evaluated for PT, OT, and ST and received dental services consisting of extraction of decayed teeth and dentures. He also had an evaluation by an audiologist.

While in the nursing facility Mr. Barefield did not receive all necessary specialized services. The only specialized service he received was service coordination, which did not begin from the LIDDA until 2014. He had rehabilitative OT for a two-month period in early 2015 and rehabilitative ST in May of 2012 for four weeks and again for one month in the summer of 2013 and one month in spring of 2015. Therapy notes show that he made improvements in skills in both of these areas and he would have benefitted from continuous habilitative OT and ST therapies. Despite decades of working, he did not receive any day habilitation (DH) services or evaluation for vocational preferences. He would have benefitted from independent living skills and yet he was never assessed for this specialized service that enables the acquisition of skills to promote independence, socialization, and exposure to the community. He had few opportunities to leave the nursing facility and spent much of his time in his room watching television. After his transfer to the group home, he began attending DH five times a week. He is also active in accessing the community and goes out three or four times a week. He has been taught by community nurses to do his own blood checks and give himself his daily insulin injections, an important skill. He takes care of all his medical supplies, his diabetes is stable, and he is healthy. These significant achievements recognize his abilities for independence and self-determination and highlight the missed opportunities during his almost 7 year stay in a segregated nursing facility.

For the six and a half years that Mr. Barefield was at the nursing facility, he did not receive a program of active treatment continuously implemented. He did not receive a comprehensive functional assessment so his needs, strengths, and preferences were not identified. He did not receive any of the necessary specialized services, except for intermittent rehabilitative OT and ST and service coordination. He spent much of his time in bed watching television or outside smoking. He did not even participate in eating most of his meals in the dining room. After decades of abusive living and working conditions, his life primarily consisted of watching television, eating, and sleeping punctuated with smoking breaks.

He did not have a person-centered individual service plan (ISP) during his time at the nursing facility. His ISP of 11/7/14 does not provide much information about his strengths, needs, and preferences. The SPT usually consisted of Leonard, the service coordinator, and one or two nursing facility staff. He had two outcomes: to live as independently as possible and to improve his ability to communicate. Absent any specialized services, it is hard to understand how he would have accomplished these goals. The goals do not have any specific measurable objectives or specific criteria for achievement. He is described as spending most of the time by himself, either in his room or sitting outside smoking. By contrast, his ISP of 8/18/15, after his transfer to the group home, has eight outcomes: to have good oral health including dentures, to be safe in his home, to go on community outings, to live as independently as possible, to go to DH, to monitor my diabetes, medications and health. His SPT meetings now include clinicians, staff from the group home, his Disability Rights Texas (DRTx) attorney, and service coordinator. His ISP is based upon comprehensive assessments and his strengths, needs, and preferences.

Mr. Barefield has benefitted from living in the community as outlined in the preceding paragraphs. Prior to the involvement with Disability Rights Texas (DRTx), the record frequently indicated that he was "very vocal about his satisfaction with living at (the) nursing facility." At his first CLO meeting on November 7, 2014 he reportedly "expressed no desire to leave the nursing facility". But with support from DRTx, in April 2015, he expressed interest in an alternate placement. Staff from one of the providers invited him to an overnight visit which occurred in July of 2015, and he decided to move as soon as possible.

Since his transfer on September 1, 2015 he has increased his already many capabilities. He now self-administers his own medication, including insulin injections and blood sugar checks. During the interview he told me that it is a lot better and he has his independence, "no one is watching over me every minute and I get to do the things I like to do". He has had his teeth taken care of including dentures and his health is stable.

I strongly disagree with Bruni's statement that the PASRR process was followed for Mr. Barefield. While in the nursing facility he was denied the specialized services necessary to increase skills, avoid deterioration, and maximize independence and self-determination.

While Leonard Barefield is competent and may have elected to remain in the nursing facility at one point, it is unlikely that his choice was truly informed, since he had spent decades in segregated and abuse settings, since there were virtually no opportunities to learn about community options, and since he received no services or supports that would allow him to participate in community activities. After becoming a named plaintiff, when he was finally offered these opportunities, and with support from DRTx, he decided to move to the community.

Leonard had spent years living and working in an appalling situation prior to his entry to the nursing facility, resulting in an investigation and the removal of Leonard from the turkey farm. When he came to the nursing facility he found people who were kind to him and cared for him. The abusive situation ended but, most likely, the traumatic effects did not. His context for making decisions at that time were undoubtedly shaped by the abuse he experienced. Once he had the concrete experience of seeing a group home, of having appropriate supports based upon his strengths, needs, and preferences, he quickly decided to leave the nursing facility. As of September 1, 2017, he has, by all accounts, lived happily and successfully in his group home for the past two years. However, it is clear that the involvement of DRTx is the primary motivator that provided Leonard with concrete information about community living and support services. It is most likely the single most important reason that he lives today in a group home and is able to say that his life is a lot better and that he gets to do the things that he likes to do.

Tommy Johnson

Tommy Johnson is a sixty-five-year-old gentleman who, as of September 1, 2017, resided in a nursing facility in Crane. He transferred to this nursing facility on June 16, 2016. Prior to that he resided in a nursing facility in Midland which he entered in December of 2008. Prior to 2008, Mr. Johnson worked and resided for over twenty years at Henry's Turkey Farm in Iowa where he, and others with intellectual disabilities from Texas, were discovered, as a result of a federal investigation, to be the victims of decades-long physical, psychological, and economic abuse by the Henry's Turkey Farm owners. He was confined to living in an uninhabitable old school house with the other men and he was made to do excruciating work for long hours and virtually no pay on the turkey farm. Following an investigation that uncovered this abuse, Mr. Johnson was transferred to a nursing facility where the nephew of the owner of the Turkey Farm was an administrator.

Tommy is described as very pleasant, quiet, and more of an observer than a participant. Although he has become much more outgoing since his transfer to Crane and will talk with people and make jokes he is still easily startled. While he was leery at first, he likes going on outings several times a week with his ILS staff. He enjoys Dairy Queen and shopping. He also likes to take naps and watch television. He is ambulatory and requires only supervision for his personal care needs. His roommate is a friend from the Turkey Farm and they are close. He has diagnoses of Type 2 Diabetes, hypertension, chronic obstructive pulmonary disease, osteoarthritis, major depressive disorder, hyperlipidemia, muscle wasting and atrophy, lack of coordination, history of MRSA and history of pneumonia. His diabetes is controlled without medication.

Tommy did not have a comprehensive functional assessment at either of his nursing facilities. He had a PASRR Level 1 done on June 16, 2016 and June 17, 2016 which was positive for mental illness, developmental disability and intellectual disability. The section on preference for living situation is left blank. He had a PASRR Evaluation (PE) on June 23, 2016. It is positive for intellectual disability and recommends specialized services of service coordination, alternate placement, independent living skills (ILS), behavior supports, physical therapy (PT) and occupational therapy (OT). Although his preference for living situation was listed as the nursing facility, he is also described as being able to live in the community with supports. He had various standard long-term care assessments by the nursing facility, which evaluated his medical/nursing needs such as fall risk, skin breakdown, activities of daily living and similar. He has a thorough nursing care plan dated March 2017. He had an MDS recorded in May and August of 2017, and others in 2016. He had his first PT, OT, and speech therapy (ST) assessments done in December 2015, nearly 7 years after entering the nursing facility. He did not have assessments of his affective development, auditory functioning, cognitive development, social development, and adaptive behaviors or independent living skills. Those assessments that were completed were not done within a circumscribed period of time, usually thirty days, and do not present a comprehensive picture of Mr. Johnson's strengths, needs, and preferences.

Tommy did not receive all necessary specialized services until recently and as a result of the advocacy of Disability Rights Texas (DRTx). Despite his diagnoses of muscle wasting and atrophy and lack of coordination, he did not receive a PT or OT evaluation until December 2015. He did not receive ILS services until the middle of 2016 and when he did it was not at the recommended frequency. Despite a history of working for thirty years, he was not assessed for interest in working or considered day habilitation (DH) until 2016. He began going to DH twice weekly but it appears that transportation stopped picking him up and he only went for about a month. After much advocacy from DRTx he began receiving habilitative OT, PT, and ST in December 2015 but it appears the services were intermittent. An MDS from June of 2016 indicates he was not receiving any PT, OT, or ST. He is currently receiving OT alternating with PT, as well as ST, and ILS, and has shown improvement in strength, flexibility, balance and coordination. He enjoys exercising and especially likes ST.

When I asked him if he liked going out with his staff person (ILS) he said he could “almost” go every day. His current nursing facility is providing specialized services although they appear to be using the rehabilitative system for payment. He has been offered day habilitation but only goes for special occasions because the nearest day hab facility is 45 miles away. He enjoys ILS very much and goes out with his staff person several times a week. Prior to the implementation of ILS the SPT team was recommending an air mattress for his bed as a specialized service (DME) because “he likes lying in bed and taking naps”. This recommendation was discontinued once he transferred to the new nursing facility and began ILS. The SPT stated that he is no longer spending so much time napping that their worries about skin breakdown are no longer relevant. It is clear from my interview with Mr. Johnson and from the record, that he is much happier and active now that he is receiving the necessary specialized services.

One area that is mentioned only obliquely is his thirty years of abusive treatment at the Turkey Farm in Iowa and the impact upon his physical and mental health. The SPT meeting of 6/30/16 states that “The turkey farm conditions were deplorable and had long term effects on his hands, feet and joints…” Tommy should be assessed for post-traumatic stress disorder by a therapist skilled in working with individuals who have suffered years of abuse and who have cognitive impairments. He presents with many of the same characteristics as people who have suffered from trauma. It is hard to imagine that he would not have been traumatized by that experience and that he continues to feel the effects. We know from other victims of trauma that help is needed to overcome the damage.

Bruni’s statement that Mr. Johnson was receiving the specialized services identified in his PE is incorrect. While behavioral support is recommended in his most recent PE, it has not been provided. He did not receive the necessary PT and OT services despite having a diagnosis of muscle wasting. Additionally, she incorrectly states that he is regularly being provided Day Habilitation. Tommy has not regularly received Day Habilitation in over a year since his transition to his current nursing facility.

Prior to 2016, Tommy Johnson was not receiving a program of active treatment, continuously implemented. At the Midland nursing facility, he spent much of his day napping, including when he was sitting outside his room near the doorway. His other primary activity was watching television. He did not have a comprehensive functional assessment that described his needs, strengths, and preferences and, therefore, he was not receiving the necessary specialized services until December 2015. The SPT consisted of 3 or 4 people including Tommy and the service coordinator. Once DRTx became involved, the SPT was usually 8-10 people including clinical specialists. Once he began receiving specialized services, the difference in Tommy is striking. He decreased significantly the amount of time spent napping and watching television, became more talkative, and made strides in his functional abilities. Given the absence of any behavioral assessment or support, Mr. Johnson is still not receiving a program of active treatment.

Tommy did not have a person centered individual service plan (ISP) until June 30, 2016. But that ISP did not include an adequate transition plan. His prior ISP's had only one outcome: "I want to nap on a daily basis." This is not a goal that will help Tommy acquire the behaviors necessary for him to function with as much self-determination and independence as possible and will not prevent or decelerate regression of loss of current optimal functional status. In fact, it almost guarantees the opposite as is evidenced by the recommendation of the SPT that a necessary specialized service for Mr. Johnson is a pressure relieving air mattress because he spends so much time in bed. Contrasting with this lack of a professionally appropriate ISP is the ISP of 6/30/16 which has four outcomes such as getting out in the community, having friends, benefitting from a communication aid and maintaining level of independence. This ISP also recommends OT, PT, ST, and ILS. Neither of the ISPs identifies the support services necessary for Tommy to live in the community and Section 9, Phase II is blank. By the SPT quarterly meeting of 6/21/17 he has an iPhone and an iPad and is working on learning how to use the iPad in OT.

Tommy Johnson would benefit from living in the community. He requires very little assistance with his daily needs and has shown growth through the provision of specialized services. The more frequent addition of ILS has helped him to become much more social and see the world as an exciting place, full of adventure and not something to be feared. His medical conditions are similar to many people who are successfully supported in the community and all his medical concerns can be managed by community health care providers.

Although Tommy is competent, it is difficult for me to say whether he has made an informed choice to remain in the nursing facility. It does not appear that significant efforts have been made to address barriers to transition, including Mr. Johnson's trauma history, understandable fears of certain living situations, and lack of recent exposure to new possibilities for community integration. Further, the record shows that he expressed a desire a leave the segregated nursing facility as far back as 2009. Shea-Delaney does not appear to assess whether Mr. Johnson's remaining in the nursing facility was an informed decision. Prior to beginning his ILS services, his only concept of living in the community was in a setting where he was abused for thirty years. When he was freed from that deplorable situation and went to the nursing facility, he suddenly found people who were kind to him and did not abuse him. He had no other context or understanding that his situation was so far removed from human decency. As he spends more time around people who will protect him, help him grow and care for him he may begin to see that his is able to be happier in the wider world.

Johnny Kent

Born in December 1949, Johnny Kent is a 68-year-old man who, as of September 1, 2017, had resided in a nursing facility in Crane, Texas. He has lived here since June 16, 2016 when he was transferred from another nursing facility in Midland, Texas. He was admitted to that nursing facility in 2008. Prior to 2008, Johnny worked and resided for over twenty years at Henry's Turkey Farm in Iowa where he, and others with intellectual disabilities from Texas, were discovered, as a result of a federal investigation, to be the victims of decades-long physical, psychological, and economic abuse by the Turkey Farm owners. He was confined to living in an uninhabitable old school house with the other men and he was made to do excruciating work for long hours and virtually no pay on the turkey farm. Because of the federal investigation the men who were living there were removed. Several of the men in the Iowa Bunkhouse, including Mr. Kent, were transferred to a nursing facility in Midland where the nephew of the man that owned the Turkey Farm was an administrator. The level of abuse that Mr. Kent and others endured received national media attention and was widely discussed in the developmental disability field.

Johnny Kent is described as a hard worker who likes to keep busy, will smile readily, and is very close to his friends. He is especially close to his roommate with whom he lived at the Turkey Farm. He has been given the task of cleaning the dining room tables after lunch and he is very conscientious about doing so. He does not like to be interrupted by anything until he has completed his work. He enjoys going on outings including out to eat, shopping, to parks, and fishing. He has diagnoses of hypertension, depression, osteoarthritis, and seizures. When he was in Midland, the MDS assessment stated that he had non-Alzheimer's dementia. According to his records, one month later, on 7/6/16 at the Crane nursing facility, he no longer has non-Alzheimer's dementia. On August 31, 2017, Johnny expressed his desire to move out of the nursing facility and requested an HCS waiver slot. Throughout this time, Mr. Kent also received individual advocacy to obtain services from an attorney at Disability Rights Texas.

Johnny Kent did not have a comprehensive functional assessment of his habilitative needs that identify his strengths, needs, and preferences. During his time at the Midland nursing facility he had assessments for physical therapy (PT), occupational therapy (OT), and speech therapy (ST). He had several MDS assessments done as required by long term care regulations on September 4, 2015 and September 30, 2015, and in 2016 he had MDS assessments done March 1, May 14, July 6, July 21, October 22, and December 25. He had other long-term care medical/nursing assessments done in areas such as fall risk, skin breakdown, and similar. These assessments were done at varying times and were not done within a circumscribed period of time of thirty days. He had PASRR Level 1 done on June 17, 2016 when he transferred to the Crane nursing facility and a PASRR Evaluation (PE) done on June 23, 2016 which recommends LIDDA specialized services of service coordination, alternate placement, independent living skills (ILS), and behavior supports and nursing facility specialized services of OT, PT, and ST. He again had OT, PT, and ST assessments at Crane. He has not had any assessments of his cognitive development, social development, and vocational needs. The determination of his intellectual abilities which is reported as moderate, has not been done recently. There is very little information regarding his cognitive abilities and one is left to wonder what his true capabilities are.

Johnny Kent is still not receiving all necessary LIDDA and nursing facility specialized services, since he, like all of the men who were abused at the Turkey Farm, would benefit from some form of behavior support. At various times he has received PT, OT, and ST. He did not receive any ST until after his transfer to the Crane nursing facility. He experienced difficulties with the PT at the Midland nursing facility and refused to continue PT. According to service coordinator notes from the SPT meeting, he was discharged from PT after he struck an aide in the back. The nursing facility and members of the team disagreed as to whether this constituted his refusal to participate or a different motivator. After considerable discussion it was agreed that this was very atypical behavior. Johnny himself stated at the meeting that he liked riding the bike and bouncing the ball in PT and wanted to have his services after he finished his dining room job and before 4:00 pm. However, he needed another assessment by the PT and there was a two-month interruption before his PT began again.

After an initial delay, he began receiving independent living skills (ILS) in September 2016, but not at the recommended frequency of four hours/week. He was receiving it for 17 hours a month by the time of his SPT meeting of 6/21/17. He enjoys these outings and has made friends in the community. He has visited Day Hab (DH) sites and declined to attend. His PE of 6/23/16 recommended LIDDA specialized services of service coordination, alternate placement, ILS, and behavioral supports (BS) and nursing facility specialized services of PT, OT, and ST. He did not consistently receive ST as there was turnover in the ST position and months when the position was not filled. He has consistently received service coordination. He was offered and accepted visits to two different community providers and three day habilitation (DH) providers in January 2016. He declined to go to DH and stated he did not want to leave the nursing facility. Despite his years of trauma and abuse and contrary to the recommendations in his PE, his team apparently felt that he did not need behavior support.

Bruni's statement that Johnny is receiving the specialized services identified in his PE is incorrect. The records indicate that he has never received behavioral support, even though he may have benefited from behavioral support due to his long history of abuse.

Johnny was not receiving a program of continuous active treatment consistently implemented. There have been long periods when he did not receive all the necessary specialized services and the nursing facility services of OT and PT have at times been rehabilitative services through Medicare with interruptions. He did not receive ILS for many years and then, not at the frequency recommended initially. He is currently receiving these services as recommended. One of Johnny's attributes is that he likes to work and yet his work currently consists of wiping down the tables in the dining room after lunch. No other opportunities for work, including volunteering, have been explored. He is more active since moving to the Crane nursing facility and enjoys outings.

During his stay at the first nursing facility, until June of 2016, he did not have a professionally appropriate ISP. His ISP had only one outcome that he likes to do tasks around the nursing facility. There are no outcomes to increase his skills on activities of daily living or independent living skills. He has no outcomes related to his PT, OT, and ST therapies. Only 3 people were present at the SPT meetings in addition to Mr. Kent. There was minimal involvement from his clinicians. Section 9, Phase II was blank. His more recent ISP of March 16, 2017 lists four outcomes: I want to be safe, I want to have tasks to complete to keep me busy; I want to have friends and I want to have money. The goals are worked on in his specialized services and the clinicians participate in the SPT meetings. There are typically now about 10 people at his SPT meetings. ILS is providing opportunities for him to access the community on a weekly basis where he has made some friends. He has a task of cleaning up the dining room after lunch. He is receiving OT, PT, and ST, has a cell phone and a tablet that he is learning to use in OT. He has met a goal of using his seat belt whenever he goes in a car and that goal has been discontinued. His team meetings are attended by members of the relevant professionals from his life and, since his move to the Crane nursing facility, they are collaborating to implement his ISP. However, Johnny does not have an ISP that recognizes his many abilities and preferences, such as his strong desire to work and his enjoyment of socialization. Compared with individuals of similar abilities and interests, Johnny has minimal activities and opportunities for working and socialization, his two strong preferences.

Johnny is appropriate for and would benefit from living in an integrated setting with appropriate supports. His PE recommends alternate placement. His health care needs are minimal and can be easily met in the community. He requires only supervision for personal care and has a history of working. He enjoys socializing and would benefit from being in a more integrated environment. Records indicate that he first expressed a desire to leave the nursing facility as early as 2009. However, transition planning did not occur until after Johnny became a named plaintiff and received individual advocacy from Disability Rights Texas (DRTx). Prior to receiving ILS in September of 2016 Johnny had no regular opportunities to experience the community. He was given an opportunity to tour two different group homes in January 2016. He had CLO meetings semi-annually as required. He expresses a strong desire to be with Dave, a man who is also the nursing home administrator and who is the nephew of the owners of the turkey farm. He is so close to Dave that Johnny left his previous nursing facility to follow Dave to the new location, despite previously repeated statements that he wanted to remain at that nursing facility. It is clear that his attachment is to Dave and not necessarily to living in a nursing facility. In August 2017, Dave left the Crane nursing facility. Shortly after that, Johnny expressed a desire to also leave the nursing facility, despite firm refusals to do so earlier. This time he has indicated he does not want to go to the nursing facility where Dave now works, but instead is interested in looking at group homes in that area.

On August 31, 2017, Johnny informed his SPT team at a SPT meeting, that he wished to transition to the community and requested an HCS waiver slot. On September 1, 2017, Johnny was notified by the LIDDA IDD Enrollment/ Service Coordinator that HHSC had frozen the release of HCS waiver transition slots and that he would be put on a waiting list for an attrition HCS waiver slot. This directly contradicts Bruni's statement that waiver slots were provided to all plaintiffs wishing to transition to the community and Shea-Delaney's statement that Johnny has continuously chosen to live in a nursing facility. Once again Johnny has indicated he wants to leave the nursing facility but this time, after finally having the opportunity to regularly engage in the community, he is expressing his desire to see some group homes. The circumstances of the abuse he endured at the turkey farm and the continuing impact of that on his mental health, combined with his involvement since childhood with Dave left him with a very strong attachment to Dave, a fear of returning to a similarly abusive situation, and virtually no positive experiences outside the nursing facility. Given Johnny's history it is unsurprising that he did not initially decide to leave the nursing facility. It is hard to separate out his emotional needs for stability and safety from his ability to fully understand the benefits of living in a community setting.

Johnny's desire to now explore group homes shows the gradual understanding of what it means to live outside a nursing facility. Johnny came from a highly restrictive and abusive setting where he lived and worked in for twenty years. That life has profoundly impacted his ability to understand the benefits of living in a community of people who support you, are kind to you and want what is best for you. For an individual with such extensive experiences of abuse and institutionalization, individualized exploration of community options supported by a comprehensive program of active treatment is critical. We know that other people, those without cognitive limitations suffer from post-traumatic stress disorder and that should be considered as a factor in Johnny's life.

Johnny is receiving services at a level greater than the majority of those randomly selected for my initial review. He routinely has SPT meetings consisting of all his professional staff unlike many of those who I reviewed and who had only one or two people other than the service coordinator present for the SPT meetings. There were often supervisory level LIDDA staff present at his meetings. Although there were interruptions in specialized services, he did eventually receive PT, OT, ST, and ILS as recommended. It does not appear that he received this elevated level of attention prior to joining the case as a named plaintiff and receiving individual representation from an attorney at Disability Rights Texas. Despite this attention, Johnny represents a picture of missed opportunities for growth and self-determination. He is a healthy, active, and energetic man who survived years of an extremely abusive work and living situation. He continues to live in a segregated setting with minimal opportunities for socialization and no opportunity for meaningful work.

Joe Morrell

Joe Morrell is a 74-year-old gentleman who, as of September 1, 2017, resided in a Host Home setting in Lubbock. He began living in the home on August 1, 2016. Prior to that he lived at a nursing facility in Midland and prior to the nursing facility he worked on a turkey farm in Iowa. While residing and working in a segregated and abusive setting in Iowa – the infamous Henry's Turkey Farm that was the subject of a federal investigation - Mr. Morrell was forced to live with other men with IDD in a dilapidated old school house that lacked sufficient heat and was infested with vermin. He, along with the other men, was forced to work long, grueling hours at the turkey farm with virtually no compensation for nearly thirty years. Mr. Morrell was also physically and psychologically abused by his supervisors at the turkey farm. Following an investigation that uncovered this abuse, Mr. Morrell, together with several other residents of the Turkey Farm bunkhouse, were transferred to a nursing facility in Texas, where the nephew of the family that owned the Turkey Farm was an administrator.

Mr. Morrell is described as very pleasant, and enjoys going shopping, Mexican music, and attractions such as Sea World. He took a vacation in San Antonio last year and enjoys visiting new places and participating in the community. He also takes pride in his appearance and likes buying nice clothes. He is blind in his left eye from a trauma and has glaucoma in his right eye. As a result, he has no depth perception and has difficulty in darkness. He needs some assistance when walking and will use a walker or a transport wheelchair for long distances. He has Type II Diabetes Mellitus, peripheral vascular disease, and a history of venous stasis ulcers on both lower legs, osteoarthritis, moderate periodontal disease, and urinary incontinence. He was diagnosed with myelodysplastic syndrome in December 2016. He sees a specialist for treatment and is considered stable. He was also diagnosed with stage 1 esophageal varices, or abnormal blood vessels.

Mr. Morrell did not have a comprehensive functional assessment during his several years in the nursing facility. He had a PASRR Level 1 done on May 8, 2013, which was positive for intellectual disabilities, developmental disabilities, and mental illness. He had a PASRR Evaluation (PE) on August 27, 2013, that is positive only for intellectual disabilities. The PE recommended only the LIDDA specialized service of service coordination and no nursing facility specialized services. He had nursing facility MDS assessments on July 23, 2015, February 5, 2016, and May 3, 2016. He had other standard long term care assessments related to skin care, fall risk, and similar. He had physical therapy (PT) and occupational therapy (OT) assessments in October 2014 after a fall at the nursing facility. He did not have a timely assessment of his sensorimotor development, and he did not have assessments of his affective development, speech and language development, auditory functioning, cognitive development, social development and adaptive behaviors, or independent living skills.

While in the nursing facility Mr. Morrell did not receive all necessary specialized services. He had a brief--one month--series of rehabilitative OT and PT services after he fell. Despite having issues with vision, he never received OT or PT to help him with ambulation and increase his ability to navigate his environment. It's stated that he could not partake in nursing facility outings due to his vision impairment. He spent much of his time at the nursing facility in bed, watching television, which further contributed to generalized weakness. The service coordinator's progress notes indicate that in December 2015, the nursing facility administrator finally agreed to provide Joe with specialized OT, PT, and ST, but stated that there would be a delay because of staffing issues in the OT department. In December of 2015, according to the service coordinator's progress notes, Mr. Morrell began receiving specialized speech therapy services while at the nursing facility. These progress notes also indicate that in early January of 2016, the nursing facility incurred problems billing for these services. The service coordinator referred the nursing facility to DADS, but told facility staff that if the billing problem could not be resolved, the nursing facility should terminate the specialized ST.

Despite a lifetime of work, while he resided that the nursing facility, he was never assessed for vocational interests. He did not receive independent living skills (ILS) that would have enabled him to access the community and maintain the vocational skills he used while living on the Turkey Farm for almost thirty years. My review of the records indicate that he attended day habilitation for a one month period in February 2016 but had stopped going by the time of the service coordinator visit on March 1, 2016 apparently because he lost interest. On the rare occasions when he was taken on outings by the nursing facility, he enjoyed going to Walmart or out to eat. Only after he decided to transition out of the nursing facility to a Host Home in the community, were PASRR services of OT, PT, and ST finally provided, beginning in January 2016 and ending at the time of his discharge to HCS waiver services, a fact Bruni acknowledges. During that time, Mr. Morrell made progress during his therapies and increased his independence in his new home. It seems quite likely that given this progress, he could have made even greater gains if he had received these services when he was first determined to be eligible for PASRR services in 2013.

Mr. Morrell did not receive a program of active treatment, continuously implemented during his stay at the nursing facility. He did not receive a comprehensive functional assessment or any specialized services other than service coordination for the majority of his stay. He spent much of his time in his bed, watching television. His three and half years of living in the Midland nursing facility are marked by the absence of nearly all activities other than eating, sleeping, and watching television, at least until he began his transition and finally started receiving nursing facility specialized services.

During his stay at the nursing facility, he did not have a person centered individual service plan (ISP) that is appropriate to his developmental strengths, needs, and preferences. The ISP had one outcome: that he wants to remain as independent as possible in the nursing facility, and yet there were no goals and objectives or specialized services such as ILS that would have helped him achieve this goal. The service planning team (SPT) consists of only a few people, three for example at his SPT meeting of May 15, 2016. The ISP did not provide information regarding the conditions under which he lived for thirty years at the Iowa turkey farm and does not recommend that Mr. Morrell be assessed for post-traumatic stress disorder because of the conditions under which he lived and worked. Section 9, Phase II was blank despite his desire for independence and interest in community placement. Eventually a transition plan was developed when he identified the agency to provide him community placement services.

Joe Morrell moved to a Host Home setting on August 1, 2016 and by his own statements during my interview, likes it very much, and benefits from this new-found independence and freedom. (My review of the record and interview with Mr. Morrell do not agree with Bruni's date of December 2016.) He goes to day habilitation (DH) five days a week and goes to parks, shopping, to see friends and on vacation. He said he wanted to live in a house with columns, a big window, and a porch and his home has all these features. The home was renovated for his accessibility needs with modifications to the bathroom and a ramp. The transition process was described by staff of the provider as difficult, with little cooperation from the nursing facility. At the time of discharge, the nursing facility said he did not have any open wounds; however, during the nursing assessment in the community, the nurse discovered open, undressed wounds on both lower legs. The wounds required home health services weekly for over four months.

The service coordinator, Disability Rights Texas (DRTx), and the provider developed an effective transition plan which included assessments by OT, PT, ST, nutrition, and nursing professionals. It outlined his medical providers and had seven outcomes for Joe to achieve, all based upon professional assessments and reflective of his preferences, strengths, and needs. The initial assessments were conducted within thirty days of his transfer. He received OT, PT, and ST after transitioning to the community. He had an ISP done on June 20, 2016, prior to his discharge that included 16 people--not three as during his earlier SPT meetings in 2013. The service coordinator continued to follow him after his transfer and is responsive to his needs.

Once options were made available and appropriate information provided, Joe Morrell decided to leave the segregated setting of a nursing facility and did so. Despite a statement in the SPT meeting of November 7, 2014 that he wanted to remain in the nursing facility, he quickly changed his mind when he learned that one of his friends had moved out to a group home. And even after this change of heart, the Section 9 of the ISP that should address, among other things, barriers to transition, was left blank. However, in the CLO dated October 27, 2015, it is documented that Mr. Morrell decided that he did, in fact, want to transition to the community.

The involvement of DRTx clearly assisted him to understand his options and helped him find an appropriate provider, a Host Home setting. DRTx's advocacy on behalf of Mr. Morrell resulted in accelerating community placement planning for him. Mr. Morrell received ongoing individualized opportunities to explore community living options. He attended day hab, visited multiple community providers, and participated in two overnight stays. Overtime and with regular exposure to community living options, regular participation in community activities, and regular engagement in community opportunities, Mr. Morrell gained an understanding of the community and chose to transition. Because of the advocacy of DRTx Mr. Morrell was provided information, support, and advocacy to decide where he would like to live. This is a clear example of the individualized and ongoing support necessary to help individuals with IDD make informed choices about living options. Of note, Mr. Morrell's LIDDA summary clearly indicated his status as a named plaintiff and that DADS requested frequent updates of Mr. Morrell's status.

Joe Morrell has enjoyed the full benefits of community living and expressed his pleasure with his new life in the community during my interview. It is sad to think of the many years he lost merely existing at the nursing facility, years that cannot be regained.

Attachment A

Steward v. Smith
5:10-CV-1025-OLG
In the United States District Court
for the Western District of Texas
San Antonio Division

REBUTTAL REPORT OF BARBARA PILARCIK CONSIDERED MATERIALS

Attachment A

	DOCUMENT	**BATES NUMBER**
1.	Expert Report, *Steward, et al. v. Smith et al.*, Prepared by Eleanor Shea-Delaney, Senior Consultant, Bailit Health Purchasing (March 30, 2018).	
2.	Expert Report of Kathy A. Bruni, MPA, LCSW (March 30, 2018).	
3.	Declaration of Karen Green McGowan, RN, CDDN, In Support of Plaintiffs' Motion for Preliminary Injunction and Class Certification, ECF Doc. 108-2 (July 3, 2012).	
4.	Dan Barry, *The Boys in the Bunkhouse: toil, abuse, and endurance in the Heartland*, N.Y. TIMES, (March 9, 2014), https://www.nytimes.com/interactive/2014/03/09/us/the-boys-in-the-bunkhouse.html	
5.	Expert Report, *Steward, et al. v. Smith, et al.* prepared by Barbara Pilarcik, (March 30, 2018).	
6.	NF and LIDDA records for Eric Steward	DefE-05807963-7971 PL0018430-8436, PL0018457-8476, PL0018569-8577, PL0018828-8832, PL0021767-1768, PL0011275-2844, PL0371560-1823, PL0461932-2015, PL0462016-2675, PL0021763-1766, PL0021748-1762, PL0018939-8950, PL0021872-1879
7.	NF and LIDDA records for Joe Morrell	DefE-05807972-7977 PL0109474-9478, PL0110837-0874, PL0110891-1236, PL0111367-1456, PL0111466-1485,

		PL0111517-1765, PL0112100-2101, PL0112104-2179, PL0112260-2265, PL0112327, PL0112355-2397, PL0112647-2666, PL0269169-9182, PL0369202-9261, PL0434922-5008, PL0110658-0689, PL0110877-0890, PL0111334-1353, PL0369183-9185, PL0369262-9292, PL0112077-2082, PL0112274-2282, PL0112724-2745, PL0369186, PL0481846-2285
8.	NF and LIDDA records for Johnny Kent	DefE-05807978-7991 PL0102649-2738, PL0102616-2647, PL0103334-3525, PL0102648, PL0105036-5041, PL0105881-5957, PL0105959, PL0106186-6324, PL0106327-6415, PL0106419-6647, PL0106690-6712, PL0106716-6930, PL0106977-7014, PL0107099-7105, PL0366402-6672, PL0431636-1731, PL0431823-1967, PL0367495-7499, PL0431732-1822, PL0478230-8497
9.	NF and LIDDA records for Leonard Barefield	DefE-05807992-7995 DEFP-000667064-7067 DEFP-000667203-7297,

		PL099764-9769, PL099831-9874, PL099929-9936, PL0099914-9922, PL099944-100380 PL0100387-0380, PL0100387-0400, PL0100403-0559, PL0100828-0905, PL0101059-1116, PL0101129-1143, PL0101263-1415, PL0101530-1722, PL0101846-1865, PL0101161-1164, PL0101188-1200, PL0101918-1929, PL0102061-2072
10.	NF and LIDDA records for Linda Arizpe	DefE-05807996-8006 DEFP-00040106-0121 DEFP-00040143-0144 StewardR-000230, StewardR-000248-0295, StewardR-002078-2140, StewardR-000296-0355, PL0473588-3753
11.	NF and LIDDA records for Maria Hernandez	DefE-05808007-8019 DefE-06350504-0509, DEFP-00041638-1639, DEFP-0042040, DEFP-00042077-2078, DEFP-00042810-2811 DEFP-00914396 DEFP-00914451 PL0363809-4364, PL0364369-4594,

		PL0430719-1323, PL0474480-6402
12.	NF and LIDDA records for Patricia Ferrer	DefE-05808022-8025 DefE-06351092-1096 DEFP-0070282-0292 DEFP-00070500, PL0473754-4479
13.	NF and LIDDA records for Richard Krause	DefE-05808026-8052 DefE-00108474-8483 DefE-00108544-8633, PL0478498-80369
14.	NF and LIDDA records for Tommy Johnson	DefE-05808053-8066 PL0464987-4270, PL0365710-6042, PL0431324-1635, PL0463961-3985, PL0476403-8229, PL0482286-2361
15.	NF and LIDDA records for Vanisone Thongphanh	DefE-05808067-8096 DEFP-00050911-0913 DEFP-00050931-0933 DEFP-00055556 DEFP-01854801-4802 DEFP-01854814-4815 DEFP-02993977 PL0112850-2900, PL0371990-2031, PL0372047-2211, PL0372224-2322, PL0372436-2601, PL0374066-4300, PL0462676-2703, PL0482838-2837
16.	NF and LIDDA records for Zak Morgan	DefE-05808097-8105 DefE-00110672 PL0113074-3335, PL0113586-3590, PL0114056-4209, PL0115266-5278, PL0115287-5335, PL0115356-5368,

		PL0115390-5395, PL0115425-5650
17.	NF, LIDDA, and medical records for Melvin Oatman	PL0107330-7905, PL0434845-4921, PL0480370-1845