IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA, Plaintiff, v. COMMONWEALTH OF PENNSYLVANIA; Robert Casey, Governor of the Commonwealth of Pennsylvania; Karen F. Snider, Secretary, Department of Public Welfare; Nancy Thaler, Deputy Secretary of Mental Retardation, Office of Mental Retardation; Alan M. Bellomo, Director, Ebensburg Center; Defendants.	Civil No. 92-33J Hon. D. Brooks Smith

UNITED STATES' PROPOSED DETAILED FINDINGS OF FACT

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UNITED STATES' PROPOSED DETAILED FINDINGS OF FACT

VOLUME I

I. PROCEDURAL HISTORY OF THE CASE

This action for injunctive relief was brought by the United States of America, plaintiff herein, by and through the Attorney General, against defendants, Commonwealth of Pennsylvania et al., pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997 et seq., on February 10, 1992. The Complaint alleges that defendants are violating the constitutional rights of the approximately 472 mentally retarded and developmentally disabled residents of the Ebensburg Center ("Ebensburg"), a residential, State-operated facility. On March 23, 1992, defendants filed a motion to dismiss. The Court denied the motion on May 6, 1992, summarily rejecting the defendants' argument that voluntarily committed Ebensburg residents are not entitled to constitutional protection. The Court further found that the United States had previously given the Commonwealth due notice of alleged unconstitutional conditions. The Court held a status conference on June 22, 1992 and approved the parties' proposed discovery plan, with some modifications, on that date. Between mid-August 1992 and mid-February 1993, experts for the United States spent more than 45 days touring Ebensburg. Each and every one of these tours was announced ahead of time to Ebensburg.[1]/ The parties filed their joint pre-trial stipulation on April 22, 1993. The Court held the pre-trial conference on July 20, 1993 setting a schedule for trial of this case, which began on July 26, 1993.

This case was tried over the course of twenty-one days between July 26 and August 4, 1993, September 13-17, 1993, October 12-19, 1993, and a final day of rebuttal testimony

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[1]/ See § XVI for a discussion of Ebensburg's preparation for announced survey tours.

on December 13, 1993. At the Court's request, interim summary oral argument of the evidence was presented by the parties on August 5, 1993. The Court sua sponte conducted an approximately three hour non-evidentiary tour of Ebensburg on August 2, 1993, accompanied by counsel for the parties and the facility director.

Twenty-eight witnesses presented testimony during the trial. The United States offered fourteen witnesses, consisting of ten expert witnesses, two parents, a former Ebensburg staff person, and a staff trainee. Eight of the United States' expert witnesses, along with the parents and lay witnesses, presented their testimony during the United States' case-in-chief presented during July and August 1993. The two remaining expert witnesses for the United States testified during rebuttal. The United States also offered into evidence the deposition testimony of an additional thirty-five witnesses as admissions of a party-opponent.

Following a six week recess in the trial, defendants presented their case-in-chief, beginning in September and continuing into October 1992. Defendants called nine witnesses during their case-in-chief: five independent experts, along with Ebensburg's consulting neurologist and physical therapist, the facility director, and the director of program services. They called an additional four witnesses during their rebuttal case: three expert witnesses[2]/ and a State medical assistance surveyor, and re-called one of their original expert witnesses as well as Ebensburg's director and the consulting neurologist.

During the course of the trial, over 4,100 pages of trial transcript were recorded and more than 550 exhibits were admitted into evidence, including over 5,000 pages of

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[2]/ One of the expert witnesses presented videotape testimony on December 16, 1993.

deposition testimony. Information about more than 450 of the approximately 472 Ebensburg residents is in evidence through exhibits and testimony.[3]/ The United States' experts specifically discussed more than 200 residents during their collective testimony. For an overview of the qualifications of the United States' experts and their methodology in evaluating conditions at Ebensburg, see Attachment C in the Appendix.

Because the Court indicated that this is a fact intensive case in which the ultimate issues will turn on the evidence, the United States has prepared comprehensive proposed findings of fact which synthesize the extensive evidence, including admissions by defendants in deposition testimony. Tr. 10/19/93 at 124-125. Attachment A in the Appendix sets forth the name of each deponent, along with a brief description of the deponent's position. Attachment B is a list of acronyms used throughout the United States' proposed findings of fact. Attachment D contains client summaries that illustrate systemic issues in the United States's proposed findings of fact. For ease of reference, the Appendix also includes copies of a few of the United States' exhibits which are discussed throughout the United States' proposed findings of facts.

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[3]/ More than 400 residents, alone, appear in United States' Exhibits 135 and 136, which are Ebensburg's computer print-outs of injuries and incidents since 1989.

II. GENERAL OVERVIEW OF MENTAL RETARDATION AND SERVICES FOR PEOPLE WITH MENTAL RETARDATION

Mental retardation is essentially a difficulty in learning, which affects an individual's ability to solve problems, engage in abstract reasoning, and apply knowledge to every day life. Tr. 7/26/93 (Stark) at 41. Mental retardation has been formally defined by the American Association on Mental Retardation ("AAMR") as:

> substantial limitations in present functioning. It is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skills areas: communication, self care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests before age 18.

Mental Retardation: Definition, Classification, and Systems of Support (AAMR, 1992); U.S. Exhs. 570(a) and 570 at 5. This definition was adopted by the Supreme Court in Heller v. Doe, ___ U.S. ___ (1993); 113 S.Ct. 2637, 2643 (1993). It emphasizes the effects of mental retardation and underscores the need for training to address these effects as opposed to focusing on the cognitive limitations of an intelligence quotient ("IQ") score. Tr. 7/26/93 (Stark) at 51. As such, a person's IQ is not as critical as how the individual learns to function within a given IQ. Id.

Each person with mental retardation is a unique individual and the manifestation of mental retardation in any given person is the product of four dimensions, which are the same factors that affect how any individual functions. Tr. 7/26/93 (Stark) at 47-48. The four dimensions that have an impact on mental retardation are: (1) intellectual functioning and adaptive skills; (2) psychological/emotional state; (3) physical and health status; and (4)

environmental conditions. Tr. 7/26/93 (Stark) at 48-49; U.S. Exh. 570 at 23; U.S. Exh. 571.

The field has moved away from a traditional definition of mental retardation where the existence and levels of mental retardation are measured solely by a person's intelligence quotient. Tr. 7/26/93 (Stark) at 49, 51.[1]/ Instead, the focus is on adaptive skills and how well people actually function in the day-to-day environment. Id. at 51. Teaching people with mental retardation appropriate adaptive skills in a variety of domains, including communication, self care, home living, social skills, community use, self direction, health and safety, functional academics, leisure, and work, thus becomes a basic goal in providing services. Tr. 7/26/93 (Stark) at 52-53; U.S. Exh. 574.

Mental retardation is also affected by a person's emotional or psychological well-being; a person can be mentally ill as well as mentally retarded. Tr. 7/26/93 (Stark) at 56. There is a difference between mental illness and mental retardation. Id. Mental retardation is a disability which affects an individual's intellectual development and social adaptation, whereas mental illness is a disorder of thinking, emotions and behavior. Mental retardation occurs usually either prior to, at, or shortly following birth whereas mental illness can occur at any time in life and often the onset is during adulthood. Mental retardation is on-going; mental illness can be episodic. Id.

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[1]/ Traditionally, mental retardation was measured and categorized by different levels according to IQ. In this conceptualization of IQ, mild mental retardation was an IQ of 55-70, moderate mental retardation was an IQ of 40-55, severe mental retardation was an IQ of 25-40, and profound mental retardation was an IQ of 25 or below. Tr. 7/26/93 (Stark) at 50; U.S. Exh. 572. Approximately 2.1% of the population at large fall into the mild mental retardation range, 0.1% into the moderate mental retardation range, and less than 0.1% into the severe and profound range. Tr. 7/26/93 (Stark) at 50-51; U.S. Exh. 573.

An individual can have physical disabilities in addition to mental retardation, such as a vision or hearing impairment, epilepsy, cerebral palsy, scoliosis, or dysphagia. Tr. 7/26/93 (Stark) at 58. It is important that people with significant physical disabilities that affect their nutritional and physical status have comprehensive, interdisciplinary nutritional and physical management plans that set forth the principles of an individual's care and treatment. Tr. 7/28/93 (McAllister) at 146-147; Tr. 7/29/93 (McGowan) at 157. A physical management plan specifies an individual's care throughout the day, including handling, touching, moving, transferring, positioning, facilitating active participation in one's environment, and fostering the development of skills to enable the person to function as independently as possible. Tr. 7/28/93 (McAllister) at 146, 162-163. A nutritional management plan is a program that ensures that an individual is adequately nourished, has good respiratory health, and is able to eat without distress. Tr. 7/28/93 (McGowan) at 117.

The environment in which people with mental retardation live affects how they function and is "critical to their overall development." Tr. 7/26/93 (Stark) at 59, 60, line 70. The environment must be stimulating, not barren or chaotic. Id. at 59. When individuals who are mentally retarded are congregated with a large number of other individuals who are also mentally retarded, it can be more difficult to teach them and therefore it is more difficult for them to learn. Id. at 59-60. The environment is one of the most important factors in alleviating or changing the effects of mental retardation, along with individualizing services and teaching adaptive skills. Id. at 65.

Estimates of the number of people who are mentally retarded in the United States range from 1.2 to 3% of the general population or 3 to 7.5 million people. U.S. Exh. 578.

There are hundreds of causes of mental retardation, including biomedical, social or environmental, behavioral, and educational. Tr. 7/26/93 (Stark) at 60-63; U.S. Exhs. 576 & 577. Often, there are multiple causes for the mental retardation. Id.

Although mental retardation is characterized by difficulty in learning, it is commonly accepted in the field that every individual who is mentally retarded has the capacity to learn, no matter how severely impaired. Tr. 7/26/93 (Stark) at 41-42; U.S. Exh. 593. Nancy Thaler, who is the Director of the State Office of Mental Retardation agrees that every individual with mental retardation has the capacity to learn and the potential for growth and development. U.S. Exh. 870 (Thaler Dep.) at 53. This is a basic concept, known as the developmental principle, which has been commonly and widely accepted in the field of mental retardation for at least the past twenty years. Id. An integral part of this concept is the fact that every individual with mental retardation has the potential for developing new skills. For example, as far back as 1970, when the President's Committee on Mental Retardation published its policy statement on residential services for individuals with mental retardation, the Committee recognized that "each individual has potential for some progress, no matter how severely impaired." Tr. 7/26/93 (Stark) at 42; U.S. Exh. 593 at 5. The President's Committee concluded that the goal of all residential facilities should therefore be "to develop physical, intellectual and social capabilities to the fullest extent possible." Id.

Individualization of services is a basic concept in the field of mental retardation that has been commonly accepted for the past twenty-five years. Tr. 7/26/93 (Stark) at 65. The importance of individualization has been widely recognized in federal legislation, such as the

Individualized Education Act, 20 U.S.C. § 1400, et seq., and the Vocational Rehabilitation Act, 29 U.S.C. § 709 et seq. Id.

"Normalization" is another central concept in services for individuals who are mentally retarded. This means providing services in a setting and in a manner similar to that provided for people who are not mentally retarded. Normalization of lifestyle is an important goal for individuals who live at Ebensburg. U.S. Exh. 630 (Seymour Dep.) at 38.

Mentally retarded people are not born with maladaptive or inappropriate behaviors. Tr. 7/26/93 (Stark) at 57. These behaviors are learned responses and can stem from the environment. Id. Maladaptive behaviors can also be a way to communicate needs, such as a desire for attention or protection or an expression of a basic desire, such as pain, hunger, or fear. Id.

Where there is a failure to provide adequate training programs to teach individuals with mental retardation adaptive skills to function in their environment, harm is inevitable. Tr. 7/26/93 (Stark) at 53-55; U.S. Exh. 575 (attached). Dr. Stark explains this "pattern of harm," as it manifests itself at Ebensburg, as follows: Where mentally retarded people spend day after day inactive in a non-stimulating environment where they are not learning adaptive skills, they get bored. Without meaningful activity, they may withdraw, engage in self-stimulation, or become frustrated and angry. This, in turn, can lead to escalating incidents of self-injurious behaviors, aggressive or assaultive behaviors, and a loss of skills or regression. The resulting harm includes bodily injury from dangerous behaviors, chemical restraints to control behaviors, and physical and mental deterioration, including an inability to care for oneself. Tr. 7/26/93 (Stark) at 53-55; U.S. Exh. 575 (attached). Societal

attitudes towards mental retardation have undergone a number of evolutionary stages as an enhanced understanding about mental retardation has come about. Tr. 7/26/93 (Stark) at 66-69; U.S. Exh. 580.

Societal attitudes have directly affected the way in which services have been provided to individuals with mental retardation. The concept of custodial care has been changed to one of teaching adaptive, functional skills and segregated services have been changed into integrated services. Tr. 7/26/93 (Stark) at 70-72; U.S. Exh. 581. The total number of people with mental retardation in institutions peaked in the 1970's and has dramatically decreased since then. Tr. 7/26/93 (Stark) at 72; U.S. Exh. 582. With a reduction in the institutional population, the average number of people in each mental retardation facility also declined. Tr. 7/26/93 (Stark) at 73; U.S. Exh. 583. The average number of people in each institution peaked in the 1960's with close to 1600 people and dropped dramatically down to 250 people in the 1990's. Id. As de-institutionalization occurred, there was a concomitant increase in the number of people with mental retardation living in community facilities. For example, in 1967, there were a total of 257 people in community-based residential facilities, which grew to 11,000 people in 1990. Tr. 7/26/93 (Stark) at 73-74; U.S. Exh. 584. In Pennsylvania, as of 1991, 50% of the people with mental retardation, or approximately 7,500 people, live in institutions. Tr. 7/26/93 (Stark) at 74; U.S. Exh. 585. Close to 4,000 people, or 26% of the people with mental retardation in the Commonwealth of Pennsylvania live in state operated institutions. Id. During the 1980's, Pennsylvania closed four state institutions. Tr. 7/26/93 (Stark) at 75; U.S. Exh. 586. The last institution, Pennhurst, closed in 1987. Id.

State institutions in Pennsylvania are operated by the Department of Public Welfare, through the Office of Mental Retardation (OMR), and the Bureau of Direct Program Operations within OMR. U.S. Exh. 11. One of the goals of the Department of Public Welfare is to "protect and serve Pennsylvania's most vulnerable citizens." U.S. Exh. 11.

III. OVERVIEW OF EBENSBURG CENTER

As of February 1993, there were approximately 472 people who lived at Ebensburg Center. Tr. 7/26/93 (Stark) at 77. All of the people who live at Ebensburg are adults. Id. at 79. Most have grown up at Ebensburg. Id. The number of people who live at Ebensburg has remained relatively constant over the past five years. Id. at 78. The average population at Ebensburg in 1989 was 489 and in 1992 it was 475. Id. Between 1990 and 1992, only thirteen people were placed from Ebensburg into the community: six people were placed from Ebensburg into the community in 1990; three in 1991; and four in 1992. Id. During this same time period, there were twelve admissions to the facility and seventeen deaths. Id.

The average daily per person cost of living at Ebensburg was $208.00 as of February 1993. Tr. 7/26/93 (Stark) at 75; U.S. Exh. 587. The per annum cost for each resident is $75,920.00 Id. Based upon a population of 472 residents, this means that the total per annum cost of providing services to the people who live at Ebensburg is $35,834,240.00. Id.

There are five buildings at Ebensburg in which people live: Keystone, Laurel, Sunset, Horizon, and Villa. Tr. 7/26/93 (Stark) at 80. Approximately 96 people live in each building in four different living areas. Id. at 81. There are approximately 24 people in each living area. Id. Keystone consists primarily of individuals with physical disabilities. Id. Laurel is comprised of all women and Sunset consists of all men. Id. Horizon has both male and female residents and two living areas for individuals with visual impairments. Id. Villa houses individuals who are higher functioning. Id. at 81-82. In June of 1992,

Harmony House, one of the residential buildings at Ebensburg, was closed and the individuals who lived there were transferred to the other living units. Id. at 83. The number of people living in Horizon, Sunset, and Keystone increased, however, as a result of the closure of Harmony. U.S. Exh. 608 (Devine Dep.) at 63-64. Mr. Bellomo admits that a negative effect of closing Harmony House was the increase in the number of people living in several of the units, "which does not allow us much space." U.S. Exh. 603 (Bellomo Dep.) at 121, line 7.

David Devine, has served as Director of Residential Unit Management ("DRUM") at Ebensburg since October 3, 1990. U.S. Exh. 608 (Devine Dep.) at 12-13. In this capacity, he is the Ebensburg administrator who is ultimately responsible for ensuring that the residents are receiving adequate residential services and care. U.S. Exh. 608 (Devine Dep.) at 22. He is also responsible for supervising the five Unit Managers who oversee each of the five residential buildings at Ebensburg. U.S. Exh. 608 (Devine Dep.) at 19, 22. These five Unit Managers and the buildings for which they are responsible are:

- Michael McGuire--Horizon House
- Richard Bonfanti--Keystone House
- Frank Seymour--Laurel House
- Wayne Weimer--Sunset House
- Deborah DeGretto--Villa House.

U.S. Exh. 608 (Devine Dep.) at 18; Dep. Exh. 5 (Ebensburg Table of Organization); U.S. Exh. 604 (Bonfanti Dep.) at 9; U.S. Exh. 630 (Seymour Dep.) at 10.

Goals of Ebensburg:

In keeping with the field's recognition that every individual with mental retardation has the capacity to learn and the potential for growth and development, Nancy Thaler readily

acknowledges that it is Ebensburg's responsibility to ensure that its residents reach their maximum potential. U.S. Exh. 870 (Thaler Dep.) at 53, 58. The recognized goal of Ebensburg is to teach skills to individuals in order to enable them to function as independently as possible. U.S. Exh. 11.[1]/ This goal is shared by administrators of the facility. For example, according to David Devine, the goal is to help individuals develop skills to enable them to "become as independent as they can be." U.S. Exh. 608 (Devine Dep.) at 55, lines 19-20. Another goal is to help individuals develop skills to be able to live in the community. U.S. Exh. (Devine Dep.) at 54-55. Mr. Seymour sees achieving "independence in the workplace" that will lead to placement at a community setting or at home as a goal for Laurel House clients. U.S. Exh. 630 (Seymour Dep.) at 37.

Ebensburg's mission statement also calls for a team-oriented interdisciplinary process to providing services to residents. U.S. Exh. 11 at 3. Each resident's team is supposed to be comprised of all individuals who provide services to the resident. Id. The function of the team is to "identify the individual's needs for development and well-being and to design and implement the services and interventions necessary to meet those needs." Id. Ebensburg's mission is to "provide services that meet the highest standards in the field." Id. at 4. Ebensburg defines this mission as "consistently measur[ing] its performance in every aspect of its service delivery against the 'leading edge' of standards and expectations in the field of developmental disabilities." Id.

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[1]/ Ebensburg characterizes this as follows: "The facility's goal for each person admitted is to assist that person in improving and building on the skills he or she already possesses, so that he or she may achieve maximum functioning and move on successfully to other, more normalized life experiences." U.S. Exh. 11 at 1.

The Bureau of Direct Program Operations within the Commonwealth's Office of Mental Retardation is responsible for setting the direction of State centers by establishing goals and priorities. U.S. Exh. 635 (Sneed Dep.) at 56. The current goals and objectives are to ensure a good quality of life for residents. U.S. Exh. 635 (Sneed Dep.) at 56. One of the key elements in ensuring a good quality of life for residents is to provide them an opportunity to choose things that affect their lives. U.S. Exh. 635 (Sneed Dep.) at 57. Other goals that the Bureau of Direct Program Operations has established at State centers, including Ebensburg, include providing people with meaningful work and using positive approaches. U.S. Exh. 635 (Sneed Dep.) at 59.

IV. EBENSBURG FAILS TO MEET ALL RESIDENTS' BASIC CARE NEEDS.

Both Dr. Russo and Dr. Stark found that the concept that drives Ebensburg is the accomplishment of custodial care routines as opposed to the needs of individual clients. Tr. 8/2/93 (Russo) at 35-36; Tr. 7/26/93 (Stark) at 223. Despite this fact, Ebensburg does not ensure that all people who live there receive adequate care at even the most basic levels. Dr. Stark had significant concerns about the primary care provided to residents as he reviewed occurrence reports and toured Ebensburg. Tr. 7/26/93 (Stark) at 220-222. For example, on two successive days in mid-February 1992, staff put Keystone residents down on the floor to sleep because their bedrooms were being painted. Tr. 7/26/93 (Stark) at 222; U.S. Exh. 87. After the first night, Karen S. was found "covered with ants." U.S. Exh. 87. Staff again put the residents down on the floor that evening, and the next day Janice G. was found with "massive amounts of ants crawling over entire body."[1]/ Tr. 7/26/93 (Stark) at 222; U.S. Exh. 87 at 00000917. It took these two incidents before staff decided to push the residents' beds into the dayroom while the painting took place. U.S. Exh. 87 at 00000918.

Similar types of incidents have continued to occur at Ebensburg. On July 8, 1993, several weeks before trial commenced in this case, a nurse found Theresa B. to have bloody drainage coming from her ear during medication administration time. U.S. Exh. 1022; Tr. 10/14/93 (Bellomo) at 75-76. When she was checked by the doctor, Theresa was found to have "seven small and one large maggot-like insects" in her ear which were flushed from her

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[1]/ Both Karen S. and Janice G. have significant physical disabilities. Karen S., who has scoliosis, is shown on Ms. McAllister's videotape (U.S. Exh. 261 being transferred to a sidelyer). Tr. 7/28/93 (McAllister) at 220. She is also shown in her sidelying board in U.S. Exh. 710. Tr. 7/28/93 (McAllister) at 172-173. United States' Exhibit 741 is a picture of Janice G. Tr. 7/28/93 (McAllister) at 186.

ear. Id. Five hours later, the bloody drainage continued and the next day the doctor checked her and flushed an additional "five large maggot-like insects" from her ear. Id. Theresa was sent to the emergency room where an additional four maggots were removed from her ear and she was detained overnight. Id. The Unit Manager noted that, in all, a total of seventeen maggot-like worms were removed from her ear and that this incident raised infection control issues. Id. During her tours of Ebensburg, Ms. McGowan had concerns about the persistent existence of flies in the dining rooms at Ebensburg which poses "genuine health hazards." Tr. 7/29/93 (McGowan) at 92. In October 1993, State surveyors continued to find flies on residents and residents' food during mealtimes at multiple locations and on multiple days. U.S. Exh. 1103 at 10.[2]/

During his tour of Ebensburg, Dr. Stark encountered a number of instances reflecting inadequate care at Ebensburg, even at the most basic custodial care level. Tr. 7/26/93 (Stark) at 85. He was "very concerned" as he toured Ebensburg in February 1993, on a day when four other experts involved in this litigation were touring, and found that residents were not even clean. Tr. 7/26/93 (Stark) at 220. A strong smell of body odor, urine, and dirty diapers permeated a number of areas. Id. State surveyors have cited Ebensburg for deficiencies in this area. For example, in November 1992, State Medical Assistance ("MA") surveyors found 12 Keystone residents in one living unit whose "attends [diapers] were heavily saturated with urine and one was soiled with feces. U.S. Exh. 60 at 00503763. The surveyors were concerned about the practice of keeping individuals in their wheelchairs

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[2]/ Marcia Stiles, who serves as the infection control coordinator at Ebensburg, does not schedule any routine inservicing of staff on any regular basis in infection control. U.S. Exh. 638A (Stiles Dep.) at 44.

between 8:00 a.m. and 1:00 p.m. before they were changed. They noted the potential for skin breakdown and found that one resident in this living unit had a "reddened sacral area approximately 3 1/2 by 4 1/2 inches." Id.

When Mr. Tackett worked the second shift in Keystone on April 4, 1992, he found the bathing process akin to an "assembly line." Tr. 8/3/93 (Tackett) at 27. He estimated that the entire process of placing more than twenty residents in the tub, washing them, dressing them, and placing them in bed only took somewhere in the vicinity of fifteen to twenty minutes, perhaps slightly longer, but at any rate the process took place "much too quickly." Id. at 28. Ebensburg nurses have had similar concerns about the bathing process as recently as 1993. In the February 26, 1993 meeting between the nursing union and Ebensburg management, nurses expressed concerns that "[i]ndividuals are not being properly bathed -- they are being hosed up one side and down the other -- this is not sufficient." U.S. Exh. 995. This same topic came up again at a May 5, 1993 meeting. Nurses stated that they knew individuals were not being properly bathed because of the odor, that "[i]ndividuals that have just been bathed should not smell," and that it was "really bad" at Ebensburg. U.S. Exh. 995. They further stated that:

> this has been reported through the chain of command and supposedly was looked into, but it is still continuing. Unit #4 can be smelled. Was brought to Marie's attention and Marie looked into. You know as soon as you go into a ward area that due to the smell of the stench that individuals have not been bathed.

Id. Dr. Stark also found as he toured Ebensburg that staff were not attending to residents' basic care needs. Tr. 7/26/93 (Stark) at 220. For example, he found Robert H. sitting by himself in a day program. Robert had regurgitated partially digested food and smeared it

into his nose and face and body. Even after Dr. Stark brought this to the attention of staff, it "took a while" for them to clean Robert up. Tr. 7/26/93 (Stark) at 220. Dr. Stark found another resident with dried blood on his ear. Five hours later, he saw the same resident on the floor and no one had yet cleaned up the blood. Tr. 7/26/93 (Stark) at 220. Dr. Stark also saw residents with dirty clothes. Mr. Bellomo admitted that "[t]here is no reason why someone should be ill groomed." U.S. Exh. 603 (Bellomo Dep.) at 125, lines 24-25. He expects "100 percent of the people 100 percent of the time" to notice residents' personal hygiene and grooming and correct any concerns. U.S. Exh. 603 (Bellomo Dep.) at 125, lines 23-24.

Ebensburg also does not adequately protect residents' privacy. Ebensburg has been repeatedly cited by State surveyors in every annual survey between 1989 up to and including the October 1993 survey for failing to meet the Title XIX standard of protecting clients' rights by ensuring privacy during treatment and care of personal needs. Def. Exh. J, 42 CFR § 483.420(a)(7). During the October 1990 MA survey, State surveyors observed a nude client and another client who was not wearing a blouse. U.S. Exh. 57 at 00004041. Ebensburg promised in its plan of correction to inservice staff. Id. During the October 1991 MA survey, State surveyors observed a completely nude client for ten minutes in the TV room with several clients present and the three staff who were present made no effort to redirect the individual. U.S. Exh. 58 at 1.[3]/ In its plan of correction to the Commonwealth, Ebensburg promised again to inservice staff on privacy issues and to require supervisors to

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[3]/ When a staff person finally intervened, it consisted of standing six feet away, making a small gesture towards the bedroom and saying softly "Go to your bedroom." This resident is deaf and did not have his glasses on. Without glasses his vision is 20/800. U.S. Exh. 58 at 00004069; Tr. 8/4/93 (Amado) at 54-55.

monitor these situations more closely. U.S. Exh. 58 at 1. About ten months later and two weeks before Dr. Amado's August 1992 tour of Ebensburg, Mr. Bellomo observed seven individuals in a Sunset House dayroom locked out of their bedrooms and the bathroom with no clothing on; most residents were only in their underwear and one was completely naked. Mr. Bellomo stated that his impression of this living area was that it was "out of control." U.S. Exh. 109. Several months later, State surveyors visited the same living unit, Sunset House, and found five residents wearing only Attends. U.S. Exh. 60 at 00603757. In its plan of correction, Ebensburg promised once again to inservice staff and "enforce" privacy issues. Id. Most recently, State surveyors again observed clients walking around undressed or in their underwear in clear view of staff, surveyors, and other clients during the MA survey that took place as this case was being tried. U.S. Exh. 1103 at 1-2. Dr. Amado testified that privacy issues should be a critical component of staff training and Ebensburg's promises to address this issue have either not been implemented or have not been adequate. Tr. 8/4/93 (Amado) at 56.

V. EBENSBURG DOES NOT PROTECT ITS RESIDENTS FROM HARM.

A. The Harm At Ebensburg Is Pervasive.

Each of the witnesses who testified on behalf of the United States during its case-in-chief, including experts, parents, a direct care staff worker, and a staff trainee, independently agree that Ebensburg is not protecting its residents from harm in very basic ways: Dr. Amado, Dr. Russo, and Dr. Stark all concluded that Ebensburg fails to protect residents who are being injured due to self-abusive and aggressive behaviors. Tr. 8/4/93 (Amado) at 76-77; Tr. 8/2/93 (Russo) at 75-79; Tr. 7/26/93 (Stark) at 105.[1]/ Ms. McAllister found that Ebensburg residents with physical disabilities are suffering injuries due to unsafe staff actions and wheelchairs that are in a state of disrepair. Tr. 7/28/93 (McAllister) at 214, 225-226; U.S. Exhs. 781, 791. Both Dr. Sulkes and Ms. McGowan found that Ebensburg staff were subjecting residents to serious harm by their feeding practices. Tr. 7/27/93 (Sulkes) at 103-107; Tr. 7/29/93 (McGowan) at 91, 96-97, 128-132. Ms. McGowan also determined that Ebensburg is failing to monitor and intervene in unsafe eating behaviors which have resulted in chokings requiring emergency procedures and hospitalizations. Tr. 7/29/93 (McGowan) at 144, 204; U.S. Exh. 273. Dr. Alvarez concluded that residents are suffering repeated, significant harm resulting from Ebensburg's failure to protect them from injuries due to seizures. Tr. 7/30/93 (Alvarez) at 78-94. Dr. Fahs concluded that Ebensburg residents taking psychotropic medications, which have serious side effects, are suffering harm because

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[1]/ In the program that Dr. Amado ran in Minnesota in a state-operated facility for people with mental retardation, there were far fewer injuries than the current rate at Ebensburg. Tr. 8/4/93 (Amado) at 88.

they are taking drugs that may not be indicated and may not be effective, while continuing to suffer injuries due to their behaviors which Ebensburg is not appropriately addressing. Tr. 8/3/93 (Fahs) at 65-69, 101, 119, 128, 130. Mrs. Weakland testified about repeated harm to her son, James W., who, within a three year period of living at Ebensburg, had three emergency hospitalizations for such severe injuries as a ruptured globe in his eye, a fractured jaw, and a ruptured spleen along with broken ribs. Tr. 7/26/93 (Weakland) at 190-196.[2]/ Ms. Dekowski recounted the repeated injuries suffered by her daughter, Denise V., who now has a permanently dented head from her head-banging, walks with a limp, and has scars from bites. Tr. 7/26/93 (Dekowski) at 172-175. Damien Tackett, an Ebensburg direct care worker, described staff failing to intervene in James E.'s self-injurious behaviors. Tr. 8/3/93 (Tackett) at 20-24. And Robin Hebenthal, a staff trainee, testified about nine incidents of staff abuse that she witnessed during the course of only one and a half days at Ebensburg. Tr. 8/3/93 (Hebenthal) at 199-214.

Based upon his observations at Ebensburg and subsequent review of documents, including thousands of individual occurrence reports over the past several years, Dr. Stark concluded that the individuals who live at Ebensburg are being subjected to unsafe and harmful conditions. Tr. 7/26/93 (Stark) at 84-86, 102. In Dr. Stark's opinion, "the frequency, type, and circumstances surrounding injuries demonstrated failure to protect individuals who live at Ebensburg from harm." Id. at 84-85. In fact, the injuries that people were suffering was the first thing that struck Dr. Stark as he toured Ebensburg in late

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[2]/ The transcript reflects that James' eye injury occurred in 1984, however according to Ebensburg records, this injury took place in 1989. U.S. Exh. 135 at 00040138; Tr. 7/26/93 (Weakland) at 191.

February 1993:

> In virtually every area I saw people with scars, distorted foreheads, ears, amputated fingers, lacerations, black eyes, contusions, open sores, scratches, and casts.

Id.[3]/ He further concluded that "individuals at Ebensburg are chronically and repeatedly being injured, and that these injuries are widespread and not limited to just a few individuals." Id. at 87, lines 14-17.

During the month of February 1993 alone, which is the month that Dr. Stark toured Ebensburg, the injuries that residents suffered included fractures, lacerations requiring sutures (including a lacerated scrotum which had to be sutured), human bites on the scalp, back, shoulder, leg, and wrist, contusions, abrasions, hematomas, bruises, cuts, a puncture wound, scratches, and people choking on food. Tr. 7/26/93 (Stark) at 87; U.S. Exh. 135; Tr. 10/15/93 (O'Brien) at 74-75.[4]/ In addition, residents had to be hospitalized during the month because they had ingested dangerous substances. Tr. 7/26/93 (Stark) at 87. In fact, on the first day of Dr. Stark's tour of Ebensburg, February 22, 1993, Dale J. was sent to the emergency room for coffee ground bright red emesis. Tr. 10/19/93 (O'Brien) at 76; U.S. Exh. 380. He had internal bleeding with a possible bowel obstruction from swallowing multiple objects, including a key, a zipper tab, and a coin or button, as well as other

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[3]/ United States' Exhibit 1041 lists 78 individuals with visible scars, amputations, or traumatized ears who lived at Ebensburg at the time of Dr. Stark's tour.

[4]/ United States' Exhibit 135 at 00599908-00599910 lists all of the incidents and injuries that Ebensburg recorded for the month of February 1993. Mr. O'Brien, who did not accompany Dr. Stark on his tour of Ebensburg, and, in fact, was not even present at Ebensburg for most of Dr. Stark's tour, testified incorrectly about the number of injuries that had occurred during the time frame of Dr. Stark's tour. Tr. 10/19/93 (O'Brien) at 62-64, 67. United States' Exhibit 1040 includes examples of incidents and injuries that occurred during and immediately preceding Dr. Stark's tour, some of which were never recorded by Ebensburg as an incident. Tr. 10/19/93 (O'Brien) at 67-68.

unidentifiable foreign bodies. Id. Earlier in the month of February, Winfield M. had trouble bending and was sent to the emergency room. U.S. Exh. 590 (attached). He was also found to have numerous metal objects in his stomach from ingesting these objects. Both of these Ebensburg residents had histories of swallowing dangerous objects. U.S. Exhs. 380, 590.

B. Residents Are Being Chronically And Repeatedly Injured And The Injuries Are Increasing.

The total number of incidents and injuries sustained by Ebensburg residents has increased over the past four years. Tr. 87/26/93 (Stark) at 88.[5]/ In fact, the overall number of incidents at Ebensburg in 1992 was higher than it has been since 1989. Id. There were 1,707 incidents involving Ebensburg residents between February 1991 and February 1992. Tr. 7/26/93 (Stark) at 96; U.S. Exh. 89 (attached). There were 2,433 incidents between February 1992 and February 1993. Id.[6]/ This represents a 43% increase in the number of incidents and injuries at Ebensburg in the twelve months after the United States filed its lawsuit in this case. The increase in the number of incidents and injuries continued even through the trial of this case. Between February and August 1992, there

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[5]/ The number of incidents and injuries are a count of the total number of occurrence reports written by Ebensburg staff and entered into Ebensburg's computer with a coding system. These computer sheets are entered into evidence as United States' Exhibits 135 & 136. The defendants provided the United States with computer discs with this same data. At Dr. Stark's direction, the United States retained the services of a litigation computer support firm, CACI, to count various categories of incidents. Tr. 7/26/93 (Stark) at 88-91. Where there are two people involved in an incident, Ebensburg does not fill out an occurrence report for both individuals unless the incident involves sexual behavior or the aggressor is also hurt. Tr. 10/19/93 (O'Brien) at 52-53; Tr. 8/4/93 (Amado) at 72-73.

[6]/ Ebensburg considered only a fraction of these incidents to be "non-injuries." See discussion infra § V.2.a.

were 1,193 incidents. Def. Exh. GG. One year later, between February and August 1993, there were 1,310 incidents. U.S. Exh. 1014. This is nearly a 10% increase.[7]/

More than three quarters of all incidents and injuries during 1992 were due to unknown causes or were behavior related. Tr. 7/26/93 at 103; U.S. Exh. 90 (attached). In Dr. Stark's professional opinion, injuries that are due to unknown causes and behavioral reasons are "easily preventable if the environment is structured properly." Tr. 7/26/93 (Stark) at 103-104. There was a dramatic increase in the number of injuries due to behaviors and unknown causes from 1991 to 1992. Id. at 105. In 1991, 625 incidents were caused by behaviors; in 1992, 904 were caused by behaviors. U.S. Exh. 91 (attached).[8]/ This represents an increase of 45%. Tr. 7/26/93 (Stark) at 105. In 1991, 646 incidents were due to unknown causes; in 1992, 982 incidents were due to unknown causes. U.S. Exh. 92 (attached). This represents a 52% increase in the number of incidents due to unknown causes. Tr. 7/26/93 at 105. As of February 25, 1993, when he was deposed, Mr. Bellomo was unaware that the number of unwitnessed injuries was increasing at Ebensburg. Instead, he mistakenly thought that as of the end of February 1993, the percentage of unwitnessed

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[7]/ There is also approximately a ten percent increase in the number of incidents that unequivocally involved a physical injury. U.S. Exh. 1014. In the column labeled "potential non-injuries," the following types of incidents are excluded based upon Ebensburg's assigned code for incidents contained in United States' Exhibit 73: Medical isolation (Code 12); Poisoning (Code 17); Property Damage/Loss (Code 18); Psychological Distress (Code 19); Skin reaction (Code 21); None (Code 25) and Unknown (Code 26). When the total number of each of these types of incidents is subtracted from the total number of incidents, there were at least 1,093 actual injuries between February 1992 and August 1992 and 1,190 actual injuries between February 1993 and August 1993.

[8]/ Behavior related occurrences include the following types of incidents, based upon Ebensburg's coding system as set forth in United States' Exhibit 73: assaults, fights (04) (05); "individual to individual interaction" (09); "individual to staff interaction" (10); ingestion of foreign matter (11); self-injurious act (14); and unacceptable absence (15). U.S. Exh. 90.

injuries had "continually decreased." U.S. Exh. 601 (Bellomo Dep.) at 128, line 7. Nonetheless, as of that time, he agreed that the number of unwitnessed injuries was still at "an unacceptable level." U.S. Exh. 601 (Bellomo Dep.) at 128, line 8.

The number of people being injured at Ebensburg is widespread and is increasing: In 1991, 77% of all of the individuals who live at Ebensburg had an incident; in 1992, 86%, or 409 of the 476 residents, had at least one incident. Tr. 7/26/93 (Stark) at 98-99. Thirty per cent of Ebensburg residents have had repeated, chronic injuries. Id. at 99. One hundred and thirty-one people who live at Ebensburg had an average of at least one incident every other month during the fifty month period between January 1989 and February 1993. Id.; U.S. Exh. 777 (attached). The number of incidents and injuries that each one of these 131 individuals suffered during this fifty month period ranged from at least 25 to 215. Id. Dr. Amado has also found that there are repeated injuries to a variety of people, as well as repeated injuries to the same person. Tr. 8/4/93 (Amado) at 76. Dr. Stark concluded that the harm that Ebensburg residents are suffering has been a long-term harm: "as you look at these individuals and talk to them, you can see that there is a lot of withdrawal, a lot of anger, a lot of scarring -- both physical and emotional, mental scarring." Tr. 7/26/93 (Stark) at 149, lines 11-13.

Two parents of Ebensburg residents testified at trial about the long-term harm that their children have suffered at Ebensburg. Denise V.'s mother, Marian Dekowski, who is a licensed practical nurse, chronicled the injuries that her daughter has sustained under Ebensburg's care. Tr. 7/26/93 (Dekowski) at 171. Ms. Dekowski placed Denise at Ebensburg when Denise was five years old and Denise has lived at Ebensburg for the past 31

years, except for a very short stay at Somerset State Hospital. Tr. 7/26/93 (Dekowski) at 172. When Ms. Dekowski brought Denise to Ebensburg at age five, Denise was a happy, healthy, active child who had no scars or marks on her body and could walk freely and run. Tr. 7/26/93 (Dekowski) at 172. Denise had not suffered any head injuries before she was institutionalized at Ebensburg. Tr. 7/26/93 (Dekowski) at 172.

Denise now has several scars and marks on her body and "her head has an indented look on the skull." Tr. 7/26/93 (Dekowski) at 173, line 12. Denise's head is indented because she bangs it on walls and furniture. Tr. 7/26/93 (Dekowski) at 173; U.S. Exh. 493(aa) (1992 and 1993 incident reports documenting instances where Denise has banged her head on walls). Denise now walks with a limp. Tr. 7/26/93 (Dekowski) at 174. Ebensburg has never informed Ms. Dekowski that Denise suffered a leg injury. Tr. 7/26/93 (Dekowski) at 174. Ms. Dekowski believes Denise limps due to head injuries. Tr. 7/26/93 (Dekowski) at 174; U.S. Exh. 493(cc) (form filled out by Ms. Dekowski for Ebensburg, documenting that Ms. Dekowski was disturbed by the injuries Denise has suffered). While visiting Denise, Ms. Dekowski has seen "many, many bite marks on her arms, and she has marks on her face, scars." Tr. 7/26/93 (Dekowski) at 175. During one of Ms. Dekowski's visits, Denise had a black eye and her shoulders were covered with claw marks. Tr. 7/26/93 (Dekowski) at 175; U.S. Exh. 493(bb) (incident reports documenting instances that Denise V. has suffered facial injuries during 1992 and 1993). Two days before Ms. Dekowski testified, Denise was found with multiple bruises on her upper thighs and an abrasion on her right knee. U.S. Exh. 958 (7/24/93 Inc. Rep.). Staff do not know "how, when, or where" Denise injured herself but note that she frequently throws herself to the ground and pounds

her legs. Id. Several days after Ms. Dekowski testified, Denise was again found with a bruise on her leg. U.S. Exh. 958 (7/29/93 Inc. Rep.). This time staff note the injury was discovered immediately after Denise was self-abusive.

James W.'s mother, Ms. Weakland, also testified about the significant harm that her son has suffered while under Ebensburg's care. James was first institutionalized at Cresson Center, where he did not suffer any serious injuries. In the early eighties, when the Cresson Center closed, James was transferred to Ebensburg, and he has resided at Ebensburg since that time. Tr. 7/26/93 (Weakland) at 186. At the time he entered Ebensburg, James still possessed all of his self care skills, could talk, see, and was active and healthy. Tr. 7/26/93 (Weakland) at 189. For the period January 1989 until February 1993, James suffered 57 injuries at Ebensburg. U.S. Exh. 777. James suffered three very serious injuries in that time period. In 1989, one of James' eyes was knocked out when he fell against a chair. Tr. 7/26/93 (Weakland) at 190-193.[9]/ Ebensburg records indicate that the enucleation was not the result of an accident. U.S. Exh. 135. On November 20, 1991, at 10:15 a.m., James' jaw was fractured during a fight with Alan G., another blind Ebensburg resident, at the JFK Learning Center at Ebensburg. Tr. 7/26/93 (Weakland) at 194; U.S. Exh. 501(aa). Before staff could intervene to break up the fight, a table was upset, chairs were thrown, a bench seat was three feet from the wall, and lockers were moved. U.S. Exh. 501(aa). Although Alan was bleeding from his forehead and hands, U.S. Exh. 501(aa), no incident report was filled out for Alan's injuries. U.S. Exh. 135. Despite the fact that James had a bloody

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[9]/ The transcript reflects that James' eye injury occurred in 1984, however according to Ebensburg records, this injury took place in 1989. U.S. Exh. 135 at 00040138; Tr. 7/26/93 (Weakland) at 191.

mouth, staff did not report his injury to the nurse until 5:30 that evening when he complained of mouth pain and refused supper. U.S. Exh. 501(aa) at 00210934. Although he was seen at dental clinic the following day, an Ebensburg physician did not examine him until two days later, at which time he was found to have a fractured jaw. U.S. Exh. 501(bb). James required surgery for the fracture, and his jaw was wired shut. James could only drink through a straw while his jaw was wired shut. Tr. 7/26/93 (Weakland) at 195; U.S. Exh. 501(bb) (excerpts from James' medical record concerning the jaw fracture). Following surgery, the discharge report from Mercy Hospital specifically recommended that James "is to be isolated from other combative residents at Ebensburg." U.S. Exh. 501(cc) at 338273.

On September 26, 1992, at 8:30 a.m. on Horizon House's East II living area, two staff were in the dining room, one staff was in the bathroom helping with shaving, and one staff was in the dayroom. The staff person in the dayroom heard yelling from a bedroom and when he went back to investigate, he saw Keith B. hitting and kicking James. On the incident report describing the event, James' psychology services associate ("PSA") noted that James has had altercations with Keith B. in the past. U.S. Exh. 501(dd).

About one and a half hours after the fight, when James complained of pain, staff lifted James shirt and noticed bruising on James' rib cage. Only then was a nurse called. U.S. Exh. 501(dd). Even though the nurse documented that he had bruising on his rib cage and there was a "clicking" sound when his ribs were touched, all she did was to give him Tylenol. Id. James was finally sent to the hospital at 12:30 p.m. (four hours after the original injury) and found to have a ruptured spleen, pneumothorax, and two liters of blood

in his abdominal cavity. He had to have emergency surgery to remove his spleen. Tr. 7/26/93 (Weakland) at 196; U.S. Exhs. 501(dd)(ee)(ff); U.S. Exh. 623(aa) (excerpt from deposition of James' Unit Manager describing the event). Ebensburg's Director of Nursing admits that the seriousness of James' condition necessitated more immediate medical attention than waiting an hour and a half to transport him to the hospital after a nurse saw him. U.S. Exh. 638 (Sponsky Dep.) at 116. James developed pneumonia following the September 1992 injuries. Tr. 7/26/93 (Weakland) at 199-200; U.S. Exh. 501(gg) (excerpts from James' medical record describing the pneumonia); U.S. Exh. 501(hh) (Mercy Hospital discharge report concerning the hospitalization for pneumonia). About four weeks before trial, Mrs. Weakland saw a big cut on the lower part of James' knee and now there is a scar. Tr. 7/26/93 (Weakland) at 200. On the day that Mrs. Weakland testified about Ebensburg's failure to protect James from harm, he suffered two additional injuries. U.S. Exh. 501. Staff found James that morning with a swollen and painful knuckle that was slightly discolored. Staff do not know how it happened but James stated that he punched the wall. Id. Later that day, James was pushed from behind by another resident and hit his head on the door frame, cutting his forehead.

This clear pattern of repeated harm was also evident to Dr. Stark as he reviewed occurrence reports. He found that in occurrence report after occurrence report, there are:

> instances where people are hitting, punching, pushing, biting, and scratching individuals. Aggression breeds aggression. People are both victimized and they're victimizers.[10]/ It's

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[10]/ See, e.g., United States' Exhibit 778 (attached) which summarizes fifteen injuries that Andrew H. caused and suffered from aggressive acts. Andrew has been head butted, bitten, and pushed by other residents, sustaining lacerations requiring sutures on a number of occasions. He, in turn, has bitten other residents multiple times. Id.

> almost as if there's a climate of aggression at this facility and it's disturbing to see that it continues to be sort of a way of life there. It's like it's an accepted thing or it's like this is what mental retardation is supposed to be like, and it's not.

Tr. 7/26/93 (Stark) at 125, lines 4-11. This "climate of aggression" is represented in United States' Exhibit 589 (attached), which presents a microcosm of some of the types of aggressive acts: Albert B. pushed into a table; Raymond K. kicked in the face; Thomas H. bitten on the ear. As Dr. Stark reviewed the occurrence reports, he was particularly struck by the vast number of human bites that are occurring. Tr. 7/26/93 (Stark) at 126, 127. Bites are "very serious injuries." Id. at 125. They are painful, they can take a long time to heal, and they carry a high risk of infection. Id. There were at least 46 occasions on which individuals at Ebensburg suffered bites during the first 17 weeks of 1993. Tr. 7/26/93 (Stark) at 126; U.S. Exh. 267.[11]/ Residents were bitten on their arms, shoulder, back, wrist, hand, ear, breast, calf, shin, thigh, leg, toe, head, face, and neck. U.S. Exh. 167. All of these incidents, with the exception of one where an individual was found with a bite in his left ear which took ten sutures to close, were categorized by Ebensburg as "minor" incidents.[12]/ Between January 15, 1991 and December 23, 1992, there were at least 240 occasions on which individuals were bitten. U.S. Exh. 267(b). Only three of these hundreds of occurrences of biting were rated by Ebensburg as more than a "minor"

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[11]/ This number does not include self-inflicted bites. It only includes bites inflicted by other residents.

[12]/ Ebensburg has a system of rating incidents either as "01" (minor) or "02" (serious). Tr. 10/15/93 (O'Brien) at 82.

incident.[13]/ At least 60 of these biting incidents involved Hepatitis B carriers. U.S. Exh. 267(b).

Some Ebensburg residents have been bitten repeatedly. For example:

- Mary Ann R. was bitten thirteen times between July 1992 and April 1993 on her back, forehead, shoulder, arm, elbow, wrist, and finger. U.S. Exh. 644 (attached). In August 1992, she was bitten five times. Id. During February 1993, she was bitten four times. Id. On several occasions, she received multiple bites. For example, on August 27, 1992, she was bitten on her arm, elbow, and back. Id. On February 14, 1993, she was bitten several times by another resident and had multiple areas on her shoulders that were reddened with teeth prints and the skin was broken. Id.

- Larry D. has also been a frequent victim of bites. Tr. 7/26/93 (Stark) at 128. Larry was bitten on at least ten occasions between the end of February 1992 and early December 1992. U.S. Exh. 646 (attached). Most frequently, he is found with multiple bites on his shoulder, chest, hands, wrist, arms, fingers, and face. Id. On one day alone in March 1992, he was found with seven bites on his arm and shoulder. Id. On September 21, 1992, he was found with "five fresh bites" on his arms and finger. Id. The very next day he was again found with four bites on both arms and a finger. Id. Several times, staff were unaware that Larry was being bitten until they heard him screaming. Tr. 7/26/93 (Stark) at 128.

- Michael B. was bitten six times in a three month period during late 1992. U.S. Exh. 645 (attached). Four of the times, he was bitten by James B. (#1102), despite repeated instructions to staff on occurrence reports to keep Michael B. away from James B. U.S. Exh. 267(c). Frequently, the same resident is the biter. Tr. 7/26/93 (Stark) at 129. Ebensburg fails to take adequate action to address the behavior of the biter and to protect the victim. Tr. 7/26/93 (Stark) at 127-129. See also § VII.E.3.

United States' Exhibit 926 (attached) updates the chart of bites presented during Dr. Stark's testimony and demonstrates that bites continue to be a frequent injury at Ebensburg. There were at least 39 bites between May 1, 1993 and August 23, 1993. They include individuals who were bitten on the forearm, back, hand, thigh, leg, shoulder, finger, calf,

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[13]/ The three incidents rated as something more than minor were: Albert K. whose foot had to be sutured because of a deep bite wound on his foot on 7/14/92, James P. who suffered a bite on his scrotum that had to be sutured on 3/12/92, and Debra S. who had part of her nose bitten off on 1/28/91.

abdomen, lip, and toe, resulting in bleeding, broken skin, abrasions, and black and blue marks.

C. Ebensburg Underreports And Minimizes Injuries.

The Commonwealth of Pennsylvania has not disputed any of the figures put into evidence by the United States regarding the overall number of incidents at Ebensburg.[14]/ In fact, if anything, the defendants agree that the number of incidents is actually higher because there is underreporting in Ebensburg's system for recording incidents. Tr. 10/19/93 (O'Brien) at 56; U.S. Exh. 986. The defendants' attempts to dismiss the dramatic increase in the number of occurrences as an artifact of a change in Ebensburg's reporting system were subsequently abandoned when Mr. O'Brien testified that there had been no change in the reporting system. Tr. 10/19/93 (O'Brien) at 16. Instead, defendants have attempted to trivialize the occurrences and claim that not every occurrence involved an injury.[15]/

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[14]/ Due to the inclusion of self-inflicted bites, Mr. O'Brien testified that there was a higher number of bites at Ebensburg than what is reflected in United States' Exhibit 267 (a) and (b), which only include bites of others (318 bites as opposed to 286). Tr. 10/15/93 (O'Brien) at 131-132. Even with the higher number, both Mr. O'Brien and Mr. Bellomo admitted that this number does not include all bites that occurred at Ebensburg. Tr. 10/14/93 (Bellomo) at 90; Tr. 10/19/93 (O'Brien) at 12. There are six bites, alone, during March and April 1993 that are recorded in United States' Exhibit 267 which do not appear in Ebensburg's computer print-out. U.S. Exh. 126. For example, Ebensburg's calculation of the number of bites does not include the bite to Thomas H.'s ear on 4/15/93 that required 10 sutures because it was incorrectly coded on Ebensburg's computer print-out. Id. Mr. O'Brien testified that he used the computer print-out to calculate the number of bites. Tr. 10/19/93 (O'Brien) at 8. Some bites do not even appear at all on Ebensburg's computer print-out which is supposed to reflect all incidents that occur at the facility. For example, Albert K. was bitten twice on July 17, 1992, once on his foot and once on his buttocks, but neither of these bites appear anywhere on Ebensburg's computer print-out. U.S. Exhs. 136, 267.

[15]/ The defendants also attempted to compare the incident rate at Ebensburg with a study published in Superintendent's Digest about incident rates. Tr. 10/13/93 (Bellomo) at 162. The study was commissioned by the National Association of Superintendents of Public Facilities and the author does not claim that the data that he presents is statistically valid to any scientific certainty. Tr. 10/13/93 (Bellomo) at 162; Tr. 10/13/93 (Bellomo) at 79. In fact, the author labels his article an "exploratory

(continued...)

1. Ebensburg Underreports Its Incidents And Injuries.

Dr. Stark, Dr. Russo, and Dr. Amado all found that Ebensburg staff fail to write out an occurrence report each time an incident warrants such a report. Tr. 7/27/93 (Stark) at 19, 34; Tr. 8/2/93 (Russo) at 72-73; Tr. 8/4/93 (Amado) at 73, 76. As such, the actual number of incidents and injuries occurring at Ebensburg is even higher than the figures presented in Ebensburg's computer generated reports and the United States' summaries of those reports. U.S. Exhs. 89, 90, 91, 92, 135, 136, 177. Mr. O'Brien admitted that there are injuries for which Ebensburg staff have not completed an occurrence report. Tr. 10/15/93 (O'Brien) at 56. Mr. O'Brien admitted that United States' Exhibit 986 identifies 18 injuries that he agrees should have resulted in incident reports. Tr. 10/19/93 (O'Brien) at 56.[16]/ None of these incidents, however, appear on Ebensburg's computer print-outs (U.S. Exhs. 135, 136) which is what Ebensburg relies on to compute its incident and injury statistics. Tr. 10/19/93 (O'Brien) at 8. During Dr. Amado's review of Ebensburg records, he found a number of injuries documented in progress notes that did not result in incident reports. Tr. 8/4/93

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[15]/(...continued)
study" and cautions about the use of his data in drawing any conclusions. Tr. 10/14/93 (Bellomo) at 79. This is because there was a "wide variance" in the injury reporting systems at the facilities where he collected his information. Tr. 10/14/93 (Bellomo) at 78. The author therefore stresses that one should only apply the injury rates in his article when making judgments concerning the accident/injury rate in a particular facility "VERY CAREFULLY!" (capital letters and exclamation point appear in the article). Tr. 10/14/93 (Bellomo) at 79; An Exploratory Study of Accidents and Injuries Among Residents in Public Residential Facilities at 7. Moreover, the study presents 15 different tables for analyzing injury trends and Mr. Bellomo admits that the statistics "can be manipulated in a variety of different ways." Tr. 10/14/93 (Bellomo) at 80, 81. Mr. Bellomo also admitted, in the final analysis, that there actually "is no comparative data that's out there that has reliability and validity built into it that I felt that could be used." Tr. 10/14/93 (Bellomo) at 81.

[16]/ For example, United States' Exhibit 986 includes John C.'s January 27, 1992 incident where he picked at his forehead and eroded his head wound so deeply that direct pressure for 20 minutes was ineffective to control bleeding. No incident report was written and it is not recorded in Ebensburg's computer print-outs in evidence as United States' Exhibits 135 and 136.

(Amado) at 73. Dr. Amado testified about 20 instances in which residents at Ebensburg sustained significant injuries, yet no injury report was filled out.[17]/ In Dr. Amado's opinion, there is significant underreporting on Ebensburg incident forms concerning injuries to Ebensburg residents. Tr. 8/4/93 (Amado) at 76. Dr. Russo also found that there are no incident reports for several 1992 and 1993 pica incidents involving Winfield M., including vomiting rubber bands, clothing labels, cigarette butts, eating shirt buttons and papers off the floor, and limping, resulting in a pelvic x-ray showing zipper and numerous screws in his abdomen. Tr. 8/2/93 (Russo) at 72-73.

2. Ebensburg Minimizes The Seriousness Of Injuries.

a. Ebensburg Sometimes Does Not Count Significant Incidents As Injuries.

Although defendants repeatedly attempted to claim that many of the incidents for which an occurrence report is written do not involve injuries, Ebensburg has rated only a fraction of them as "no injuries." In 1991, Ebensburg rated 71 of its 1,707 incidents as no injuries (4%) and in 1992, Ebensburg rated 158 of its 2,433 incidents as no injuries (6%). Tr. 7/27/93 (Stark) at 20. A sample of individuals with the highest number of incidents during the 50 month period between January 1989 and February 1993 reveals that even Ebensburg considers only a negligible number to actually be non-injuries. U.S. Exh. 777.

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[17]/ Recent incidents for which there are no occurrence reports include three episodes of self-injurious behavior for James E., all involving picking areas of his face and head open; an incident wherein James W. was bitten three times, all three bites breaking the skin; an incident of self-injurious behavior for Brock E. (mistranscribed in the trial transcript as Brett E.); nine separate instances of self-injurious behavior in January 1992 by John C.; two injuries caused by Eugene B.'s self-injurious behavior; Sandra W. being bitten; two episodes of pica behavior for Winfield M.; and a pica incident where a two inch wooden peg was found in Ronnie B.'s bowel movement. Tr. 8/4/93 (Amado) at 73-76.

In some instances, such as with Raymond H.'s 74 incidents during this time period, Ebensburg considered each one to be an injury. Id. In the case of James S.' 215 incidents during this time period, Ebensburg only considered five of them to not be an injury. Id.[18]/ Even those incidents where Ebensburg claims no injury occurred are significant because, as pointed out by Dr. Stark "something happened" because an occurrence report was written. Tr. 7/27/93 (Stark) at 33.[19]/ A number of the occurrences that Ebensburg does not count as an injury in fact involve significant incidents. Many involve pica, chokings, sexual incidents, missing people, and even some incidents where an individual actually sustains a visible injury. U.S. Exh. 990, 990(a). For instance, in March 1992, Thomas C. fell going from the bathroom to the play area. Staff note that his color is pale and he seems dazed. Id. On the back of his incident report, staff further note that he has "ecchymosed areas outer aspect of left eye." Id. This incident was rated as a non-injury by Ebensburg.[20]/ In April 1992, a physician removed a pill bottle from Ivy W.s throat, and Ebensburg also rated this incident as "no injury." U.S. Exh. 590(a). Other examples of significant incidents that Ebensburg does not count as an injury include two Darlene F. pica incidents in April 1992

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[18]/ Even categorizing these five incidents as non-injuries is questionable. They involve: a choking from eating too quickly; two elopements, including one where James was found standing on Route 22; and an incident where James fell, was crying, and said his face hurt. Tr. 10/19/93 (O'Brien) at 36; U.S. Exh. 777.

[19]/ The range of circumstances for which an occurrence report is written include: abrasions, bite injuries, bleeding, bruises, contusions, burns, scalding, concussions, death, dislocations, edema, fractures, medical isolation, lacerations (with and without sutures), oral injuries, pain, poisoning, property damage, psychological distress, scratches, skin reactions, strains, sprains, unspecified internal injuries, other, none, and unknown. U.S. Exh. 73.

[20]/ This incident was rated with Ebensburg's category code "25" (no injury) and "26" (unknown effect).

where she ate numerous cigarettes; Brian B.'s pica in October 1992 with a paper dixie cup; Ron A.'s February 1993 choking involving the Heimlich; Mary D. being left behind in her day program and found "sobbing" in January 1993; and Calvin H.'s drinking Mennan skin bracer in May 1992. U.S. Exh. 990. Dr. Stark "strongly disagrees" with most of Ebensburg's characterizations of incidents that it does not consider to involve an "injury." Tr. 7/27/93 (Stark) at 19, 35. He found "numerous examples" of situations where he considered residents to be injured but Ebensburg recorded them as "no injury." These include a resident who inserted his penis into the anus of another resident, a resident who was pushed into a door and kicked in the knee, a resident who was choked by another resident, a resident who was punched in the jaw, and a resident who banged her head against the window with sufficient force to break it. Tr. 7/27/93 (Stark) at 70-71.[21]/ United States' Exhibit 105 includes an incident report concerning a severe behavior episode involving Franklin B. Franklin became uncontrollable at his day programming site, and banged his head so hard against a loading dock door that he broke the door. Ebensburg rates this incident as resulting in no injury to Franklin. Tr. 8/2/93 (Russo) at 16-18. Based upon his review of occurrence reports, Dr. Amado agrees that only "a very small, small part" of the total number of reports contain an incident where there was actually no injury. Tr. 8/4/93 (Amado) at 85, lines 16-17.

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[21]/ Moreover, Ebensburg rarely reports injuries where pain, as opposed to a visible injury, is the consequence. Tr. 7/27/93 (Stark) at 38.

b. Ebensburg Considers Some Significant Injuries To Be "Minor."

Ebensburg has a system of categorizing incidents which distinguishes between those it considers to be minor and those which it considers to be more serious. Tr. 10/15/93 (O'Brien) at 82. Ebensburg rates those incidents that fall into the minor category as "01." Id., U.S. Exh. 73. Ebensburg rates those incidents that are more serious (i.e., those that require medical intervention) as "02." Id. Instances of death, abuse, and communicable disease are rated as "03." Id. Dr. Stark disagrees with many of Ebensburg's characterizations of incidents it considers to be "minor." Tr. 7/27/93 (Stark) at 32, 34, 45. For example, Ebensburg categorizes the vast majority of bites as minor injuries, even where the skin is broken, the wound site is bleeding, and a Hepatitis B carrier is involved. Tr. 7/27/93 (Stark) at 32; Tr. 10/19/93 (O'Brien) at 29-30; U.S. Exhs. 135, 267, 267(b).[22]/ Moreover, Ebensburg does not categorize all incidents that require medical attention as a serious incident, even though, by its own definition, they are serious events. Tr. 10/19/93 (O'Brien) at 29, lines 5-6. Mr. O'Brien specifically testified that if a mealtime choking necessitated medical intervention, it should be categorized as a serious incident. Tr. 10/19/93 (O'Brien) at 28-29. All of the chokings that occurred at Ebensburg between 1991 and 1993, however, were rated as minor incidents by Ebensburg, even if they required the Heimlich maneuver and even if the resident was transported to the hospital following the choking incident. U.S. Exhs. 135, 136, 273, 988 (emergency hospitalization for choking

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[22]/ Despite the fact that Hepatitis B is a communicable disease and Ms. Sponsky, Ebensburg's Director of Nurses, believes that these bite injuries are health concerns (U.S. Exh. 636 (Sponsky Dep.) at 51), Ebensburg rates these bites as an "01," not an "03." There were at least 60 bites involving Hepatitis B carriers at Ebensburg during 1991 and 1992. U.S. Exh. 267(b).

episode this summer which was rated as a minor incident). If a nurse or doctor has to remove an object that is lodged in someone's throat, Mr. O'Brien would expect that to be rated as an "02" incident because there was medical intervention. Tr. 10/19/93 (O'Brien) at 29. It would surprise him if this was not the case. Tr. 10/19/93 (O'Brien) at 29. In fact, Ebensburg not only rated each of the pica incidents where an object was lodged in a resident's throat as a minor event, it also considered them to be "non-injuries." (See discussion supra § V.C.2.a.). Tr. 10/19/93 (O'Brien) at 50; U.S. Exh. 990, 990(a).

United States' Exhibits 317, 1026, and 1039 represent occurrence reports completed by Ebensburg that were rated by Ebensburg as minor incidents but, in fact, necessitated hospitalization and therefore represent serious injuries by Ebensburg's own definition. Tr. 10/19/93 (O'Brien) at 24. In United States' Exhibit 317, John C. was bleeding from his nose so severely that he had to be sent to the emergency room with two IV lines; the doctor thought he might be in shock, and John was kept in the hospital in full restraints for a number of days to insure that he did not remove the packing from his nose. Ebensburg rated this incident as a minor event. Tr. 10/19/93 (O'Brien) at 25-26. In September 1992, Albert K. was pushed over in his wheelchair and was unconscious for 8-10 minutes and was transported to the hospital by ambulance. U.S. Exh. 1039. Ebensburg rated this incident as minor, although Mr. O'Brien agrees that it was serious. Tr. 10/19/93 (O'Brien) at 27. United States' Exhibit 1026 describes an incident involving Chris D, who was pushed into a wheelchair, fell forward hitting his chest, was lacerated, pale, had sinus bradycardia in June

1993, was transported to the emergency room. Ebensburg also rated this incident as minor, not serious. Tr. 10/19/93 (O'Brien) at 26.[23]/

c. Ebensburg Staff Dismiss Injuries As "Routine Risks."

The same attitude of minimizing injuries is reflected in the attitude of Ebensburg staff. It was obvious to Dr. Stark from the sequence of events described in occurrence reports, comments made on occurrence reports, and his observations during his tour that Ebensburg staff almost take it as "a given" that injuries are inevitable. Tr. 7/26/93 (Stark) at 120-121, 148-149. During his tour, Dr. Stark observed residents engaging in potentially dangerous behaviors and when he asked staff why they were not intervening, the response invariably was that this was just the way residents were, or, if we intervene, it will upset the residents so "we just sort of let them go." Id. at 121-122. This phenomena was confirmed in his review of occurrence reports. For example:

On February 29, 1992, staff found a bite on Larry D.'s shoulder and a 4" abrasion near the bite. Staff reviewing the incident concluded that it is a "normal risk for every day living." Tr. 7/26/93 (Stark) at 148; U.S. Exh. 647 at 00316413. Dr. Stark strongly disagreed, stating: "this is not a risk . . . This is an issue of injury and is not a normal risk for everyday living." Tr. 7/26/93 (Stark) at 148, lines 18-22. Mr. O'Brien also agrees that

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[23]/ Other serious occurrences that Ebensburg rated as minor include the October 1992 incident in which Joe C. was missing from Ebensburg and found the next morning locked in the trunk of a car. U.S. Exh. 1039; Tr. 10/19/93 (O'Brien) at 1009. In March 1993, a staff person heard a loud scream and found Alan G. coming from the bedroom with blood coming from his forehead, blood all over his face, on both hands, blood on the wall by his bed, and blood on the walls of the outside exit door. U.S. Exh. 1039. Although ethistrips had to be used to close Alan's wounds, Ebensburg rated this injury as minor. Tr. 10/19/93 (O'Brien) at 26-27. Ebensburg also rated as minor a May 1993 incident involving Donald P., where he put his head through a window, lacerating and deeply abrading his forehead. U.S. Exh. 1039.

these comments are inappropriate, have "no business" being a part of an occurrence report, and no one at Ebensburg should be "at risk." Tr. 10/19/93 (O'Brien) at 85-86.

Sometimes, Ebensburg staff conclude that the injury occurred because the resident was simply in the "wrong place at the wrong time." Tr. 7/26/93 (Stark) at 148-149. For example:

- On April 21, 1993, Albert B. was pushed into a table by another resident who had been upset all morning. It took six sutures to close the wound on his head. His occurrence report notes that he was in the "wrong place at the wrong time." U.S. Exh. 647 at 00644254.

- On April 10, 1992, as Joseph P. was waiting for staff to clean an open sore on his foot, another resident slapped him in the face, bloodying his nose and loosening his front teeth. His occurrence report also notes that he was in the "wrong place at the wrong time." U.S. Exh. 647 at 00001788.

Dr. Stark also strongly disagreed with dismissing injuries in this fashion: "There should be no wrong place, there should be no wrong time." Tr. 7/26/93 (Stark) at 149, lines 1-2.

Despite what Mr. Bellomo and Mr. O'Brien describe as recent enhanced monitoring of injuries through risk management meetings, supervisory staff in the living units still are not always vigorously examining the circumstances of injuries and instead are continuing to dismiss them as "routine risks." U.S. Exh. 984.[24]/

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[24]/ United States' Exhibit 984 contains examples of some of these occurrence reports:

- On 5/1/93, Deron E. was sitting in the dayroom when John G. either bit or struck him in the face (staff are not certain what happened). On the part of the occurrence report where staff are supposed to make recommendations for prevention of recurrence of injury, the supervisor merely wrote: "Mr. E was innocent victim--routine risk."

- On that same day and at the same time, Paul M. was sitting quietly in the dayroom when John G. ran over and bit him on the arm. Here, the supervisor writes again: "Paul was innocent victim--no need to revise current living area. Routine risk."

- On 5/5/93, Darrel D. was sitting in his program area when another individual slapped him on his face and ear. The supervisor finds that this is "unavoidable incident during program day."

(continued...)

d. Ebensburg Staff Have Sometimes Inflicted Harm On Residents.

In other instances, Ebensburg staff not only have accepted the harm that Ebensburg residents suffer, they have actually inflicted harm. When Mr. Tackett worked on the second shift in Keystone on April 4, 1992, he was concerned that not only did staff fail to intervene when James E. was exhibiting serious self-abusive behavior, they actually treated James in an abusive manner. Tr. 8/3/93 (Tackett) at 20; U.S. Exh. 138. Mr. Tackett witnessed James crying violently and engaging in self-abusive behavior by punching his head and hitting his ear with "full force." Id. at 20, 22. When Mr. Tackett questioned another staff person about James' behavior, he was told "that's the way that Jimmy is, that's the way he'll always be." Id. at 21. At one point while he was still engaging in self-abusive behavior, James was permitted to go back into the bedroom area unsupervised. Id. at 22. At another point, surgical gloves were put on his hands and tied together. Id. at 23. Later, a staff person tied the gloves on James' hands to a metal cart, forcing James to pull the cart around with him. Id. at 23-24. This made James even "more agitated and crying violently." Id. at 24. This lasted for approximately fifteen minutes until Mr. Tackett untied James. Id. James was then

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[24]/(...continued)

- On 5/15/93, Duane P. was found with a bruise on his left foot which turned out to be a fracture. The supervisor has no recommendations, but just states "within normal risk tolerance."
- On 5/22/93, Greg G. fell on the floor while on his way to the dining room, hitting the back of his head. He was limp, listless, and had to be brought to the dining room in a wheelchair where he refused his meal. The supervisor states that he "appears at normal risk for this type of incident."
- On 6/27/93 Chris G. was found with a sore hand where there were two open areas. Again, on the back, the supervisor writes "injury most probably happened with client in cart or wheelchair during previous day. Very minor injury within normal risk tolerance."
- On 7/8/93, Jeff K. was found laying at the foot of his bed and a bleeding laceration on his head. In the recommendation section, the supervisor writes "With Jeff's behaviors (throwing himself about, etc.), this small injury is within normal risk limits."

placed on a bean bag as two staff "held the bean bag on either side and they plopped James up in the air and then caught him back in the bean bag." Id.

Ms. Hebenthal witnessed nine separate instances of abuse during the day and a half she worked on the living units and at day programs at Ebensburg. Tr. 8/3/93 (Hebenthal) at 200. Ms. Hebenthal filled out a witness statement the day after she witnessed the abuse. Tr. 8/3/93 (Hebenthal) at 200-201; U.S. Exh. 139(a). For example:

- Ms. Hebenthal witnessed a large staff person, weighing about 220 pounds, grab a small client by the shirt in a violent way and throw the client about eight feet against a cement wall, push the client into a corner, and tell the client that "he's not going anywhere in a domineering, degrading manner that was totally uncalled for and very disgusting." Tr. 8/3/93 (Hebenthal) at 202-203, lines 9-10; U.S. Exh. 139(a). When the client hit the wall, "his face and upper body slammed into the wall." Tr. 8/3/93 (Hebenthal) at 203, line 20.

- Ms. Hebenthal witnessed a large staff person throw James W., who is blind, onto the couch. James stood up and "put up his dukes," and the staff pushed James onto the couch again. The staff person then said to the other staff, "Oh, let him come at me again," and "I'll break his freaking jaw again." Tr. 8/3/93 (Hebenthal) at 210, lines 12-13.[25]/

- Ms. Hebenthal also witnessed a large staff person slap the side of the head of a small client who was attempting to tie his tennis shoes. She heard this staff person tell the client to "get his F-ing shoes tied," instead of helping the client with the task. Tr. 8/3/93 (Hebenthal) at 204-205; U.S. Exh. 139(a).

- Ms. Hebenthal also saw a client who was trying to get off the couch be pushed back down onto the couch three or four times "in a violent manner" by a staff person. Tr. 8/3/93 (Hebenthal) at 207-208, line 9.

- Ms. Hebenthal witnessed a staff person grab a client by the shirt who was lying face down on the floor, masturbating, and push the client to where the client was supposed to be. Tr. 8/3/93 (Hebenthal) at 211.

- While walking from a program site to board the bus, a heavy-set client with a bad gait was within arms distance of Ms. Hebenthal and two other staff. The client started to

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[25]/ This is the same James W. who, within a three year period, had three emergency hospitalizations for such severe injuries as a ruptured globe in his eye, a fractured jaw, and a ruptured spleen along with broken ribs, and whose mother testified about the repeated, significant harm he has suffered while at Ebensburg. Tr. 7/26/93 (Weakland) at 190-196.

fall, and Ms. Hebenthal attempted to get under the client's arm to try to steady her as she had been taught. One of the Ebensburg staff told Ms. Hebenthal, "Don't hurt your back for her. She's not worth it." Tr. 8/3/93 (Hebenthal) at 206, lines 23-24. The staff walked away from the client. Ms. Hebenthal was able to break the client's fall, but the client did fall down, hitting the cement. Tr. 8/3/93 (Hebenthal) at 206-207. The client had a hard time getting up, and reached her hand out to staff. The staff did not help the client get up and told the client that the bus would leave without the client. Tr. 8/3/93 (Hebenthal) at 207. The staff referred to the client as "Lumpy". Tr. 8/3/93 (Hebenthal) at 206-207.

- While on a bus with staff and clients, Ms. Hebenthal witnessed a staff person "forcibly, violently" grab a client who was attempting to sit next to the staff person by the shirt and put the client into another bus seat, making it clear that the staff person wanted the client "nowhere around." Tr. 8/3/93 (Hebenthal) at 205, line 11. Upon witnessing this, she asked the staff whether clients had assigned seats, and the staff told Ms. Hebenthal, "No, I just don't like him. I don't want him over here." Tr. 8/3/93 (Hebenthal) at 205. Ms. Hebenthal also heard this staff person refer to a black client on the bus as a "dumb nigger." Tr. 8/3/93 (Hebenthal) at 205, lines 19-20.

- While riding on the bus, Ms. Hebenthal witnessed a staff person grab a client who was engaging in self-stimulatory rocking behavior and forcibly push the client back into his seat. Tr. 8/3/93 (Hebenthal) at 208-209.

- Finally, Ms. Hebenthal witnessed four staff people restrain a crying client who wanted to get off the bus at a particular vocational area to which he was not assigned. One staff behind the client put a choke hold around the client's neck, another staff held one of his arms, a third staff held the other arm, and the fourth staff stood in front of the client and verbally intimidated the client. Tr. 8/3/93 (Hebenthal) at 212.

Although the abusive situations witnessed by Ms. Hebenthal involved primarily two staff persons, there were other staff involved in some of the situations (in one instance, four staff were involved). Tr. 8/3/93 (Hebenthal) at 235. When there were other staff present, the staff did not intervene or object in any way to the abuse. Tr. 8/3/93 (Hebenthal) at 235-236. When Ms. Hebenthal and the other trainees reported back to training after their time on the living and programming areas at Ebensburg, other trainees reported incidents similar to the abusive situations that Ms. Hebenthal saw taking place at Villa. Tr. 8/3/93 (Hebenthal) at 228-229.

Both Mr. Tackett and Ms. Hebenthal experienced what they perceived to be pressure from other Ebensburg staff when they reported these abusive incidents. Mr. Tackett felt that the first staff person he spoke to about these incidents was trying to discourage him from coming forward. Tr. 8/3/93 (Tackett) at 26, 44. When Ms. Hebenthal was asked to identify individuals involved in the abuse incidents she reported, she found that the particular staff members that she had accused, as well as the staff with whom they work, were required to stay overtime. Tr. 8/3/93 (Hebenthal) at 232. They stood outside of the building in a very intimidating fashion. Id. As Ms. Hebenthal describes it, staff stood at the door "waiting to lynch me, because I had enough nerve to stand up and say this guy was treating people wrong." Tr. 8/3/93 (Hebenthal) at 222, lines 7-8. She believes that she should have been asked to identify the clients confidentially or with just the particular staff present against whom she had made her allegations. Tr. 8/3/93 (Hebenthal) at 232-233. After filing a report of alleged abuse, both Mr. Tackett and Ms. Hebenthal have been the subject of suspicious activity. Mr. Tackett received threatening phone calls following his report of abuse. Tr. 8/3/93 (Tackett) at 49. After Ms. Hebenthal was asked to identify the individuals involved in the abuse incidents, she was followed home until she stopped at the State Police Barracks. Tr. 8/3/93 (Hebenthal) at 222.

During the time that he worked at Ebensburg, Mr. Tackett perceived a code of silence or peer pressure not to report anything negative about other direct care staff. Tr. 8/3/93 (Tackett) at 48-49. Dave Fulton, who is in charge of abuse investigations at Ebensburg, admits that he encounters a certain amount of conspiracies of silence among staff who work together when he conducts his investigations. U.S. Exh. 614 (Fulton Dep.) at 103-104.

Sometimes, he "runs into a brick wall" due to these conspiracies of silence. U.S. Exh. 614 (Fulton Dep.) at 104. As recently as January 1993, the executive staff at Ebensburg decided to send a memorandum to all unit managers to have them remind staff that the occurrence reports they write are "read by many and that it reflects the care and attitude of staff involved." Tr. 10/15/93 (Bellomo) at 17; U.S. Exh. 982. Moreover, the memorandum warned staff that "unnecessary" and "harsh wording" only serve to delay the process.

Mr. Fulton conducts investigations almost exclusively at the request of other people at Ebensburg. He has only conducted an investigation on his own initiative once or twice. U.S. Exh. 614 (Fulton Dep.) at 71. An Ebensburg supervisor received an phone call on September 20, 1992 from a concerned citizen naming a particular Ebensburg employee who was beating up the clients and bragging about it, and that if checked, the employee's knuckles would be skinned. U.S. Exh. 614 (Fulton Dep.) Exh. 5. Mr. Fulton does not recall investigating this complaint. U.S. Exh. 614 (Fulton Dep.) at 155. Mr. Fulton does not remember receiving the note from the supervisor. U.S. Exh. 614 (Fulton Dep.) at 156. Mr. Fulton has not conducted an overview of abuse investigations to look for trends for several years. U.S. Exh. 614 (Fulton Dep.) at 159. Although it is part of Mr. Fulton's responsibility to follow through to see that whatever problems were uncovered by his investigations are remedied, he has no authority to ensure that changes, in fact, are implemented. He states: "When I turn [the investigation] over to somebody else, that's pretty much more or less their responsibility if there's corrective action to be taken." U.S. Exh. 614 (Fulton Dep.) at 134. Mr. Fulton believes that the safety of Ebensburg residents

would be better ensured if he followed up to ensure that what caused the injury was remedied. U.S. Exh. 614 (Fulton Dep.) at 133-134.

In Dr. Stark's opinion, there are four major reasons why incidents and injuries are a frequent occurrence at Ebensburg:

1. Ebensburg staff are not adequately supervising or monitoring residents;

2. Ebensburg staff are not adequately intervening to stop behaviors that are causing injuries;

3. Ebensburg is not adequately fulfilling its obligation to review injuries, determine causes and take preventative steps; and

4. there is a lack of meaningful activity and training programs which results in a "pattern of harm."

Tr. 7/26/93 (Stark) at 106.

D. <u>Staff Are Not Adequately Supervising And Monitoring Residents</u>.

A large percentage of incidents occur at Ebensburg while staff are not even present to prevent them. The defendants agree that fully forty percent of the incidents during 1992 were categorized by Ebensburg as being caused for unknown reasons. Tr. 7/26/93 (Stark) at 103, 109; U.S. Exh. 90 (attached); Tr. 10/15/93 (O'Brien) at 76; Def. Exh. FF. These are unwitnessed events where staff find the individual injured and do not even know how it happened. Tr. 7/26/93 (Stark) at 109. The type of injuries that are unwitnessed run the spectrum from scratches, bruises, and abrasions to fractures, lacerations requiring sutures, and injuries requiring emergency hospitalization. Tr. 7/26/93 (Stark) at 109; U.S. Exh. 135.[26]/ Moreover, in analyzing the circumstances surrounding injuries, Dr. Stark found

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[26]/ "Unknown" injuries appear on United States' Exhibits 135 and 136 with the code number "17" in the column labeled cause.

that injuries frequently occur during times when staff are involved in other functions, such as mealtimes, medication administration, bathing, toileting, are off the living unit on a staff break, or are involved with paper work, rather than being attentive to residents. Tr. 7/26/93 (Stark) at 110-111. United States' Exhibit 589 (attached) presents a summary of 26 examples that Dr. Stark selected as a sample from the numerous occurrence reports that he reviewed to illustrate this phenomena. The Commonwealth has not refuted any of these examples contained in the summary chart in United States' Exhibit 589. For example:

- On April 15, 1993, Thomas H. was found naked at 7:40 a.m., sitting on the changing table in the bathroom with a bloodied and lacerated ear due to a human bite which took 10 sutures to repair. At the time staff discovered the injury, they were all involved with morning care. The injury was not found until a staff person returned to the area after taking a client off the living area for bloodwork. U.S. Exhs. 589 at 2; 589(a).

- On March 6, 1993, Alan R. was found on the floor with his face covered with blood. No one observed how he hurt himself. At the time of the injury, which occurred on a weekend at 10:30 a.m., two staff were on break, one was in the chart room, and other staff were involved with weighing individuals. Id.

- During dinner time on February 15, 1993 -- one week before Dr. Stark toured Ebensburg -- Jeffrey C. was found choking David L., who had bitten Jeffrey so hard that David had blood on his tooth. There were no direct care staff supervising either of these residents. Instead, one staff person was on break, two were in the dining room, and two were in the bathroom. This incident was not discovered until a Licensed Practical Nurse ("LPN") happened to walk through the area and saw the choking in progress. A supervisor acknowledged in the occurrence report that staff need to be retrained not to leave clients unobserved. Id.

Dr. Stark also had concerns about instances he reviewed in occurrence reports where Ebensburg residents were missing and staff were unaware that individuals had even left the area or had been left behind.[27]/ For example:

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[27]/ Since 1985, Pennsylvania Office of Mental Retardation policy has stated that leaving a resident who requires supervision unattended constitutes neglect. Tr. 10/19/93 (O'Brien) at 61.

- On July 8, 1992, Beverly B. was discovered outside of the Administration Building by a volunteer resource coordinator. Tr. 7/26/93 (Stark) at 221; U.S. Exh. 594(b). She had left Horizon House unnoticed and, when found, her right eye was "practically swollen closed" and she had a two-inch circular abrasion on her shoulder. "Blood was on the shoulder of her blouse and seeping from the wound." U.S. Exh. 594(b) at 00050396.

- On February 11, 1992, Vincent P., who lives at Sunset House, was left behind at the end of the day at programs because staff were distracted with a behavioral episode. Tr. 7/26/93 (Stark) at 221; U.S. Exh. 5949(c). He was found fifteen minutes later sleeping on a couch in a program area. The nurse noted that there was a need for closer supervision. Yet, one month later, Ronald A., another client from Sunset House was also left behind in program area. He was found a half hour later in his program area sleeping on the floor with his coat on. The need for closer supervision was noted again. On June 20, 1992, however, Ronald A. was again found to be missing. U.S. Exh. 594(e). This time, he was missing from his program area and later found in the bathroom of his living area. Id. He had wandered through the tunnel connecting buildings backs to his living area. A staff person says that she sent Ron out to the bathroom and "hollered" to another staff person who was in the bathroom that she was "sending Ron out." Id. at 00050031. A supervisor stresses that staff need to be "sure all individuals are accounted for at all times." Id.

- On January 25, 1993, Mary D. was discovered to be missing from her living unit. She was later found behind closed doors in JFK Learning Center, sitting at a table, sobbing.

On October 1, 1992, one week after Dr. Russo toured Ebensburg, Joe C. was found to be missing at 11:45 in the evening. U.S. Exh. 313. Joe was not found until the next morning, locked in a car trunk. His temperature was 94.6 degrees and he was urine soaked. U.S. Exh. 313. Id.[28]/ Joe reported that he left because he had been in an altercation with another resident and was afraid to stay on the unit because he thought this individual was "going to beat him up." U.S. Exh. 313 at 200501. Minutes before he eloped, staff knew that Joe was "extremely upset." U.S. Exh. 313 at 00200493. Staff left him alone, however, even after he threatened to take rat poison, to kill himself, and elope because three staff were

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[28]/ Ebensburg counts this incident as "minor." Tr. 10/19/93 (O'Brien) at 109; see U.S. Exh. 136 at 00591506.

busy getting their paychecks and a fourth was on his break. U.S. Exh. 313 at 00200493-498; 00200500. This was not the first time that Joe had eloped in the middle of the night while the same staff were on duty. In fact, in July of 1991 at 1:35 in the morning, he left the living area after having a behavioral outburst and was found 25 minutes later in a bus by the garage. U.S. Exh. 313 at 00209559. In March 1992, he left the unit at 6:55 a.m. after he alleged that he was kicked in the chest and mouth by a staff person and was found 20 minutes later in the upper level of a barn. U.S. Exh. 313 at 00001539.[29]/ In a psychiatric consult following the incident where he was found locked in the trunk of the car, Dr. Goldschmidt, the consulting psychiatrist, wrote that when Joe is "upset he needs to be monitored one to one and otherwise he needs to be watched until he learns safety matters." U.S. Exh. 331 at 00303685. Several months later, on February 28, 1993, again in the middle of the night, Joe was angry and put his fist through a window requiring sutures. U.S. Exh. 331 at 00590481. At the time of the incident, two staff were involved with laundry and one was on break. U.S. Exh. 331 at 00590487.[30]/ His occurrence report

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[29]/ This was also not the first time that Joe alleged that staff had kicked him. On June 9, 1991, at 11:15 p.m., Joe C. came out of his bedroom, complaining of pain in his left rib area, and stated that a particular staff person on the 3-11:00 p.m. shift had kicked him. About 45 minutes earlier that evening, Joe had been put in a time out room by that staff person. On June 11, 1992, an Ebensburg x-ray was inconclusive for fracture. On June 13, 1991, an orthopedic consultant verified that two of Joe's ribs were fractured. Joe was having difficulty breathing and still complaining of pain on June 18, so Ebensburg again x-rayed Joe, and confirmed acute fractures of two of Joe's ribs and an opacity consistent with pulmonary contusion. Joe was admitted to Mercy Hospital, where he was diagnosed with pneumothorax and chest tubes had to be inserted. U.S. Exh. 129.

[30]/ This incident occurred despite the fact that Mr. Bellomo claims to have been responsive to Ms. Ferut's concerns that staff have laundry responsibilities that detract from their client care responsibilities. Tr. 10/14/93 (Bellomo) at 158.

again notes that there needs to be an "emphasis on staff efforts to avoid Joe's emotional escalation." Id. at 00590482.

The same phenomena of residents being injured and engaging in dangerous behaviors while staff are involved with meals, bathing, toileting, medication administration, and breaks continued to occur through the trial of this case. United States' Exhibit 985(a) (attached) is a summary of a sample of eight such incidents that occurred between May and August 1993.

There are also a number of instances that Dr. Stark characterizes as "disturbing" where Ebensburg residents have engaged in pica[31]/ and staff were unaware that they ingested a foreign object until the residents were found in distress or foreign objects were found in the person's feces, vomit, or confirmed through an x-ray in the hospital. Tr. 7/26/93 (Stark) at 116. United States' Exhibit 590 contains a summary of some these instances of pica. The summary is not an exhaustive list but merely illustrative of situations that have occurred at Ebensburg. Tr. 7/26/93 (Stark) at 116. The Commonwealth has not refuted any of these examples or the summary of them contained in United States' Exhibit 590 (attached). These instances include:

- Winfield M., who has vomited rubber bands, clothing labels and cigarette butts. He was found limping by staff and an x-ray revealed a zipper and numerous screws in his abdomen. During February 1993, he was discovered having trouble bending; an x-ray found a mass of metallic objects inside him. U.S. Exh. 590 at 1.

- Brian B. who refused to eat breakfast, was drooling and unable to swallow and was found to have a paper dixie cup in his throat. Several months earlier, Brian choked during lunch and was found to have a thermometer ear tip lodged in his throat. Prior to this incident, he choked during supper and was taken by emergency transport to the hospital where he threw up a piece of wood that he ingested. Id. at 1-2.

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[31]/ Pica is the ingestion of inedible objects or substances. Tr. 7/26/93 (Stark) at 115.

- Ivy W. was discovered by staff to have a small bottle lodged in her throat when she exhibited difficulty swallowing during a mealtime. Id. at 1. Ivy's pica behavior is well known to staff and they admit that she should be monitored closely. U.S. Exh. 590(a) (4/13/92 Inc. Rep. with staff comments attached). A staff person who was "pulled" from Ivy's unit on the day of the incident states that before she left, she "noticed 3 pill bottles on the table in day room; they shouldn't have been out without supervision." Id.

- Staff have frequently found cigarette butts and filters in Darlene F.'s emesis, sometimes mixed with blood. U.S. Exh. 590 at 1-2.

These same types of incidents continued through the summer of 1993. For example, on August 4, 1993, Carol D., who has pica, was found crouched on the floor, cyanotic and gasping for breath. U.S. Exh. 987. A nurse removed a 6" length of shirt from her throat. Id. On June 22, 1993, staff saw a metal screw fall from David W.'s mouth. U.S. Exh. 987. The next day, staff found a large amount of cloth strands, paper, and a small rock in his bowel movement. Id.; Tr. 10/15/93 (Bellomo) at 40.

The phenomena of staff not being present to supervise and monitor residents, and being inattentive to residents even when they are present, is one that Dr. Stark observed during his February 1993 tour as well as a "common theme" that he identified in Ebensburg documents and surveys by outside reviewers. Tr. 7/26/93 (Stark) at 115.

E. Ebensburg Staff Are Failing To Intervene Even When They Observe Dangerous Behavior.

Even where Ebensburg staff are present and supervising residents, they fail to intervene, or to intervene successfully, when they observe dangerous behaviors occurring. Tr. 8/4/93 (Amado) at 76-77. During his February 1993 tour, Dr. Stark repeatedly saw situations where individuals were agitated, pacing, roaming, and milling where staff were oblivious and not redirecting them to engage in a meaningful activity. Id. at 121. In one instance, Dr. Stark had to alert staff who were oblivious to several pica attempts by David

N. Despite the fact that David had had an emergency psychiatric consult earlier that day, staff were unaware that he picked up a piece of toy off the floor and stuck it in his mouth and then later placed an entire piece of paper in his mouth. There was no staff intervention until Dr. Stark brought these incidents to staff's attention. Tr. 7/26/93 (Stark) at 117-118. Dr. Stark attributes the failure to intervene to staff not knowing what to do and not picking up on and intervening when early warning signs are present. Tr. 7/26/93 (Stark) at 119. Dr. Amado, Dr. Russo, and Dr. Stratton (Ebensburg's Chief of Psychology) all unequivocally agree with Dr. Stark's conclusions that Ebensburg staff simply lack the knowledge to manage residents' behaviors. Based on his observations of staff interventions at Ebensburg and his review of incident reports documenting instances where individuals are hurt when staff do not intervene early enough, Dr. Amado agrees with Dr. Stark that staff are not adequately trained to intervene to prevent or avoid harm to the residents of Ebensburg. Tr. 8/4/93 (Amado) at 44-45. Dr. Russo also concluded that there is a systemic failure to teach direct care staff in practical terms how to respond to behaviors and protect Ebensburg residents. Tr. 8/2/93 (Russo) at 79. Dr. Stratton agrees, as well, that Ebensburg direct care staff are not adequately trained in basic behavior management principles. U.S. Exh. 640 (Stratton Dep.) at 218-219.

Injuries occur time and again at Ebensburg due to staff's inability to intervene in a manner to prevent escalation of behaviors. Tr. 7/26/93 (Stark) at 118-119; Tr. 8/4/93 (Amado) at 44-45. In their review of injuries, both Dr. Stark and Dr. Amado agree that they reflect situations where residents act in ways that suggest they should be closely monitored but staff fail to adequately monitor and intervene, their behaviors escalate, and

injuries result. Tr. 7/26/93 (Stark) at 119; Tr. 8/4/93 (Amado) at 47. For example, John B. was scratched all over his face and neck by David F. "who was attacking all ward individuals." U.S. Exh. 107 (John B. Inc. Rep.). Staff note that David's behavior started while in the dining room and continued back in the living area. Id. Earlier in the day on January 19, 1992, James S. had been restrained in a papoose board due to his aggressiveness, but continued to disturb others after being released. At 10:30 a.m., James hit Ibrahim D., and Ibrahim kicked James about 10 times in the head and face before staff could separate them. U.S. Exh. 107. The Unit Manager at Villa, where the incident between James and Ibrahim took place, agrees that early intervention is the "key" to stopping aggressive behaviors. U.S. Exh. 607 (Degretto Dep.) at 163. She acknowledges that in order to intervene early, staff have to know the antecedents of the aggressive behaviors and have to know the resident. U.S. Exh. 607 (Degretto Dep.) at 163. She also identifies "positive approaches" and "communication" as big factors in early intervention. U.S. Exh. 607 (Degretto Dep.) at 163. This is the same unit where the incidents involving Joe C. took place. See discussion supra § V.D.

The videotape taken by Dr. Russo during his tour of Ebensburg further documents the inability of staff to effectively intervene in client behaviors. Tr. 8/2/93 (Russo) at 89; U.S. Exh. 260. In one segment, a staff trainee tries (unsuccessfully and then just gives up) to get David W. to wear his helmet. Because David engages in the behavior of toe walking, and is prone to falls, David must wear a helmet to prevent injuries. David had fallen three times in the previous six months, each time requiring numerous sutures, Tr. 8/2/93 (Russo) at 89, and has sustained numerous serious injuries due to falls because he refuses to wear his

helmet. Tr. 8/2/93 (Russo) at 90. Ebensburg has not provided behavior programs for either helmet tolerance or toe walking for David. Tr. 8/2/93 (Russo) at 89-90. Dr. Alvarez testified that the neurologist at Ebensburg is failing to involve the psychologists in development of helmet tolerance programs for those Ebensburg residents who need them. Tr. 7/30/93 (Alvarez) at 206-207.

Both Dr. Stark and Dr. Amado also reviewed a number of occurrence reports and progress notes in records where individuals were self abusive to the point that they caused injuries to themselves. Id. United States' Exhibits 107 and 591 include a number of such examples. These incident reports also raise concerns about insufficient levels of staffing as well as concerns that staff are inappropriately leaving clients alone when the individuals' behaviors demand attention. Tr. 8/4/93 (Amado) at 47. For instance:

- Vincent P. has been allowed to continually pound his face with his fists to the point that he causes bruises, open wounds, and bleeding on his face. United States' Exhibit 591(a) contains examples of fifteen such instances where staff permitted Vincent to injure himself. For example, on October 2, 1992, he punched his left and right cheeks causing swelling and abrasions on both cheeks. On December 17, 1992, he punched his face until his cheek bled. On April 1, 1993, he hit his face with his fist while a speech therapist was assessing his language skills. Staff observed him as he "smeared blood around his mouth and cheeks" until the blood was finally wiped from his hands. Tr. 7/26/93 (Stark) at 119; U.S. Exh. 591.

- On February 15, 1993, staff saw Franklin B. slapping his face and banging his head against the wall. Staff's response was to notify the nurse, who found Franklin still actively slapping his face and banging his head when she arrived. Id.

- On February 23, 1993, Gordon A. started beating himself during the night. The next day he was found to have reddened areas on his inner legs, upper chest and face, upper and lower arms, a lacerated lip and blood around his two front teeth. Id.

- On July 8, 1992, while leaving for her break, a staff person found Jonathan B. with a laceration over his eyebrow that required 10 sutures. His incident report notes that he was "screaming and carrying on all morning" and self-abuse is suspected. Id.

- On March 18, 1992, Francis R. was biting and slapping himself for several hours. He threw himself out of his wheelchair, banged his head on the floor, and bit his wrist. Francis suffered open areas, bleeding, an abrasion, and discoloration under his eye. Id.

- On September 26, 1992, Richard M. had been engaging in self-injurious behavior and moving furniture around since about 3:00 p.m.. Approximately three hours later, at 6:00 p.m., dining room staff discovered Richard with blood on his clothing and his finger bleeding. Part of his fingertip was amputated. U.S. Exh. 107.

- On April 21, 1992, Stephen D. was allowed to pound his ear until it bled following a change in his daily routine, in spite of the fact that staff are well aware that Stephen is very sensitive to changes in his daily routine. U.S. Exh. 107.

Dr. Stark explained that if an individual begins hurting him or her self, at the very least, staff should be intervening to block the behavior and re-direct the person to meaningful activities. Tr. 7/26/93 (Stark) at 120. He did not see this occurring during his tour nor did he see it reflected in the sequence of events described in occurrence reports. Tr. 7/26/93 (Stark) at 120-121.

Even the facility director, Alan Bellomo, has documented a number of instances where he has observed individuals who were self-abusing themselves without staff intervention. Tr. 7/26/93 (Stark) at 122-123; U.S. Exh. 200-206. In reviewing these memoranda, Dr. Stark found that not only did they confirm his findings that staff fail to intervene when residents are actively involved in self-injurious behavior, they also represent a systemic failure at Ebensburg where residents continue to be injured and harmed, even where Mr. Bellomo has focused on them and directed staff to take action. Tr. 7/26/93 (Stark) at 123. For example:

- On September 10, 1992, Mr. Bellomo observed Theresa B. delivering three slaps to her face of varying intensity during a 60 second period. U.S. Exh. 200. Mr. Bellomo admits that this is an "unacceptable" situation. U.S. Exh. 603 (Bellomo Dep.) at 55-56. Theresa has a history of self abusive behavior, including slapping her face and pounding her

head on the floor. She has been found with black and blue and swollen lips, suspected to be the result of self-abuse. U.S. Exh. 200 (6/24/92 Inc. Rep.). Despite Theresa's history and his observations, Mr. Bellomo determined that her three year old behavior program was acceptable but, in a written note to the Unit Manager, stressed the importance of consistently implementing her program. U.S. Exh. 200. The very next day, Theresa was found in the dining room with blood on her face. As a staff person approached her, "she started to slap her face extra hard making the blood flow more and spraying the blood around." U.S. Exh. 200 (9/15/92 Inc. Rep.).

- On August 27, 1992, Mr. Bellomo observed Lee V. slapping his face 15 times in a 60 second period with no staff intervention. U.S. Exh. 203. Two weeks later, Mr. Bellomo again observed Lee V. delivering 12 blows to his face and pounding his chest two times in a 60 second period without any staff intervention. U.S. Exh. 204. This is the same resident who is delivering blows to his face on the United States' feeding videotape without any staff intervention. U.S. Exh. 258.

There are other occasions where Mr. Bellomo has witnessed and documented residents engaging in self-injurious behaviors where staff do not intervene to stop or block the abuse. Tr. 7/26/93 (Stark) at 123. Incidents of uninterrupted self-abuse that Mr. Bellomo witnessed and documented during the month of September 1992 as he toured the facility include:

- James B. hitting himself in the head twelve times in a 30 second period. U.S. Exh. 202.
- Roberta V. striking herself approximately five times in the head. U.S. Exh. 205.
- Michael B. slapping himself on the head four times in rapid succession. U.S. Exh. 206.
- David G. delivering "five slaps of significant intensity to the side of his face." U.S. Exh. 201.
- T.V. slapping her face hard while waiting for her delayed lunch to arrive. At the same meal, Joyce Y. delivered eight punches to her face from the time she entered the door until she sat down at the table. U.S. Exh. 165(c) at 2.
- Theresa C. slapping her head while being fed. U.S. Exh. 165(b).
- Gwen C. delivering five blows to her chest. Tr. 7/29/93 (McGowan) at 141.

When Mr. Tackett worked on the second shift in Keystone on April 4, 1992, staff allowed James E., who was exhibiting serious self-abusive behavior by punching his head

and ear, to go back into his bedroom area unsupervised. Tr. 8/3/93 (Tackett) at 22; U.S. Exh. 138.

The finding by all three psychology experts that staff at Ebensburg are failing to intervene appropriately when residents are exhibiting potentially dangerous behaviors has been corroborated by surveyors for the Commonwealth as recently as October 1993. During their most recent survey of Ebensburg, state surveyors found that Ebensburg staff were unable to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of the clients. Based on observations conducted during various times throughout the day in every single residential building at Ebensburg, "individuals were engaged in stereotypic, self-stimulatory and self-injurious behaviors including spinning, rocking, finger flicking, hand slapping, hand mouthing, playing with saliva, mouthing objects and clothes, face slapping and biting. Staff intervention was minimal." U.S. Exh. 1103 at 6. One of the State surveyors in the October 1993 MA survey characterized this citation as a "systemic deficiency" at Ebensburg. Tr. 12/13/93 (Bordner) at 217-218.

F. Ebensburg Is Failing, Systemically, To Determine The Causes Of Injuries And Take Preventative Action To Protect Residents.

1. Ebensburg Fails To Take Adequate Action Even In The Face Of Repeated, Serious Injury.

Dr. Stark concluded that Ebensburg is not fulfilling its responsibility to review injuries, determine their causes, and take adequate preventive steps to protect residents from harm. Tr. 7/26/93 (Stark) at 106, 130. He found Ebensburg's non-responsiveness to injuries to be a systemic problem. Tr. 7/26/93 (Stark) at 134. Sometimes staff will meet

and acknowledge the injuries, but rarely do they actually take any effective action. Tr. 7/26/93 (Stark) at 130. Dr. Stark found that the three most frequent responses to injuries at Ebensburg were to continue the same program, "monitor," or to change medications. Tr. 7/26/93 (Stark) at 130- 133. For example:

- James S. had the highest number of incidents at Ebensburg during the 50 month period between January 1989 and February 1993. Tr. 7/26/93 (Stark) at 130. During this time he sustained more than 200 injuries. United States' Exhibit 479 is a compilation of some of James' more recent incident reports, along with Ebensburg's own summary chronicling its inaction in the face of continuing, significant injury and repetitive harm. Tr. 7/26/93 (Stark) at 131-132. For 40 injuries between March and October 1992, Ebensburg's only response is "no change to IHP (individual habilitation plan)" and "behavior plan to continue," with the exception of a recommendation to start a psychotropic medication, a recommendation to change his living area, and a notation that James was "counseled" after he ripped off his toenail. Tr. 7/26/93 (Stark) at 131; U.S. Exh. 479. There is no response to his injury on June 23, 1992, when he put his head through a glass window in the dining room. U.S. Exh. 479 at 00050469. James' case is also illustrative of Ebensburg's failure to intervene at an early stage to prevent self-injurious behavior, despite James' known history of inflicting wounds to his head with sharp objects. Tr. 7/26/93 (Stark) at 132. For example, on July 13, 1992, James came into the day room with blood on his hands and face. He showed staff that he had stabbed himself on the forehead with a pair of scissors. Tr. 7/26/93 (Stark) at 132. His occurrence report notes that he had been crying all day and was upset because his parents did not attend the family picnic. Tr. 7/26/93 (Stark) at 132; U.S. Exh. 479. According to Pennsylvania Office of Mental Retardation policy, leaving a resident who requires supervision unattended or allowing a resident access to harmful substances such as chemicals and sharp instruments constitutes neglect. Tr. 10/19/93 (O'Brien) at 61.

- Ebensburg's most frequent response to Greg A.'s 24 injuries in 20 months between August 1991 and April 1993 was that staff should "monitor," and "monitor more closely." U.S. Exh. 279 (substituted) (attached).

- Ebensburg's response to Andrew H.'s frequent serious injuries has varied from commenting that his "laceration is clean and dry; should heal" to "no change in ATP (active treatment plan)." U.S. Exh. 778 (attached).

- On October 5, 1992, Dr. Goldschmidt, Ebensburg's consulting psychiatrist was concerned that Gary K. was possibly being abused. U.S. Exh. 360. She asked staff to observe whether he was being abused and stated that she wanted to see him "next time I come." Id. Dr. Goldschmidt did not see Gary again until some five months later -- March 3, 1993. Id. In the meantime, Gary continued to suffer significant injuries. For example, several weeks following Dr. Goldschmidt's consult, he was found to have a bloody bruise

under his eye when he returned from his day programs. Id. Later in the day, he was bitten on the arm. In November 1992, Gary returned from his day programs with a laceration on his face that require seven sutures. In January 1993, he was kicked in the head, suffering an abrasion on his nose and swollen areas around both of his eyes. Id. In February he was hit in the eye by another resident and suffered a corneal abrasion. Id.

2. Ebensburg Administrators Are Not Cognizant Of Injury Trends.

Key administrators at Ebensburg are not even aware of the injury trends of residents at their facility. As of February 25, 1993, Mr. Bellomo thought that there had been a facility-wide decrease in the number of injuries and accidents, when in fact there had been more than a 40% increase in the number of injuries at Ebensburg in the past twelve months and the overall number of incidents at Ebensburg in 1992 was higher than it had been since 1989. Tr. 7/2/6/93 (Stark) at 88, 96; U.S. Exh. 601 (Bellomo Dep.) at 26.[32]/ As of late February 1993, Mr. Bellomo also thought that the percentage of unwitnessed injuries had "continually decreased" at Ebensburg, when in fact the rate had increased by 52% in the prior twelve months. Tr. 7/26/93 (Stark) at 105; U.S. Exh. 92; U.S. Exh. 601 (Bellomo Dep.) at 128. Mr. Bellomo admits that "[o]ne unwitnessed incident is unacceptable to me. I, as an administrator, feel that it is incumbent upon us to know and to put things into place that is going to make the environment as safe as possible." Tr. 10/14/93 (Bellomo) at 45, lines 2-5. Mr. Fulton, who heads the risk management committee, however, has never initiated an investigation to look at trends of injuries with unknown causes. U.S. Exh. 614 (Fulton Dep.) at 79-80. The only routine written report generated by Ebensburg concerning trends with respect to injuries caused by unknown causes is Mr. Fulton's annual report of all

[32]/ Even accepting Ebensburg's distinction between incidents and injuries, there was still a 37% increase in injuries in the twelve months preceding Mr. Bellomo's deposition.

facility accidents. U.S. Exh. 614 (Fulton Dep.) at 77-79. As of the time of his deposition in January 1993, Dr. Stratton thought that Ebensburg was "getting close" to the point where there were no injuries due to behaviors, when, in fact, injuries due to behaviors had increased by 45% in the past 12 months and constituted 34% of all incidents. U.S. Exh. 640 (Stratton Dep.) at 209-210; Tr. 7/26/93 (Stark) at 105.; U.S. Exh. 91. Ebensburg has never attempted to identify individuals whose behaviors pose the greatest risk in terms of injury to themselves or to other people. U.S. Exh. 639 (Stratton Dep.) at 67. Dr. Chamovitz does not review computer data or incident reports regarding seizure-related injuries. U.S. Exh. 606 (Chamovitz Dep.) at 157.

Ebensburg's Director of Nursing only reviews occurrence reports involving fractures, sutures, and lost teeth. U.S. Exh. 636 (Sponsky Dep.) at 49. Although she believes that bite injuries raise significant health concerns, she does not review any incident reports that involve bites. Id. at 51. Ms. Sponsky did not review incident reports involving three separate residents' broken limbs discovered on October 18, November 10, and November 12, 1992, until late November 1992. U.S. Exh. 638 (Sponsky Dep.) at 118. Although she reviewed all three of these incidents on the same day and each one of the fractures was discovered with no known cause, Ms. Sponsky did not investigate the circumstances surrounding any of these incidents. Id. at 119. She does not evaluate occurrence reports to ascertain if they present any common problems, or even to see if they present nursing care issues. Id. Ms. Sponsky stated on the first day of her deposition that her primary purpose in reviewing occurrence reports is only to look at whether the nurse documented the injury and treatment on the occurrence report form with sufficient specificity. Id. at 50-51. The

very next day, Mr. Bellomo wrote her a memo directing her to expand the scope of her incident report review. U.S. Exh. 638 (Sponsky Dep.) Exh. 41. Ms. Sponsky had no idea why Mr. Bellomo wanted her to do this and, as of one month later, still had not identified any issues as a result of her review. U.S. Exh. 638 (Sponsky Dep.) at 121-122.

Mr. O'Brien agrees that "if somebody has an occurrence, we need to check it out right away." Tr. 10/19/93 (O'Brien) at 59, lines 5-6. It was not until March 1993, however, that Ebensburg initiated daily risk management meetings to discuss injuries. Tr. 10/19/93 (O'Brien) at 57. The decision to hold these meetings was made based upon discussion with an outside expert that Ebensburg hired for purposes of this litigation, and subsequently decided not to call as a witness at trial, to evaluate Ebensburg's risk management process "from a safety standpoint." Tr. 10/19/93 (O'Brien) at 57, lines 21-22.

An example of Ebensburg's risk management committee response to an injury is contained in United States' Exhibit 306. James B. has a history of self abuse by hitting his face. U.S. Exh. 306 (ambulance report). He has suffered nosebleeds in the past due to his self-abuse. U.S. Exh. 136 at 0091505. On June 18, 1993, James was sent to the emergency room via ambulance for a severe uncontrolled nosebleed which Ebensburg determined was due to self-injurious behavior. Id.; U.S. Exh. 946.[33]/ James' nose was packed at the hospital and he was returned to Ebensburg, where he repeatedly pulled out the packing in his nose. U.S. Exh. 306 (progress notes). The next day, while administering medications the nurse "noted packing in outer part of nose gone and blood oozing on face." Id. Later that

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[33]/ The cause of James' nosebleed is listed as a "14" for self-injurious behavior in United States' Exhibit 946.

evening, an aide found his elbow bleeding with a "deep and gaping" laceration which required sutures. Id. On June 21, 1993, James was noted to be self abusive by slapping his face "frequently." Id. Ebensburg's risk management committee met on June 21, 1993 to discuss his nosebleed and his lacerated elbow. The committee's resolution of his lacerated elbow was "To be monitored--probably struck elbow on chair/table." The resolution of his nosebleed was "sharp fingernails trimmed and filed. Follow up on 6/22." Id. The "follow-up" that occurred on 6/22 consisted of the notation "nails were cut--probably causal factor." As of July 12, 1993, James' behavior plan for his self-injurious behavior of head banging, face slapping, and picking scabs and sores had not been revised since January 28, 1987. Id.[34]/ According to Mr. O'Brien, following every behavior episode such as SIB, the daily risk management committee is "requiring the team to sit down and do an occurrence report for SIB behavior, forcing the unit team to review the behavior management program for that person, to do functional analysis, to make sure that we know what it is causing the behavior, to try to attempt to deal with that behavior." Tr. 10/19/93 (O'Brien) at 56-57, lines 1-6.

Following depositions of Ebensburg administrators and staff where recommendations on occurrence reports were explored (including recommendations made by Betty Ferut, a direct care staff worker, about the need for more staff, better supervision, and fewer non-client care responsibilities), the executive staff sent a memorandum to all Unit Managers reminding them that occurrence reports are "a serious document, read by many." Tr. 10/15/93 (Bellomo) at 17; U.S. Exh. 982; U.S. Exh. 611 (Ferut Dep.) at 25; Ferut Dep.

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[34]/ The date at the end of the behavior program reflects when the program was last revised (except for minor revisions where the date may not be changed). U.S. Exh. 640 (Stratton Dep.) at 149.

Exh. 1. The memorandum cautions that "editorial comments and recommendations that are known to be impossible to carry out only serve to delay an already complex process."

3. Ebensburg Fails To Protect Residents Even When Directed To Do So.

As the Director of the Bureau of Direct Program Operations of the Commonwealth Office of Mental Retardation, Dr. Sneed was responsible for the nine state operated mental retardation facilities and the three mental retardation units on the grounds of State mental health centers. U.S. Exh. 635 (Sneed Dep.) at 14.[35]/ He was responsible for ensuring that these facilities were in compliance with federal, state, and local standards and regulations and live within their budget. U.S. Exh. 635 (Sneed Dep.) at 14. Dr. Sneed was also responsible for ensuring that residents at these facilities and units "maintain a suitable quality of life, that they receive proper medical care, nursing services, and other quality of life issues." U.S. Exh. 635 (Sneed Dep.) at 15, lines 1-3. He was further responsible for ensuring that residents receive proper programming. U.S. Exh. 635 (Sneed Dep.) at 15.

On November 19, 1990, Dr. Sneed issued a memorandum to all facility directors, including Mr. Bellomo at Ebensburg, regarding the need for improved reporting of steps taken to prevent the occurrence of client assaults on other clients. U.S. Exh. 635 (Sneed Dep.) Exh. 1. In the memorandum, Dr. Sneed directed that:

> as a matter of routine reporting procedures, whenever an assault allegedly occurs between clients (with the victim receiving bruises, contusions, fractures, etc.), I am requesting that you direct all supervisory staff to describe which steps are being taken to prevent both parties in the assault from experiencing a

[35]/ Mr. Bellomo testified that at sometime during the trial of this case, Dr. Sneed left this position. Tr. 10/14/93 (Bellomo) at 132-133.

> recurrence of that assault. By December 7, 1990, all MR-34's [occurrence reports] dealing with one client assaulting another must describe the steps taken to prevent recurrence of behaviors for both clients involved in the assault. To merely state that the victimizer (in the assault case) had never been involved in any other assault is not sufficient. Instead, we need to know what's being done to prevent any subsequent assaults from occurring.

Tr. 7/26/93 (Stark) at 137-138; U.S. Exh. 225; U.S. Exh. 635 (Sneed Dep.) Exh. 1. Dr. Sneed states that a response by the supervisor in the "Recommendations for Prevention of Recurrence" section on the back side of the occurrence report that "closer observation or monitoring of the assault victim" is not sufficient. U.S. Exh. 225. "We also need to know what is being done to prevent the assaultive person from victimizing clients." Id. Dr. Sneed's directive in this memorandum was still in effect as of March 16, 1993. U.S. Exh. 225; U.S. Exh. 635 (Sneed Dep.) at 21. The types of preventive measures that Dr. Sneed envisioned were necessary as a result of his memorandum were: moving a person to another living area, engaging a resident in counseling, or developing or revising a behavior program. U.S. Exh. 635 (Sneed Dep.) at 21, 23. Although Dr. Sneed's intent in issuing this memorandum was to ensure that State centers spell out steps they are taking to prevent a reoccurrence of any incident, he does not know if any steps were taken at Ebensburg. U.S. Exh. 635 (Sneed Dep.) at 20-21.

Two months after Dr. Sneed issued his directive to all facility directors, Debra S. sat down next to Sandra W., who turned and bit off a piece of Debra's nose. U.S. Exh. 477. The piece of nose that Sandra bit off was placed in saline and Mercy Hospital attempted surgery to repair the wound, but Debra's nose could not be restored. U.S. Exh. 477. At the time of the incident, staff were aware that Sandra had bitten five individuals, including 3

staff and 2 peers, in the past several weeks. U.S. Exh. 477. "Being that Debra can't defend herself against [Sandra]" and that "[Debra] is the one that [Sandra] goes after all the time," staff recommended that Debra be moved away from Sandra. U.S. Exh. 477. Sandra bit Debra again on July 31, 1991, November 4, 1991, April 23, 1992, and June 1, 1992. U.S. Exh. 267(c).

Shortly after the event involving Debra S., Dr. Sneed followed up with a specific request regarding two incident reports involving Ebensburg residents. U.S. Exh. 226. The first incident occurred at 7:30 a.m. on February 13, 1991, where Eileen G. was found bleeding from a two inch deep laceration on her scalp which required five sutures. U.S. Exh. 226 at 00002994. Staff were busy with morning care and "there was no witness to how Eileen hurt herself." Id. at 00002995. Four staff were back in the bedrooms and one staff was coming out of the bedroom. They speculated that Ruth J. pushed her because Ruth (Client #1152) was "pushing others down all morning." Id. at 00002994 and 00590470.[36]/ Despite Dr. Sneed's specific interest in Eileen G., Ebensburg did not take the types of steps that he envisioned as preventive measures. Eileen was not moved to a different living area and she continued to be victimized by Ruth and others. U.S. Exh. 360 (attached); U.S. Exh. 136 at 00003399. After six months of suffering a number of additional serious injuries from aggressive acts, Eileen was finally transferred to another living unit. U.S. Exh. 360. Her interdisciplinary team was concerned, however, that she would cause injuries to other residents in her new living unit. Id. Indeed, in the following seven months, her progress

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[36]/ Several months earlier, on December 12, 1990, Ruth was also the cause of an injury to Eileen where her eyebrow was lacerated and ethistrips had to be applied. U.S. Exh. 136 at 00003399.

notes document at least 23 instances of pushing, shoving, punching, slapping, and hitting other residents, knocking them to the floor from their wheelchairs, stepping on them, sitting on top of them, and pulling their arms and hair. U.S. Exh. 360.

The other incident in Dr. Sneed's memo involves George F. who bit James R.'s toe so hard on February 9, 1991 that he fractured it. Tr. 7/26/93 (Stark) at 144; U.S. Exh. 226. Dr. Sneed specifically requested Mr. Bellomo to examine the circumstances surrounding this incident and to respond by discussing the:

> program that has been designed to limit/ reduce his behavior. If such a program doesn't exist, have staff outline how the program will be developed and implemented (including target dates(s) for implementation). Our concern is the client will continue to bite (attack) other relatively defenseless individuals.

Mr. Bellomo never provided Dr. Sneed with a written response. Tr. 10/14/93 (Bellomo) at 134. In fact, despite Dr. Sneed's specific request in February 1991 for a behavior program with implementation dates, Ebensburg has yet to provide George with a behavior program to address his biting. Tr. 7/26/93 (Stark) at 144. The only action that Ebensburg has taken is to increase George's Haldol and, some sixteen months later, to begin taking data on George's biting behavior. U.S. Exh. 348. As was Dr. Sneed's specific concern, George has continued to bite a number of other Ebensburg residents. George has bitten or was suspected to have bitten at least 19 residents between March 1991 and March 1993. U.S. Exh. 348 (attached). He has bitten people on the thumb, arm, upper and lower back, and shoulder and continues to bite residents on their toes, feet, and ankles. In August 1992, George was suspected to have been the cause of Charles R.'s partially amputated toe tip which was discovered by staff when they found blood on Charles' sock with part of his toe, "jagged,

hanging, and cyanotic." Id. Charles had to be sent to the emergency room. In March 1993, the psychology services associate who works in Charles' living unit noted that he would complete a functional analysis on George's biting "within the next three weeks." Id.; U.S. Exh. 348(a). In fact, George did not have any type of behavioral evaluation until three months later. U.S. Exh. 348. The only recommendations to come out of the evaluation were: (1) collect behavior data; continue Haldol therapy; (2) frequent visual monitoring; and (3) redirection of behavior. Id.

James B. also frequently bites other Ebensburg residents. In the 19 months between February 1992 and August 1993, James B. (resident # 1102) bit other individuals living at Ebensburg on 24 different occasions. U.S. Exhs. 267(c), 926, 860.[37]/ Ebensburg's responses on occurrence reports to James' biting fail to address Dr. Sneed's directives that notations such as "closer observation or monitoring of the assault victim," and "isolated incident" are not sufficient; "instead, we need to know what's being done to prevent any subsequent assaults from occurring." U.S. Exh. 225. In occurrence report after occurrence report involving James B., staff simply report that "closer monitoring" is needed and "no further action" is required.[38]/ After James had bitten people 17 times in 15 months, staff's

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[37]/ On Ebensburg's computer summary of incident reports (U.S. Exhs. 135, 136), a pound sign (#) followed by a number in the column describing the incident represents the client number of the aggressor who caused the injury. Tr. 10/19/93 (O'Brien) at 52.

[38]/ See, e.g., the following occurrence reports in United States' Exhibit 267(c): 2/2/92 Inc. Rep. for Michael B. (try to keep him away from James B.; no further action at this time); 8/7/92 Inc. Rep. for Michael B. (keep James B. away; no further action); 8/20/92 Inc. Rep. for Michael B. (staff again reminded to intervene and separate James B. and Michael B.; no further action at this time); 10/21/92 Inc. Rep. for Michael B. (staff again instructed to keep James and Michael separated); 11/18/93 Inc. Rep. for Michael B. (no programming change indicated; no further action at this time); and 7/16/92 Inc. Rep. for Estelle M. (staff to continue to monitor; no further action at this time).

recommendation for prevention of recurrence on his occurrence report is "this was an isolated incident; although #1102 (James B.) has history of this behavior it is infrequently seen; continue current plan." U.S. Exh. 926 (5/17/93 Inc. Rep.).

Clifford P. is another example of Ebensburg's failure to take adequate action to address behaviors and protect residents despite heightened attention at the State level. Tr. 7/26/93 (Stark) at 147. The Pennsylvania Department of Public Welfare placed Ebensburg on a provisional license in 1990 as a result of the State's concern about how Ebensburg responded to sexual incidents, precipitated by Clifford's sexual behaviors towards other residents. Tr. 7/27/93 (Stark) at 66-67; U.S. Exh. 603 (Bellomo Dep.) at 112-114.[39]/ According to Mr. Bellomo, the State surveyors were "most concerned" about an incident, documented in Clifford's program, that he "molested" another resident. Id. Since 1990, Clifford has been found engaging in sexual activities on numerous occasions, including engaging in anal sex and "sniffing behavior." Tr. 10/14/93 (Bellomo) at 116. In its 1990 plan of correction to address the State's concerns about Clifford, Ebensburg promised to develop a comprehensive, individualized plan for him. U.S. Exh. 57 at 00004049. In fact, however, Ebensburg did not even develop a behavior program to specifically address Clifford's sexual behaviors until December 4, 1992 -- more than two years later despite the fact that Clifford's behaviors continued. U.S. Exhs. 440; 440(a) at 00390065; U.S. Exh. 780. For example, in August 1992, he was found laying on top of a resident who was naked, except for her bra. U.S. Exh. 440; U.S. Exh. 440(a) at 0076449. In September

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[39]/ This is not the only time that the Commonwealth has placed Ebensburg on a provisional license in the recent past. In 1991, the Commonwealth again placed Ebensburg on a provisional license. U.S. Exh. 1101. In the following year, State surveyors through the inspection of care process again had concerns about repeated deficiencies that Ebensburg failed to correct. U.S. Exh. 1101.

1992, Clifford's unit manager made a special request for help with Clifford: "We think he needs some counseling or teaching other than what we can offer. Can you arrange or help or advise?" U.S. Exh. 440(a) at 00200810. Mr. Bellomo reviewed this request. Tr. 10/14/93 (Bellomo) at 117-118. Clifford was not even assessed by a sexuality counsellor until January 1993 -- three and a half months later. U.S. Exh. 440. In the interim, Clifford was involved in at least seven sexual incidents with other Ebensburg residents. Id. Following Clifford's assessment, it took another two months to get a recommendation from the assessor. In the meantime, Clifford was found face down between another resident's rectal area. Both residents were naked. Id. When Clifford's interdisciplinary team received the recommendation from the assessment it took several weeks before the team actually met to discuss it. Tr. 10/14/93 (Bellomo) at 122; U.S. Exh. 440. The recommendation was that Clifford needed counselling. Id. This is the same recommendation that State surveyors had made two and a half years earlier and the Unit Manager again made some nine months earlier. Id.; Tr. 7/26/93 (Stark) at 67.[40]/ Clifford's team met on April 5, 1993 and planned a meeting with Mr. Bellomo to secure funding for counseling. U.S. Exh. 440; U.S. Exh. 440(a) at 00390216. Clifford's inappropriate sexual behaviors continued. U.S. Exh. 440. As of six months later, at trial on October 14, 1993, Mr. Bellomo still did not know whether the counselling had even started. Mr. Bellomo stated:

> Clifford had an appointment to see Dr. Farr -- it was either last week or within this next week. I mean it is scheduled. He is to -- he is going to State College to meet with Dr. Farr.

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[40]/ Mr. Bellomo specifically stated in deposition testimony read at trial that the State surveyors thought that "I needed to have counseling for people who were having difficulty with expressing their sexuality." Tr. 7/26/93 (Stark) at 67, lines 12-14.

[Q: So it hasn't take place yet; is that correct?]
A: No, not with Dr. Farr; or if it did, it just took place.

Tr. 10/14/93 (Bellomo) at 123, lines 1-6.

VI. EBENSBURG FAILS TO PROVIDE RESIDENTS WITH MEANINGFUL, PURPOSEFUL ACTIVITY IN BOTH THE LIVING ENVIRONMENT AND IN DAY PROGRAMS, RESULTING IN HARM.

Based upon his observations during his tour as well as his review of documents, Dr. Stark concluded that it is evident that a lot of the injuries occurring at Ebensburg are the result of behaviors that reflect boredom and a lack of stimulation and meaningful things to do. Tr. 7/26/93 (Stark) at 124. In a setting where individuals with mental retardation must co-exist with 23 other bored mentally retarded individuals, dangerous behaviors can develop. People can turn inward and develop self-injurious behaviors or they can turn outward and become aggressive. Id. Individuals also learn the maladaptive behaviors of others and imitate them because they have not learned more appropriate behaviors. Id. The development of these behaviors due to a lack of stimulation and meaningful things to do results, inevitably, in the pattern of harm that Dr. Stark has described. Id.; U.S. Exh. 575 (attached); see discussion supra § II, and infra § VI.B.[1]/

Defendants, including their psychology expert, do not dispute the existence of the pattern of harm. Defendant Nancy Thaler, the Director of the State Office of Mental Retardation, readily acknowledged that it is a commonly accepted principle that individuals with mental retardation are more likely to develop maladaptive behaviors if they are not provided with appropriate meaningful activities throughout the day. U.S. Exh. 870 (Thaler Dep.) at 55. Mr. Bellomo agreed that maladaptive behaviors are more likely to occur if individuals prone to such behaviors are congregated without meaningful things to do. U.S.

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[1]/ There are a greater number of incidents and injuries during times when clients at Ebensburg are on their living units without anything to do. Tr. 8/4/93 (Amado) at 66; U.S. Exh. 658.

Exh. 603 (Bellomo Dep.) at 116. In Dr. Reid's words, "[t]he more programming with meaningful activities that go on, generally the fewer accidents and injuries that occur." Tr. 9/16/93 (Reid) at 35. Dr. Reid agreed that maladaptive behaviors are usually reduced if individuals who are mentally retarded are engaged in meaningful activities. Tr. 9/16/93 (Reid) at 45.

A. Ebensburg's Living Environment Is Harmful.

Both Dr. Russo and Dr. Stark found that the concept that drives Ebensburg is the accomplishment of custodial care routines as opposed to the needs of individual clients. Tr. 8/2/93 (Russo) at 35-36; Tr. 7/26/93 (Stark) at 223. Dr. Russo found that the typical Ebensburg day consists of wake-up time, dressing time, medication time, waiting for the bus time, programming time, after programming time to sit around and wait for dinner, dinner time, medication time, and bathing time. Tr. 8/2/93 (Russo) at 35-36. Ebensburg's own documents confirm this finding. For instance, when Mr. O'Brien criticized the lack of activity at about 8:40 p.m. in Laurel House one night, the unit director defended the lack of activity by stating that 8:40 p.m. "is not program or activity time. This is bathing and medication time and treatment time." U.S. Exh. 180.

1. Ebensburg's Living Areas Are Barren And Lack Meaningful Activity.

All three of the United States' psychology experts agree that time spent by residents on the residential living areas at Ebensburg, where residents spend the vast majority of their day, is filled with idleness and boredom. Tr. 7/26/93 (Stark) at 124; Tr. 8/2/93 (Russo) at 32; Tr. 8/4/93 (Amado) at 57. Dr. Stratton, the head of Ebensburg's psychology department, also admits that Ebensburg's environment sometimes leads to boredom and

frustration. U.S. Exh. 640 (Stratton Dep.) at 216. During his tours of Ebensburg, Dr. Russo observed barren living areas; living areas with insufficient or inappropriate materials or activities; and living areas with very insufficient staff interaction, programming and services. Tr. 8/2/93 (Russo) at 32. Dr. Russo repeatedly observed:

> [E]nvironments of care where clients were perpetually in a waiting state. They were waiting to go to bed. They were waiting to go get their medicines. They were waiting to be fed. They were waiting to be bathed. What waiting meant is that of the twenty-four individuals typically assigned to one side of one unit at Ebensburg, the great majority of them would be in this large open day room with little in the way of activities or materials for very significant parts of their day.

Tr. 8/2/93 (Russo) at 32, lines 15-23. Dr. Stratton admitted that a fair amount of time on the living areas at Ebensburg is waiting time -- waiting for medications, waiting to go to meals, waiting to go to programs. U.S. Exh. 640 (Stratton Dep.) at 217. Dr. Stratton further admitted that behavior programs will not be effective if there is not some meaningful activity that takes place throughout the day. Id. at 37-38.

Dr. Russo memorialized this lack of activity on a videotape, taken on September 23, 1992, and entered into evidence as United States' Exhibit 260, which represents what Dr. Russo typically saw as he toured Ebensburg day after day. Tr. 8/2/93 (Russo) at 86. The videotape shows day rooms full of clients with nothing going on and staff rarely in evidence. On the tape, clients typically sit by themselves, in isolated and self-stimulatory or self-abusive activity, with staff wandering around providing little or no interaction with the residents, and with no meaningful activities occurring. Tr. 8/2/93 (Russo) at 82-89. The materials cabinets in the day rooms are sometimes closed and inaccessible even when all 24 individuals are present on the living unit, Tr. 8/2/93 (Russo) at 89, and when the cabinets

are open, they are rather barren with many broken toys and other age inappropriate materials that clients seldom use. When clients use the toys, toys are used as self-stimulatory objects, instead of for their intended functions. Tr. 8/2/93 (Russo) at 83-84.

Ebensburg contemporaneously memorialized and confirmed the levels of inactivity that Dr. Russo observed in the fall of 1992. Tr. 8/2/93 (Russo) at 84. For instance, United States' Exhibits 179 and 180 are memos written by Mr. O'Brien the day following his tour with Dr. Russo on October 22, 1992. Tr. 8/2/93 (Russo) at 34. In United States' Exhibit 179, Mr. O'Brien confirms that at about 8:00 p.m. at Sunset House on September 22, 1992, in three of the four units, the touring party observed "nothing going on," "lack of materials," and "no materials out." In Exhibit 180, Mr. O'Brien confirms that at about 8:40 p.m. at Laurel House on September 22, 1992, in two of the four units, there were "no materials," "nothing was happening," and "clients milling around." On West II of Laurel House, there were no materials and a staff person was "guarding the door." U.S. Exh. 180.

Time and time again on the living areas, Dr. Amado also saw lack of materials and people milling around, pacing, sleeping, sitting, staring into space, self-stimulating, or becoming aggressive. Tr. 8/4/93 (Amado) at 57. At trial, Dr. Amado read from his dictated 1992 notes regarding his observations of a living area at Sunset House one evening. On that evening at about 8:00 p.m., Dr. Amado observed 22 residents sitting or walking around in a day room barren of materials and with no activities whatsoever being offered during what was supposed to be structured leisure time. Tr. 8/4/93 (Amado) at 63-64. While Mr. Bellomo was in Laurel House on August 18, 1992 during one of Dr. Amado's tours of Ebensburg, Mr. Bellomo was not satisfied that the individuals in West II were

engaged in adequately meaningful activity. U.S. Exh. 601 (Bellomo Dep.) at 160. Dr. Amado found that the few activities provided to residents at Ebensburg are insufficient, not of interest to the residents, and do not comport with generally accepted standards in the field. Tr. 8/4/93 (Amado) at 72.

In Dr. Reid's words, "[t]here's certainly room for improvement" in the degree to which individuals at Ebensburg are involved in meaningful activities. Tr. 9/16/93 (Reid) at 11. Dr. Reid agreed with the United States' experts that there are certainly times when individuals at Ebensburg are not engaged in meaningful activities. Tr. 9/16/93 (Reid) at 12. Dr. Reid took data that supports the United States' experts' findings that there is little activity on the living areas at Ebensburg. For instance, in February 1993, Dr. Reid found that individuals on their living areas in the Sunset, Horizon, and Laurel Houses were engaged in meaningful activities only 10.6% of the time. U.S. Exh. 959.[2]/ Dr. Reid admitted that during his tours at Ebensburg, he observed some living units at Ebensburg that did not have sufficient materials to stimulate clients. Tr. 9/16/93 (Reid) at 95.[3]/

Dr. Stratton and State surveyors agree that the lack of materials is a common problem at Ebensburg. U.S. Exh. 640 (Stratton Dep.) at 216, U.S. Exh. 794. During the November 1992 Medical Assistance survey of Ebensburg, Mr. Bordner, one of the surveyors, was

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[2]/ Dr. Reid's figures are misleading in that they only measure individuals engaged in an activity with an apparent purpose with an age appropriate material. Tr. 9/16/93 (Reid) at 65. Dr. Reid concedes that there is a great deal more to active treatment than merely carrying out an activity with an apparent purpose. Tr. 9/16/93 (Reid) at 69. Dr. Reid made no effort to determine whether the activities he observed on the living units had any relation whatsoever to an individual's skills training programs. Tr. 9/16/93 (Reid) at 65-66.

[3]/ In spite of his data and observations, Dr. Reid concluded that the level of meaningful activity on the living areas was "acceptable in regard to what's realistic and what goes on in service settings. I think there could be more, but, yes, I found it acceptable." Tr. 9/16/93 (Reid) at 38-39.

particularly concerned with the lack of equipment in the living areas. U.S. Exh. 605 (Bordner Dep.) at 222; Tr. 12/13/93 (Bordner) at 219-220. Ebensburg was cited for its failure to provide adequate materials on the living areas. U.S. Exh. 794. When the MA surveyors went back to Ebensburg in October 1993, they again found inadequate materials on the living areas throughout the facility. U.S. Exh. 1103 at 7. Mr. Bordner characterized this deficiency as systemic. Tr. 12/13/93 (Bordner) at 218-219. Finding insufficient materials on the living areas at Ebensburg in 1993 again raised special concerns for Mr. Bordner. Id. at 218. Mr. Bordner was very concerned with the lack of materials at Ebensburg because if materials were provided, "individuals could engage their minds in some productive activity as opposed to whiling away their time doing nothing." Id. at 218, lines 20-22. Dr. Stratton admitted that there are not sufficient materials to stimulate individuals in all areas of Ebensburg. U.S. Exh. 640 (Stratton Dep.) at 216.

Surveyors from the Association of Retarded Citizens ("ARC") have also documented inadequate activities on the living areas. For instance, in June 1992 on Villa, between 4:00 and 6:00 p.m., residents were "waiting for dinner." U.S. Exh. 934 at 521156. On Sunset at 5:30 p.m., the surveyors observed "everyone just sitting around, lying down, wandering. No program materials visible. 4 residents inside dayroom unattended. Very little staff/resident interaction." Id. at 521158. The surveyors recommended that Ebensburg provide more structured activities between 4:00 and 6:00 p.m. They recommended that Ebensburg "brainstorm as to how to create more activities which would develop and encourage staff/resident interaction. Surely there are things that can be done." Id. In closing, the ARC surveyors stated that "there might be residents who would like to do

something other than wandering, sleeping, or sitting around if interesting activities were developed." Id. at 521159.

Ebensburg Unit Managers have echoed the same types of deficiencies in their own living units. For example, in October 1992, Mr. Seymour, the Unit Manager of Laurel House wrote that clients and staff were "bored and uninspired" by the activities available on the living areas during the afternoon and evening and that more organization of activities was needed during this time. U.S. Exh. 194. As of his deposition two months later on December 4, 1992, Mr. Seymour still was not satisfied that there are sufficient activities for Laurel House residents during the evening hours until they go to bed. U.S. Exh. 631 (Seymour Dep.) at 61. Six months earlier, in June 1992, Diana D., a Laurel House resident who lives in West II, was found missing from her living unit in the evening. U.S. Exh. 594(a). West II is the same living area where Mr. Bellomo was dissatisfied with the lack of meaningful activity in August 1992 and where Mr. O'Brien found no materials and a staff person guarding the door in September 1992. U.S. Exh. 180; U.S. Exh. 601 (Bellomo Dep.) at 160. At the time that Diana was thought to have left West II, one staff person was on a supper break, one (who was not regularly assigned to the area) was in the bath area, and two staff were involved with a client who was choking other residents. A half hour later, Diana was found sitting in a staff person's car, reading a memo. Her occurrence report notes that she has eloped frequently and the reason she elopes is because she is looking for a quiet place to look at a book or magazine which "is nearly impossible" to do on West II because of the aggression of other residents. U.S. Exh. 594(a) at 50177. A staff person who has known Diana over the years recommends moving her to "a quieter, more

peaceful ward." Id. She remained on West II, however, and in March 1993, a number of months after Mr. Bellomo, Mr. O'Brien, and Mr. Seymour all had specifically acknowledged the lack of activity on West II in Laurel House, Diana D. again left her living area. U.S. Exh. 594. This time, a local citizen found her walking down Route 160 without a coat. Id. at 590695. Four of the staff who were on duty at the time that Diana left agreed that she leaves to find books or magazines, which she cannot have on West II because of the behaviors of other residents who steal them and aggress against her when she attempts to sit quietly looking at magazines. U.S. Exh. 594 at 590688-92. The same staff person who had recommended that Diana be moved nine months earlier again recommended that "she needs to be placed in a quieter living area where she would be able to sit undisturbed and look at books and magazines." U.S. Exh. 594.

2. Lack Of Meaningful Activity Is Particularly Acute In Keystone House.

The videotape that Dr. Stark used during his direct testimony illustrates the lack of activity on living units in Keystone. Tr. 7/26/93 (Stark) at 159-169; U.S. Exh. 262.[4]/ There is a lack of staff interaction, and nothing for residents to do so they sleep, withdraw, and resort to self-stimulation. Tr. 7/26/93 (Stark) at 169-179. Most of the residents are down on the floor, grouped together on mats. Dr. Stark described these scenes of Keystone residents as "very disturbing." Tr. 7/26/93 (Stark) at 164. At one point, Michael F. maneuvers himself off of the mat and there are no staff present. Tr. 7/26/93 (Stark) at 165. When a staff person finally comes over, he jiggles a mirror in front of Michael and then

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[4]/ Dr. Stark selected portions of the videotape taken by the FBI photographer of Keystone residents during the afternoon in August and November 1992. Tr. 7/26/93 (Stark) at 155-156. The scenes depicted on the videotape represent the same types of scenes that he observed during his February 1993 tour. Tr. 7/26/93 (Stark) at 164-165.

pretends to be shooting him with a gun. Later, the staff person returns with a fly swatter. Tr. 7/26/93 (Stark) at 165. His interaction with the residents consists of swatting flies off of them. Tr. 7/26/93 (Stark) at 165.[5]/ On the videotape, another Keystone resident's head is sandwiched between vinyl bean bags. No one makes an attempt to reposition or move him. Tr. 7/26/93 (Stark) at 166. Other residents are on an air mattress. The one resident who is receiving attention from a staff person is responding. Tr. 7/26/93 (Stark) at 167. Tim P. is in his cart, staring at the ceiling. Dr. Stark found that Tim's "world is the ceiling." Tr. 7/26/93 (Stark) at 168. His fellow residents are also not receiving any staff interaction and are self-stimulating for sensation and to entertain themselves. Tr. 7/26/93 (Stark) at 168. One resident is completely doubled over in a chair in a fetal position. Tr. 7/26/93 (Stark) at 169. In footage taken in August 1992 in another area in which there are Keystone residents, a client is pounding on a screen. When Dr. Stark returned six months later, the same person was at the same window, doing the same thing. Tr. 7/26/93 (Stark) at 167.

Data collected by Dr. Reid regarding activity on the Keystone living units supports Dr. Stark's observations. In February 1993, Dr. Reid found that individuals on their living areas in Keystone House were engaged in meaningful activities only 1.3% of the time. U.S. Exh. 959. Dr. Reid testified that materials were particularly insufficient on units that served non-ambulatory clients. Tr. 9/16/93 (Reid) at 95.

Mr. Bellomo admits that ARC surveyors have had concerns about the lack of activity and staff interaction at Keystone. Tr. 10/15/93 (Bellomo) at 27. For example, in December

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[5]/ Mr. Bellomo admits that he was "very concerned" when he saw this on the video. "It is clearly not what we expect in terms of interactions." Tr. 10/13/93 (Bellomo) at 154.

1992, ARC surveyors observed little staff/client interaction in Keystone in the afternoon. U.S. Exh. 1027 at 2; Tr. 10/15/93 (Bellomo) at 27. For instance, in East I, 22 residents were either flat in carts or on mats on the floor and some residents were sleeping but others were not. Surveyors were told that this was "change of position time." Id. ARC told Ebensburg that "this would be a time when staff really should be engaged in playing with, or reading to, or listening to an audio tape with the individuals." Id. ARC further recommended that Ebensburg implement the system for programming physically involved clients that has been adopted at the Altoona Center, where Mr. Bellomo is also facility director. Id.; Tr. 10/13/93 (Bellomo) at 130. Specifically, ARC recommended that Ebensburg adopt the Altoona Center model of small groups with specific programs. Id.

Mr. Bonfanti made rounds in Keystone in late April 1992 and was "upset" and "furious" with the lack of staff interaction in the living unit for which he is responsible. U.S. Exh. 604 (Bonfanti Dep.) at 104-105. In his own words:

> frankly I didn't find a whole heck of a lot of stuff going on. And to say the least, I was a little upset when I wrote this memo [U.S. Exh. 604 (Bonfanti Dep.) Exh. 7 requiring supervisors to make rounds]. I found that no supervisors were in the area [Correction sheet at 7]. I found very little staff interaction. I was furious. I met with them and what you would have expected me to say, I did say; and I then came out with the memo to let them know that I was quite upset.

U.S. Exh. 604 (Bonfanti Dep.) at 104, lines 23-25; 105, lines 1-5. He found that when the supervisors are not out in the living areas, the staff are not doing anything; they are "sitting and doing nothing." U.S. Exh. 604 (Bonfanti Dep.) at 105, line 17. Ms. Domino, who serves as a supervisor at Keystone, confirms that she has observed situations where instead

of staff interacting with Keystone clients as they should be, staff have been involved with putting clothes away and paperwork. U.S. Exh. 609 (Domino Dep.) at 22.

Mr. Bellomo admits that the number of recreational activities is limited for people who live on Keystone. Tr. 10/15/93 (Bellomo) at 31-32. Although Joe T. "appears to enjoy most activities," the recreation worker assigned to his unit notes in his "recreation participation review" for an entire year, from July 1992 to July 1993, that the sum total of Joe's activities consisted of "3 unit dances, 8 birthday parties, 2 VCR movies, 1 day camp, 1 halloween party, and was entertained by volunteers twice." U.S. Exh. 1017.

3. Ebensburg's Living Environment Fails To Meet Accepted Professional Standards.

In sharp contrast to the lack of meaningful activities and lack of stimulation in the living areas at Ebensburg, the field of mental retardation, in general, and the Commonwealth's and Ebensburg's policies, in particular, require that facilities provide an environment "conducive to therapeutic change." Tr. 8/2/93 (Russo) at 31; Tr. 7/26/93 (Stark) at 151; U.S. Exh. 30 at 7. Such an environment is important first and foremost because it reduces risk of harm and actual harm to individuals, and secondarily because it provides an opportunity for growth and development of new skills. Tr. 8/2/93 (Russo) at 31-32. The development of a positive appropriate environment is one of the most important things that a caregiver can do to reduce maladaptive behaviors and reduce the risk of harm. Tr. 8/2/93 (Russo) at 29. An environment that offers richness of appropriate activities,

materials, and goals to facilitate progress and the development of the individual basically also serves to reduce the likelihood of maladaptive behavior. Tr. 8/2/93 (Russo) at 29.[6]/

Dr. Reid acknowledged that when individuals are not engaged in any type of activity, their environments are not therapeutic as required by the Commonwealth's 1988 Statewide Behavior Management Policy. Tr. 9/16/93 (Reid) at 94. Dr. Reid observed individuals at Ebensburg not engaged in activities, and therefore the environment at Ebensburg is not therapeutic during those times. Tr. 9/16/93 (Reid) at 94. Dr. Stratton admitted that the environment in the living areas at Ebensburg is not always positive and empathic. U.S. Exh. 640 (Stratton Dep.) at 216. He also admitted that there are times when the environment in the living areas is not therapeutic and supportive for the people who live there. U.S. Exh. 640 (Stratton Dep.) at 216.

4. Ebensburg's Living Environment Is Contributing To Residents' Maladaptive Behaviors.

Dr. Amado concluded that Ebensburg's living environment is so inadequate that its residents suffer intellectual harm, social harm, and emotional harm. Given the lack of materials and appropriate activities, residents fill the void by engaging in repetitive and purposeless self-stimulation, and, even worse, by abusing themselves or others. Tr. 8/4/93 (Amado) at 72. Dr. Stratton admitted that the environment in the living areas at Ebensburg contributes to maladaptive behaviors, including aggression and self-injurious and self-

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[6]/ The literature suggests, for example, that where an individual is engaging in pica for self-stimulation, the pica behavior will often decrease merely by enriching the environment. Tr. 8/2/93 (Russo) at 106. Mr. Bellomo agrees. With regard to pica, he states, "I don't think anyone would dispute the fact that being busy has a tendency to mitigate some of that behavior." Tr. 10/14/93 (Bellomo) at 15, lines 8-10. He adds that "I believe that being engaged in functional, appropriate, meaningful kinds of activities do, in fact, reduce the possibility of pica." Id. at 12-15.

stimulatory behaviors, for some individuals at Ebensburg. U.S. Exh. 640 (Stratton Dep.) at 216-217.

Ms. Degretto, who is the Unit Manager at Villa, also agreed that dangerous behaviors and injuries occur when residents are on the living unit with nothing to do. She has found that when staff interact with clients, aggression is usually lessened. U.S. Exh. 607 (Degretto Dep.) at 124. For example, she identified Terry M. as one of the individuals who causes the most injuries in Villa -- mainly by throwing chairs. She has found that "keeping Terry busy" reduces his aggressive behavior. U.S. Exh. 607 (Degretto Dep.) at 168-170. She further cited another Villa resident who was both aggressive and self-abusive. When staff gave him some specific things to do between 4:00 and 4:30 p.m., it led to a reduction in his behaviors. U.S. Exh. 607 (Degretto Dep.) at 123. At the November 1992 annual review of Winfield M., another Villa resident, his interdisciplinary team noted that his injury rate decreases when he is busy and that unstructured time leads to his maladaptive behavior. Tr. 8/4/93 (Amado) at 71. Veedia H., another Villa resident, was restrained 87 times for her behavior between January 1, 1992 and July 28, 1993. U.S. Exh. 993. Only 17 of these 87 restraints occurred during a weekday between the hours of 10:00 a.m. and 3:00 p.m., the hours that Ebensburg provides day programs. Thus, fully 70 out of 87 incidents of restraint for Veedia occurred during non-program time. U.S. Exh. 993.

These same themes are echoed by other Ebensburg staff. For example, in September 1992, an Ebensburg supervisor on Horizon concluded that clients need to be involved in more productive activities in their living areas after a client grabbed Albert K.'s wheelchair

and tipped him backwards. U.S. Exh. 589 at 4. Albert fell to the floor, striking his head, and was unconscious for 8-10 minutes. U.S. Exh. 589 at 4; U.S. Exh. 589(a).

State surveyors have also been critical that Ebensburg fails to provide any meaningful activity during significant portions of the day, including periods before, during, and after medication administration. U.S. Exh. 794. For example, during October 1991, State surveyors observed Villa clients not doing anything between 3:30 p.m. and 4:00 p.m. U.S. Exh. 794 at 3. The surveyors observed clients standing around a table trying to self-initiate activities but staff prohibited them from using any leisure materials until "after the nurse gave medications." Medications were not even scheduled to be given until 4:15 p.m. U.S. Exh. 794 at 3. Ebensburg's Director of Nursing does not see any reason from a nursing perspective why residents should have to sit and wait without anything to do while medications are being given. U.S. Exh. 637 (Sponsky Dep.) at 85. The problem of ceasing all activities during medication administration time continued at Ebensburg, however, even after State surveyors had specifically cited it as a deficiency. For example, on April 29, 1993, staff stopped residents from using recreational materials during the afternoon medication time. Staff physically removed materials from the clients and placed the materials on top of a closet so that residents could not use them while staff were involved with medication administration. Albert K. attempted to reach the materials and toppled sideways in his wheelchair, lacerating his head. U.S. Exh. 589.

B. Ebensburg Fails To Provide Residents With Adequate Training Programs.

1. Acquiring Skills Enables Individuals To Protect Themselves From Harm And Become Independent.

It is commonly accepted in the field that every individual who is mentally retarded has the capacity to learn, no matter how severely impaired. Tr. 7/26/93 (Stark) at 41-42; Tr. 8/2/93 (Russo) at 31-32, 37; Tr. 8/4/93 (Amado) at 77; U.S. Exh. 593. Defendant Nancy Thaler agrees that every individual with mental retardation has the capacity to learn and the potential for growth and development. U.S. Exh. 870 (Thaler Dep.) at 53. See discussion on the developmental principle § II. The Commonwealth has not provided Ebensburg residents with the basic opportunity to learn, grow, and develop. Tr. 7/26/93 (Stark) at 151; Tr. 8/2/93 (Russo) at 32; Tr. 8/4/93 (Amado) at 77.

There is universal agreement among the United States' three psychology experts, the Commonwealth's psychology expert, and defendants, themselves, that a failure to provide adequate training programs to people with mental retardation inevitably leads to harm and denies them the opportunity to become as independent as possible. Tr. 7/26/93 (Stark) at 53-55; Tr. 8/2/93 (Russo) at 37; Tr. 8/4/93 (Amado) at 13, 16; Tr. 9/16/93 (Reid) at 35, 45; U.S. Exh. 870 (Thaler Dep.) at 55; U.S. Exh. 640 (Stratton Dep.) at 37-38; U.S. Exh. 628 (Ratchford Dep.) at 92-93. Dr. Stark explains this "pattern of harm," as it manifests itself at Ebensburg, as follows: Where mentally retarded people spend day after day inactive in a non-stimulating environment where they are not learning adaptive skills, they get bored.[7]/

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[7]/ Adaptive skills are skills that are useful and necessary to function in society. Tr. 8/4/93 (Amado) at 19-21. They include communication, self-care, home living, social skills, community use, self direction, health and safety, functional academics, leisure, and work. Tr. 7/26/93 (Stark) at 52-53; U.S. Exh. 574.

Without meaningful activity, they may withdraw, engage in self-stimulation, or become frustrated and angry. This, in turn, can lead to escalating incidents of self-injurious behaviors, aggressive or assaultive behaviors, and a loss of skills or regression. The resulting harm includes bodily injury from dangerous behaviors, chemical restraints to control behaviors, and physical and mental deterioration, including an inability to care for oneself. Tr. 7/26/93 (Stark) at 53-55; U.S. Exh. 575 (attached). Dr. Amado agrees with this progression of harm as formulated by Dr. Stark and further explains that the opposite of the pattern of harm is a phenomenon called "learning to learn." Tr. 8/4/93 (Amado) at 16, 95. When residents are engaged in a program and are successful in the program, they experience the satisfaction of achievement and tend to become more and more interested in learning and being involved in training programs. This enables them to achieve all that they are capable of achieving. Tr. 8/4/93 (Amado) at 95-96.

Dr. Amado described how the pattern of harm also affects staff, because when staff are repeatedly ineffective and unsuccessful in trying to teach skills or in trying to change behaviors, this leads to inactivity, boredom, withdrawal, self-stimulation, frustration and anger. Tr. 8/4/93 (Amado) at 17. See also § V.C.2.d. discussing Mr. Tackett's and Ms. Hebenthal's testimony about Ebensburg staff exhibiting these behaviors towards residents. Dr. Stark agrees that staff at Ebensburg suffer from apathy because of a lack of knowledge and lack of purpose. Tr. 7/26/93 (Stark) at 223. In particular, Dr. Stark described the "lack of hope and indifference" among staff that he encountered while at Ebensburg. Id. Dr. Stark attributed this attitude, in large part, to the fact that because Ebensburg residents are not moved out into the community, staff begin to feel that it is easier and quicker to take

care of residents' needs "without training them and teaching them how to take care of their [own] needs because they're not going to go anywhere." Id., lines 14-16.

The field, in general, and the Commonwealth's 1988 Statewide Behavior Management Policy, in particular, require Ebensburg to provide comprehensive training plans to meet the individualized needs of the people who live there. Tr. 7/26/93 (Stark) at 152; Tr. 8/2/93 (Russo) at 42; Tr. 8/4/93 (Amado) at 13-14; U.S. Exh. 30 at 8. Dr. Reid agreed that the purpose of residential programs for people with mental retardation is to provide individualized, goal-directed training that is integrated throughout the day in all environments. Tr. 9/16/93 (Reid) at 43-44. Dr. Reid further agreed that the mission of residential facilities is to help the client reach his or her optimal level of functioning. Tr. 9/16/93 (Reid) at 45. Indeed, Ebensburg has identified its mission as assisting residents in achieving their "maximum functioning." U.S. Exh. 11.

Instead of accomplishing this mission, residents have regressed under Ebensburg's care. Tr. 8/4/93 (Amado) at 16. For example, before being institutionalized in facilities run by the Commonwealth, James W.'s mother testified that James could see, and he was active and healthy. James bathed himself, combed his hair, and put on his shoes. He possessed all of his self-care skills. Tr. 7/26/93 (Weakland) at 187-188. Before being institutionalized, James could also speak in about three word sentences. Tr. 7/26/93 (Weakland) at 188. James was first institutionalized at Cresson Center in Pennsylvania. When Cresson closed, James was transferred to Ebensburg. At that time, James still possessed all of his self-care skills, could still talk, could still see, and was still active and healthy. Tr. 7/26/93 (Weakland) at 189. Since moving to Ebensburg, James has lost the ability to perform most

self-care skills. Tr. 7/26/93 (Weakland) at 190. Since moving to Ebensburg, James has also lost his ability to communicate with words. He now only speaks a "very few words." Tr. 7/26/93 (Weakland) at 190.

Every individual at Keystone does not have a self-care program. U.S. Exh. 604 (Bonfanti Dep.) at 109. Staff only spend five to ten minutes interacting with Keystone clients with self-care skills. U.S. Exh. 609 (Domino Dep.) at 46. Individuals who are on self-care programs at Keystone do not experience significant progress on the programs and often they have to be "backed up" on the programs because they are not meeting expected goals. U.S. Exh. 604 (Bonfanti Dep.) at 109-110. Ms. Domino, who is a supervisor and Qualified Mental Retardation Professional ("QMRP") on Keystone, also could not point to any real success stories for anyone in Keystone. She could only think of "individuals who have made progress and then have gone back again." U.S. Exh. 609 (Domino Dep.) at 48.

2. Ebensburg Fails To Develop And Implement Training Programs.

All three psychology experts for the United States found that Ebensburg is failing to provide training plans that comport with acceptable professional standards and that this failure substantially departs from generally accepted practices in the field. Tr. 7/26/93 (Stark) at 151-152, 162-163; Tr. 8/2/93 (Russo) at 38, 42; Tr. 8/4/93 (Amado) at 22-23. In contrast to the United States' experts who focused on the issue of training, Dr. Reid did not evaluate this area. He was told by Ebensburg that Ebensburg had overall training plans. He relied on this representation and did not take it upon himself to verify this by reviewing any such plans. Tr. 9/16/93 (Reid) at 94. At best, he may have looked at one skill or vocational or leisure training program as part of his evaluation at Ebensburg. Tr. 9/16/93 (Reid) at 66.

Dr. Reid did not review the toileting, bathing, dressing, or grooming skills programs for anyone at Ebensburg. Tr. 9/16/93 (Reid) at 93.

a. Ebensburg Is Not Implementing Its Own Requirements To Provide Training.

Since 1986, Ebensburg policy has required staff to provide at least five hours of professionally developed training programs for each resident off of their living units. Tr. 7/26/93 (Stark) at 152; U.S. Exh. 28. These are the programs during the day where residents are supposed to be learning adaptive skills.[8]/ The hours that individuals at Ebensburg are scheduled to be engaged in day programs are not filled with appropriate learning activities. Instead, Dr. Amado found that individuals typically receive only about fifteen to twenty minutes of actual training programs during the five hour period, and spend the remainder of the time with nothing to do. Tr. 8/4/93 (Amado) at 15. Dr. Stark also found that the amount of actual meaningful programs and staff interaction occurring throughout the facility was actually minutes, not hours. Tr. 7/26/93 (Stark) at 169. This was a "major concern" of his. Tr. 7/26/93 (Stark) at 152, 169.

At trial, Dr. Amado read from transcribed notes dictated during his review of day programming for Laurel House clients in 1990 and in 1992. On each occasion, even though there were staff available to work with the clients, the great majority of residents from Laurel House were sitting around doing nothing during Dr. Amado's observations. Tr.

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[8]/ Adaptive skills include such programs as occupational therapy, self-care, workshop, pre-vocational, and communication. Tr. 7/26/93 (Stark) at 52-53; U.S. Exh. 574. Programs teaching these skills are known as and referred to in the field, at Ebensburg, and in testimony as "habilitation," "training," "programming," and "active treatment." For purposes of clarity and ease of reference, they will be referred to herein as "day programs" and "training programs." They are distinguished from "behavior programs" which address a particular maladaptive behavior.

8/4/93 (Amado) at 60-63.[9]/ The videotape taken during Dr. Russo's tour of Ebensburg documents clients in day programs at Harmony Learning Center, sitting and engaging in self-stimulatory rituals, with no meaningful activities going on. Tr. 8/2/93 (Russo) at 85.

The lack of activity in Ebensburg day programs has been corroborated by Ebensburg administrators. For example, during Dr. Amado's tour on August 18, 1992, Mr. Bellomo observed that at 2:20 p.m. in the JFK Learning Center, "there is a lack of activity." U.S. Exh. 197. During his tours of program areas, David Devine, who is in charge of residential services at Ebensburg, frequently observed a lack of meaningful interaction between staff and residents during day programs. For instance, in Heritage House on September 14, 1992, Mr. Devine observed "JB sleeping on a couch and individuals milling about not fully involved in programming. JS was displaying very disruptive behavior which affected the whole program area." Mr. Devine noted that it was "questionable whether we would have met standards for Title XIX." U.S. Exh. 100. On September 16, 1992 in the pre-vocational area of JFK, Mr. Devine found that the "program lacked direction and seemed as if RSA's were waiting for the next scheduled activity to occur, which was toileting prior to the lunch time meal." U.S. Exh. 214. Again, he concluded that it was "questionable" as to whether Ebensburg was meeting Title XIX standards. Id. In Laurel House programs also on September 16, 1992, Mr. Devine found clients who were sitting unattended and uninvolved. Id. During his tour of Harmony House Learning Center on September 30, 1992, Mr. Devine observed several individuals sleeping and "no meaningful interaction" during their

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[9]/ Dr. Amado also found that the relatively high rate of incidents and injuries that occur even during day programming hours also suggests that people are not fully engaged during day programs at Ebensburg. Tr. 8/4/93 (Amado) at 66-67.

day programs. U.S. Exh. 212. A lack of staff interaction is unacceptable to Mr. Devine. In his own words: "There needs to be staff interaction with individuals. That's what we're here for." U.S. Exh. 608 (Devine Dep.) at 257, lines 7-8. Mr. Devine stated that Ebensburg management needs to provide alternate activities, and "fully explain and train staff as to what needs to be done." U.S. Exh. 212. A staff person working in the Harmony House Learning Center was on overtime and did not know the individuals nor their behavioral characteristics. U.S. Exh. 212. Mr. Devine admitted that it is important that staff know the individuals with whom they are working in program areas. U.S. Exh. 608 (Devine Dep.) at 261.

The Unit Managers whom Mr. Devine supervises also agree that Ebensburg residents are not receiving the level of training that they should be receiving. Mr. Seymour, the Unit Manager at Laurel House, is not satisfied that all individuals who live there are involved in functional, purposeful and useful activities at the hour-and-a-half they spend at both their morning and afternoon day programs. U.S. Exh. 631 (Seymour Dep.) at 62, 73, 75. He has also identified a need for additional materials in order to ensure appropriate socialization and interaction. U.S. Exh. 631 (Seymour Dep.) at 64-65. Mr. Weimer, the Unit Manager of Sunset House, admitted that individual training programs take "very little time" to implement. U.S. Exh. 642 (Weimer Dep.) at 112-113. He further admitted that only those particular residents with whom staff are working at any given time are actually receiving training. U.S. Exh. 642 (Weimer Dep.) at 112-113. Mr. McGuire, the Unit Manager of Horizon House, is frustrated that residents are not receiving more functional programs. U.S. Exh. 623 (McGuire Dep.) at 46. Given the current level of staffing, Horizon is not able to

implement small group programming to Mr. McGuire's satisfaction. U.S. Exh. 623 (McGuire Dep.) at 50. He is also not satisfied with the level of individualized attention from staff during programming time. U.S. Exh. 623 (McGuire Dep.) at 53. Training programs at Ebensburg are generally provided in groups of eight. U.S. Exh. 603 (Bellomo Dep.) at 113. Mr. Bellomo thinks that the groups should be smaller. U.S. Exh. 603 (Bellomo Dep.) at 113. Dr. Stratton admitted that contrary to Ebensburg's policy, the environment in day programs at Ebensburg is not always therapeutic, positive, and supportive. U.S. Exh. 640 (Stratton Dep.) at 216-217.

In her day and a half with the clients at Ebensburg, Ms. Hebenthal did not see any programming going on. Tr. 8/3/93 (Hebenthal) at 213. During the hours Ms. Hebenthal spent at programming in a house with an oven and a microwave, staff made no attempt to teach clients cooking skills. Tr. 8/3/93 (Hebenthal) at 213-214. Instead, staff sat in the kitchen, made themselves a cup of coffee, shut the partition doors, and left the clients in other parts of the house, not learning anything. Tr. 8/3/93 (Hebenthal) at 214.

Dr. Reid testified that the level of activity in Ebensburg day programs is about average, when compared to other institutional facilities and community-type agencies. Tr. 9/16/93 (Reid) at 11.[10]/ However, Dr. Reid did not testify to what those levels actually

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[10]/ Dr. Reid was comparing levels of activity to certain norms he has developed over the years. Dr. Reid admits that the facilities where Dr. Reid collected his data to form his normative sample were not randomly selected, and he cautions that conclusions based on his studies must be qualified because his sample was not random. Tr. 9/16/93 (Reid) at 58. Further, although Dr. Reid claims that he compared Ebensburg's day programs to other community programs, the only community programs in Dr. Reid's sample are located in North and South Carolina. Id. at 162. Finally, the norms against which Dr. Reid compared Ebensburg include data from institutions that were not certified by HCFA, institutions that had been sued by the Department of Justice for civil rights violations, and institutions where active treatment services had been found to be unconstitutional by the federal court. Id. at 50, 55-56.

were until it was brought out on cross-examination. In February 1993, Dr. Reid found that individuals in day programs at Ebensburg were engaged in an activity with a purpose with an age appropriate material only about 31% of the time. U.S. Exh. 962.[11]/

b. Ebensburg Has Known About Its Failure To Provide Adequate Training Since At Least 1987.

State surveyors have repeatedly cited Ebensburg for its failure to provide continuous active treatment during day programming since at least 1987. U.S. Exh. 792. Beginning in 1989, Title XIX regulations were revised to require that each client must be involved in a continuous active treatment program consisting of needed interventions.[12]/ For the four year period between January 1989 and November 1992, State surveyors concluded that Ebensburg was failing to meet this requirement. U.S. Exh. 792. In situation after situation, surveyors have observed clients engaged in active treatment for only a few minutes during day programs, with the rest of the time spent engaged in self-stimulatory or other nonproductive behavior. For instance, in 1989, during programming at JFK, the "only structured activity [for one resident] was a 3 minute objective. Remaining time was spent

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[11]/ As pointed out in the previous section, Dr. Reid's figures are misleading in that they only measure individuals engaged in an activity with an apparent purpose with an age appropriate material. Tr. 9/16/93 (Reid) at 65. Dr. Reid concedes that there is a great deal more to active treatment than merely carrying out an activity with an apparent purpose. Tr. 9/16/93 (Reid) at 69. Dr. Reid made no effort to determine whether the activities he observed at day programs had any relation whatsoever to an individual's skills training programs. Tr. 9/16/93 (Reid) at 65-66.

[12]/ The Survey Procedures and Interpretive Guidelines for Intermediate Care Facilities for the Mentally Retarded, regulation § 483.440, provides that the standard for active treatment is that each client must receive a continuous active treatment program which includes "aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services ... directed toward -- (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status." Def. Exh. T.

walking around, swaying forward/backward, and at times had hand in her pants." U.S. Exh. 792. In Keystone, surveyors observed that a client's program was implemented for one and a half minutes. The client spent the remaining time chewing her fingers and sleeping. U.S. Exh. 792. In September 1992, when ARC surveyors arrived at JFK at 10:50 a.m., "activities were over . . . individual programs had all been completed. There was time to do more group activity." U.S. Exh. 932 at 521151.

c. Ebensburg Is Discriminating In The Training It Provides.

Keystone clients in East I, East II, and West I do not receive their required five hours of day programs off of their living units. Tr. 7/26/93 (Stark) at 153-154; Tr. 8/4/93 (Amado) at 14-15. In fact, they are only scheduled for one hour of active treatment off of their living units between 10:00 a.m. and 11:00 a.m. U.S. Exh. 609 (Domino Dep.) at 29-30; Tr. 8/4/93 (Amado) at 14.[13]/ The limited amount of training programs that Keystone residents receive is in direct contravention of a specific Ebensburg policy entitled "Client Training -- Non-discrimination Due to Handicap." U.S. Exh. 28. This policy has been in effect since December 20, 1984, when Mr. Bellomo approved and signed it. Id. The policy states that Ebensburg will:

> assure that all clients are scheduled for and receive 5 hours of per day of active program training, regardless of the client's age, degree of retardation, or accompanying handicaps.

U.S. Exh. 28. Ms. McAllister observed the one hour of training programs scheduled for most Keystone residents during one morning of her November 1992 tour of Ebensburg. Tr.

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[13]/ Dr. Reid did not evaluate whether everyone at Ebensburg receives five hours of training programs off of their living areas. Tr. 9/16/93 (Reid) at 154. He admitted, however, that he would encourage Ebensburg to get individuals off the living units more. Id. at 37.

7/28/93 (McAllister) at 207. When she began her observations at 10:00 a.m., residents were still being transported into the program area. Id. Programs did not actually begin until 10:30 a.m. and concluded by 11:05 a.m. Id. at 207-208. The active treatment period was thus only thirty-five minutes long. Ms. McAllister randomly selected one of the residents, Ron E., to continuously observe. Id. at 208. She found that during this thirty-five minute block of time in which residents were supposed to be receiving active treatment, staff interacted with Ron only two times for a total of twenty seconds of interaction. Id. at 208-209. One of the ten seconds of interaction consisted of staff talking to Ron; the other ten seconds of staff interaction consisted of a staff person repositioning a vibrating tube across his chest. Id. at 209.

By Ebensburg's own admission, at best, each Keystone resident only receives a maximum of 15 minutes of active treatment during their day programs. U.S. Exh. 609 (Domino Dep.) at 31. Mr. O'Brien admitted that some individuals in Keystone do not engage in functional programs. U.S. Exh. 624 (O'Brien Dep.) at 58. In Ms. Domino's opinion, Keystone clients would benefit from more staff during the time scheduled for day programs. U.S. Exh. 609 (Domino Dep.) at 37. There is no active training in the afternoon off of the living units. U.S. Exh. 609 (Domino Dep.) at 38. Instead, it is "nap" time for the residents, where they are put down on the floor on mats and staff are involved with clothing, cleaning, and paperwork. U.S. Exh. 609 (Domino Dep.) at 40, 41, 42.

Damien Tackett described a typical day at Keystone during the time that he spent there as a direct care worker through the Spring of 1992, as follows:

The direct care staff assigned to West II at Keystone would watch television between 9:00 a.m. and 10:30 a.m. every morning. Tr. 8/3/93 (Tackett) at 10. They did this even when a supervisor was present. In fact, on one occasion, Mr. Tackett remembers the supervisor joining staff for a cup of coffee. Id.[14]/ Residents were not transported to the Learning Center until approximately 10:30 a.m. Id. at 10-11. Mr. Tackett did not often see residents receiving their individualized programs while at the Learning Center. Id. at 15. Instead, what Mr. Tackett observed, more often than not, was the staff person who was responsible for carrying out the programs "bouncing a basketball around or talking to the other aide." Id. at 15. When Mr. Tackett attempted to work with a particular resident, staff told him that he was "wasting" his time. Id. at 16. Following program time, the residents had their lunch and then were immediately placed down on mats. Id. There was "very, very little" staff interaction with residents while they were on the mats. Id. Instead, staff treated this time as another coffee break. Id. at 18.

Mr. Devine, Ebensburg's Director of Residential Services, documented these same types of deficiencies in Keystone in the year following Mr. Tackett's work there. U.S. Exh. 211; Tr. 7/26/93 (Stark) at 214-215. For example, in October 1992, Mr. Devine found that Keystone residents did not arrive at their day programs until 10:30 a.m., despite the fact that programs were scheduled to begin at 10:00 a.m. U.S. Exh. 211 (10/6/92 memo). Between 10:00 a.m. and 10:30 a.m., residents "were just waiting to go to programming." Id. Staff were involved with changing residents' diapers. Id. Mr. Devine also found that the day

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[14]/ Mr. O'Brien admits that Ebensburg probably does not have the "greatest supervisory staff in the world." U.S. Exh. 624 (O'Brien Dep.) at 72.

rooms were "too noisy for programming, and what we need to do is break it up into smaller groups." U.S. Exh. 211 (10/8/92 memo). Several weeks later, he again found that "[t]he noise level was incredibly high and TV too loud. There are just too many individuals in this area." U.S. Exh. 211 (10/20/92 memo). Despite the fact that Mr. Devine was "dismayed" to find in September 1992 that staff were excused from providing programs to catch up on paperwork, he found the same thing occurring in March 1993 -- six months later. U.S. Exh. 211 (9/21/92 & 3/1/93 memos). Instead of residents being actively involved in programs, Mr. Devine documented residents sleeping, staff not interacting with residents, staff involved in toileting rather than providing programs, and programs consisting of "watching TV" throughout his observations of day programs for Keystone residents between September 1992 and January 1993. U.S. Exh. 211.

The videotape that Dr. Stark took on February 23, 1993 illustrates these problems during the scheduled one hour of programs for Keystone residents.[15]/ Tr. 7/26/93 (Stark) at 159-169; U.S. Exh. 262. It also depicts Ebensburg's failure to follow what Mr. Bonfanti, the Keystone Unit Manager, considers to the most "basic" and "minimal" steps that need to be taken in order to achieve active treatment. U.S. Exh. 604 (Bonfanti Dep.) at 107, line 25; 108.[16]/ Based upon his observations of day programs throughout Ebensburg, Dr. Stark found that one of these basic and minimal steps -- supervisory presence -- was only sometimes being met. Tr. 7/26/93 (Stark) at 152. Ebensburg was not meeting any of the

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[15]/ Dr. Stark took the videotape of morning day programs at Keystone on February 23, 1993. Tr. 7/26/93 (Stark) at 155, 163. The scenes that he videotaped represent the same types of scenes that he observed during his February 1993 tour. Tr. 7/26/93 (Stark) at 164-165.

[16]/ Mr. Bonfanti adopted these steps from another facility for use at Ebensburg. U.S. Exh. 604 (Bonfanti Dep.) at 107.

other six basic steps. Tr. 7/26/93 (Stark) at 152-153.[17]/ Staff were not interacting with residents and residents were not involved in structured activities. Id.

The first program area that Dr. Stark videotaped on February 23, 1993 showed seven Keystone residents. Tr. 7/26/93 (Stark) at 159. When he first entered the room, the seven clients were in there alone, without any staff. Tr. 7/26/93 (Stark) at 159. A staff person came in after Dr. Stark started filming. Id. Residents in carts, including Tim P., are separated from the rest of the group and there is no attempt to involve them. Tr. 7/26/93 (Stark) at 159, 160. Absent any interaction with other residents or staff, Tim spends his day staring at a fluorescent light. Tr. 7/26/93 (Stark) at 160. "That is his life, every day, is to look at that ceiling." Tr. 7/26/93 (Stark) at 160.[18]/ Dr. Stark has interacted with Tim and believes he is very much aware of his surroundings: "As soon as you [interact with him], he starts to smile. You can see the glimmer in his eyes." Tr. 7/26/93 (Stark) at 160. Tim's parents noted on their application for his admission to Ebensburg at age three that Tim could babble and take a few steps with help. Tr. 10/15/93 (O'Brien) at 77-78. Jeff K. is also

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[17]/ These six steps are: (1) staff on their feet -- moving and interacting with individuals; (2) every client involved in structured activities; (3) free time is limited to structured leisure time with staff interaction; (4) all individuals are receiving relatively equal time and attention from staff; (5) groups are arranged so that individuals face one another and everyone is included; and (6) materials and equipment are used in structured activities.

[18]/ Tim has had the same schedule since October 1991. Tr. 10/15/93 (Bellomo) at 30; U.S. Exh. 1016. His schedule lists two behavioral objectives that he is supposed to be working on while he is at the learning center (activate hand held control for radio and respond to staff request), both of which were both discontinued in 1992 without any replacements noted on his schedule. Tr. 10/15/93 (Bellomo) at 31; U.S. Exh. 1016. Tim spends his afternoon in his living unit where he is supposed to be working on another behavioral objective (touch the keys on a keyboard), but that objective was also discontinued in 1992 and not replaced. Id. Tim's evening consists of "TV, VCR, available activities, and staff interactions."

separated from the group. Tr. 7/26/93 (Stark) at 159. Jeff, who used to be able to walk, make sounds and interact, is sitting alone, apart from the rest of the group, and banging on the lap board on his wheelchair. Tr. 7/26/93 (Stark) at 159. Dr. Stark described him as someone who is trapped in his body, not being able to do anything, yet being aware of what is going on. Tr. 7/26/93 (Stark) at 160.

Dr. Stark described what little programming that is actually provided to Keystone residents as "walking back in time for me, into the early seventies." Tr. 7/26/93 (Stark) at 163. He does not consider what he observed to be "programming." Tr. 7/26/93 (Stark) at 163. Rather, it was "simply trying to keep somebody busy and putting something in front of them." Tr. 7/26/93 (Stark) at 163. What few materials are available for the residents are age-inappropriate toys. Tr. 7/26/93 (Stark) at 159. One resident is sitting alone, facing a toy that he cannot even reach. Tr. 7/26/93 (Stark) at 161. Another resident is putting blocks in a bucket. Tr. 7/26/93 (Stark) at 162. Dr. Stark called this activity "extremely disheartening" and an outdated practice he used twenty years ago. Tr. 7/26/93 (Stark) at 162-163.

Dr. Stark contrasted what he observed at Keystone with a videotape of John, his son. Tr. 7/26/93 (Stark) at 210; U.S. Exh. 262(a). Like Tim P., John had meningitis when he was a few months old and has significant physical disabilities along with his severe and profound mental retardation. Tr. 7/26/93 (Stark) at 210, 211. John has been through thirteen operations, has to be suctioned frequently, is dependent on a tube to be fed, has twenty to thirty seizures a day, and has spastic cerebral palsy. Unlike Tim, his limbs are not severely contractured because John has received adequate care over the years. Dr. Stark

believes that John is as severely involved as any Ebensburg resident, if not more involved. Tr. 7/26/93 (Stark) at 211. In contrast to Tim, who spends his day staring at the ceiling, John is involved with other people in meaningful activities, such as cooking, swimming, and learning to operate a switch to activate a computer. Tr. 7/26/93 (Stark) at 211. Because John has only slight movement in his hands, the switch is attached to his jaw. By moving his jaw, he can activate the switch and control what is happening on the computer. Through use of the switch, John can communicate, has some control over his environment, and gains some independence in his life. Tr. 7/26/93 (Stark) at 212. John has also learned to communicate by blinking his eyes and indicating "yes" or "no." This videotape demonstrates that even the most severely involved people with mental retardation and physical disabilities are "capable of learning and interacting with their environment." Tr. 7/26/93 (Stark) at 21. In Dr. Amado's experience, as well, the majority of very physically involved clients like the individuals who reside in Keystone will benefit and participate in far more than one hour a day of active treatment, and, in fact, their stamina, their interest, and their desire to participate increases as there is more and more available for them to do. Tr. 8/4/93 (Amado) at 104.

Ms. Domino is a "firm advocate" of moving Keystone clients off the living area. U.S. Exh. 609 (Domino Dep.) at 44. Among the benefits of moving clients off the living area are that it focuses staff on providing programs rather than "getting sidetracked with other things that have to be done." U.S. Exh. 609 (Domino Dep.) at 44. Mr. Bonfanti believes that the individuals who live in Keystone "absolutely" should have more opportunities to get out into the community. U.S. Exh. 604 (Bonfanti Dep.) at 148, line 24.

Given the resources available at Ebensburg, "there are lots of limitations" in the ability to get Keystone residents out into the community. U.S. Exh. 604 (Bonfanti Dep.) at 149, line 5.

d. Ebensburg Fails To Provide Training In Basic Living Skills.

Over the years, State surveyors have concluded that Ebensburg fails to provide training in basic skills of every day living. U.S. Exh. 792 (12/83, 1/89, 8/92). These are known in the field as "activities of daily living." They include such things as toileting, bathing, grooming, and dressing. U.S. Exh. 640 (Stratton Dep.) at 34. As recently as August 1992, when State surveyors reviewed the record of every resident at Ebensburg through the Inspection of Care ("IOC") process, they found that a "significant number" of residents' self-help needs were not being met. U.S. Exh. 792 at 4.

Dr. Russo testified in detail about Ebensburg's systemic failure to provide toilet training programs and the harm that is resulting to the residents of Ebensburg due to Ebensburg's failure. Tr. 8/2/93 (Russo) at 39-42. Ebensburg policy, which has been in effect since January 1984, requires every client who does not eliminate appropriately or independently and shows signs of readiness to be on a toilet training program, barring a bona fide physical impediment. U.S. Exh. 25. Ebensburg is not complying with its own toilet training policy. Tr. 8/2/93 (Russo) at 39-40. Ebensburg has been specifically cited by state surveyors for its failure to provide bowel/bladder training programs to its residents. U.S. Exh. 792. As far back as January 1989, State surveyors found that in two buildings that they sampled, none of the 83 incontinent clients had a bowel/bladder training program. Id.

Only eleven Ebensburg residents are currently on a toilet training program. Tr. 8/2/93 (Russo) at 40. These programs are very limited in scope and function (such as

appropriate use of toilet paper) and not the total skill acquisition programs expected for a population such as Ebensburg's. Tr. 8/2/93 (Russo) at 40. Interviews with Ebensburg staff revealed that there was very little awareness among staff as to which individuals need toilet training programs and have the physical capacity to develop toileting skills. Tr. 8/2/93 (Russo) at 40. Dr. Stratton does not know the percentage of people at Ebensburg who are capable of being toilet trained. U.S. Exh. 640 (Stratton Dep.) at 41-42.

Individuals capable of being toilet trained who instead are maintained in disposable Attends undergarments are being harmed. Tr. 8/2/93 (Russo) at 41. Darren W. is an example of this cycle of harm. Id. Darren W. has no toilet training program and wears Attends on a routine basis. Darren's father contacted Ebensburg on a number of occasions to say that Darren was reluctant to have a bowel movement in a diaper and Darren's reluctance was leading to constipation, which in turn was leading to rectal digging. Darren's father asked if instead of wearing diapers, could Darren be allowed to sit on a toilet to have a bowel movement. Instead of putting Darren on a toilet training program, Ebensburg restrained Darren in a jumpsuit to prevent his behavior of rectal digging on almost a daily basis from approximately June until the end of September 1992, when Dr. Russo visited Ebensburg. Tr. 8/2/93 (Russo) at 41-42. In addition, in spite of the use of restraints for rectal digging, Ebensburg at no time provided a behavior program to Darren to reduce his behavior of rectal digging. Tr. 8/2/93 (Russo) at 76.

There are a significant number of toilet training programs available for people with severe and profound mental retardation and toilet training is one of the easiest training areas for this population. Tr. 8/2/93 (Russo) at 42. Defendant Nancy Thaler, the person

responsible for all the services for individuals in the Commonwealth with mental retardation, recognized at her deposition that in the absence of physiological impairments, most individuals who are severely or profoundly retarded can learn to toilet themselves. U.S. Exh. 870 (Thaler Dep.) at 54. She stated that it should not be the norm that it takes several years to toilet train such an individual. U.S. Exh. 870 (Thaler Dep.) at 55.

3. The Training Programs That Ebensburg Develops Are Inadequate.

Where they do exist, the training programs at Ebensburg substantially depart from accepted professional standards in the field for three reasons: 1) they are not individualized; 2) most do not teach functional skills; and 3) they do not take into account individual preferences. Tr. 8/4/93 (Amado) at 22-23.[19]/ At Ebensburg, the onus of learning is put on the learner, and this is not consistent with generally accepted professional standards. Tr. 8/4/93 (Amado) at 39-40. The field requires that the onus for teaching be on the trainer. Tr. 8/4/93 (Amado) at 40.

It is critical that training programs for individuals with mental retardation are individualized because each individual has a unique learning difficulty, and it is important to capitalize on individual assets and learning styles in order to make learning as efficient as possible. Tr. 8/4/93 (Amado) at 23. Ebensburg does not employ any of the five ways to

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[19]/ Ebensburg does not train staff who are expected to write skills training programs how to write those programs, and typically, the staff at Ebensburg who have been promoted to positions responsible for writing these programs were once direct care staff on the living units. Tr. 8/2/93 (Russo) at 80.

individualize a training program. Tr. 8/4/93 (Amado) at 23-29.[20]/ Instead, as with its canned behavior programs, Ebensburg uses canned skills training programs available in the marketplace without individualizing and refining them as required by generally accepted professional practices. Tr. 8/4/93 (Amado) at 30-33; U.S. Exh. 112 (collection of pre-written, non-individualized Ebensburg skills training programs on which Ebensburg at most fills names in the blanks and sometimes does not even do that); U.S. Exhs. 112, 113 (examples of Ebensburg's use of exactly the same skills program for different clients). Ebensburg has been repeatedly cited by State surveyors, including as recently as October 1993, for its failure to provide individualized training programs for its residents. U.S. Exh. 792; U.S. Exh. 1103 at 7 (October 1993 MA Survey, citing Ebensburg for failing to design programs that meet individual needs).

Dr. Amado found examples of Ebensburg's failure to provide individualized training programs in every single record he reviewed. Tr. 8/4/93 (Amado) at 35-39.[21]/ Dr. Amado testified about 12 specific cases in which individuals are being denied the opportunity to develop needed skills by Ebensburg's failure to provide individualized training programs to develop purposeful, meaningful, and adaptive skills. Tr. 8/4/93 (Amado) at 35-39. For example:

- In John B.'s 1992 speech and hearing screening, the assessor notes that John will lower his pants to indicate the need to toilet. There is no training program in John's record

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[20]/ The five ways to individualize a training program include: 1) individualizing prompts; 2) individualizing teaching units; 3) selecting outcomes that are meaningful to the individual; 4) individualizing data collection; and 5) individualizing teaching methods. Tr. 8/4/93 (Amado) at 23-29.

[21]/ Several records that Dr. Amado reviewed had been selected by Ebensburg psychologists as representational of their best work. Tr. 8/4/93 (Amado) at 11-12.

to teach John a socially acceptable way to express his need, and the assessor does not recommend that one be developed. Tr. 8/4/93 (Amado) at 35.

- All of the skills programs for Edward S. are canned and generic. Edward S., who is blind in one eye and severely visually impaired, is being taught to identify plastic fruit by feeling the items on the trainer's tray. This skill will not help him identify real fruit. Edward can hear and speak in short sentences, yet Ebensburg is teaching him to communicate using gestures. This makes no sense given the fact that Edward can speak and given his visual impairment. Further, Edward's reinforcement for good work is to have staff smile at him, but the program does not tell staff where to stand so that Edward can see the smile, if Edward can see a smile at all. Finally, although his record indicates that he would benefit by being given a choice of tasks and reinforcers each day, Ebensburg has never employed this strategy. Tr. 8/4/93 (Amado) at 35-36, 38.[22]/

- James E. has a skill training program to teach him to push five balls over a metal arc. Dr. Amado observed James with this activity in front of him. James just sat there. At no time did he touch the balls and at no time did staff try and teach him. Tr. 8/4/93 (Amado) at 80-81. James has severe self-injurious behavior that he uses to communicate with staff, but has no communication objective in his program.[23]/ Given James' needs, a program to push balls over an arc is totally inappropriate. Tr. 8/4/93 (Amado) at 36.

a. Ebensburg Fails To Revise Training Programs When Necessary.

Based on his review of records, Dr. Amado found that it is not unusual for Ebensburg to keep an individual on an ineffective program for years without individualizing the program, until the program is terminated for lack of progress. Tr. 8/4/93 (Amado) at 40. Dr. Stratton admitted that keeping an individual on a skill development program for months without revising the program if the person does not gain any skills is not good professional practice. U.S. Exh. 640 (Stratton Dep.) at 40. For the past three years, Ebensburg, itself

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[22]/ Dr. Reid did not review the case of Edward S. and could not comment on the program teaching Edward to feel plastic fruit, although he allowed that that type of program could be inappropriate. Tr. 9/16/93 (Reid) at 33.

[23]/ See Mr. Tackett's testimony about James' self-injurious behavior and the inappropriate staff response that Mr. Tackett witnessed on April 4, 1992, § V.C.2.d.

has reported that residents have met only a "small percentage of actual goals" established for them. U.S. Exhs. 36, 37, 640 (Stratton Dep.) Exh. 17.

Because effective programs work in a very short period of time, Ebensburg's failure to adequately revise skills programs in a timely manner is totally unacceptable. Tr. 8/4/93 (Amado) at 40. State surveyors have repeatedly cited Ebensburg for its failure to revise training programs. U.S. Exh. 792. For instance, in 1990, Inspection of Care ("IOC") surveyors cited Ebensburg for its failure to re-evaluate skills programs of individuals who had not made progress for "an extended length of time." Id. In 1991, the surveyors made the same finding. Id. In 1992, IOC surveyors noted that Ebensburg's corrective action plans for previous active treatment deficiencies had not been successful and that "major active treatment areas continue unimproved." Id. As recently as the October 1993 MA Survey, State surveyors found Ebensburg was failing to revise programs where no progress was being made within a reasonable time frame and included examples of programs that had not been revised in years. U.S. Exh. 1103 at 8-9.

Ebensburg's standard response to lack of progress on a skills training program is to lower the criteria for performance rather than to rewrite and individualize the programs to enhance the probability of success. Tr. 8/4/93 (Amado) at 39. Dr. Reid did not evaluate whether any of the review processes in place at Ebensburg are effective. Tr. 9/16/93 (Reid) at 154-155. He did not determine the length of time any individual had been engaged in the same task and did not evaluate the progress, or lack thereof, for self-help skills for a single resident at Ebensburg. Tr. 9/16/93 (Reid) at 42, 67, 156. Although Dr. Reid testified that "backing up" or lowering program expectations can be appropriate, he did not evaluate

whether Ebensburg's use of backing up is being done appropriately or effectively. Tr. 9/16/93 (Reid) at 154.

b. Skills Training Programs Lack Psychology Input.

Although required by the field, in general, and by both State and Ebensburg policy, in particular, the psychology department at Ebensburg is not involved in the development and design of the Ebensburg skills training programs. Tr. 8/2/93 (Russo) at 38-39. Since at least 1976, when Dr. Stratton first came to Ebensburg, the goal of Ebensburg's psychology department has been to develop adaptive and socially relevant skills to increase the independence of the people who live at Ebensburg and to enhance the social interactions of the people who live at Ebensburg. U.S. Exh. 639 (Stratton Dep.) at 17-18. Despite this goal, the psychologists at Ebensburg have no role in developing, writing, teaching, or assessing the effectiveness of skills programs. Tr. 8/2/93 (Russo) at 12; Tr. 9/16/93 (Reid) at 32-33; U.S. Exh. 621 (Kleman Dep.) at 17-18 (PSA's do not review or revise training programs written by residential services workers). PSA's are not involved in developing programs for activities of daily living, such as eating, dressing, and grooming. U.S. Exh. 640 (Stratton Dep.) at 34. PSA's are not involved in developing leisure skills programs. U.S. Exh. 640 (Stratton Dep.) at 34. PSA's are not involved in developing communication programs. U.S. Exh. 640 (Stratton Dep.) at 34. Even though Ebensburg psychologists attend annual and mini-staffings of individuals in their caseloads, this is insufficient participation by psychologists in the development and design of individual training plans. Tr. 8/2/93 (Russo) at 137-138. Because Ebensburg psychologists are not involved in the design of skills training programs, many of the clients at Ebensburg are not making adequate

functional gains in skills. Tr. 8/2/93 (Russo) at 39. Dr. Reid did not evaluate the degree to which psychologists at Ebensburg are involved in developing skill acquisition programs. Tr. 9/16/93 (Reid) at 148. Dr. Reid did not evaluate whether the inter-disciplinary team process at Ebensburg was effective. Tr. 9/16/93 (Reid) at 147. Dr. Reid relied on Ebensburg's representations concerning the degree to which the psychologists are involved in the IDT. Tr. 9/16/93 (Reid) at 148.

Involvement by psychologists in the design of skills programs is "absolutely critical." Tr. 8/2/93 (Russo) at 39, line 2. Just as psychologists need to be involved to determine the motivation behind an individual's maladaptive behavior, so must psychologists determine what motivates each individual to learn and incorporate that knowledge into skills training programs for each individual. Tr. 8/2/93 (Russo) at 39. Dr. Stratton thinks it is important to have the input of the PSA's into the development of the skills training programs because the PSA's know the basic principles of learning and training people. U.S. Exh. 640 (Stratton Dep.) at 36-37. PSA's are not involved with the skills programs because the focus of their jobs is to minimize the intrusive interventions. Dr. Stratton acknowledges that you cannot minimize intrusive interventions without developing positive skills and behaviors in other areas. U.S. Exh. 640 (Stratton Dep.) at 37. Dr. Stratton believes that Ebensburg's highest priority during the coming year should be upgrading training of functional skills, which would help reduce the number of injuries and make it less likely that individuals would exhibit challenging behaviors. U.S. Exh. 640 (Stratton Dep.) at 229-230.

c. Ebensburg Fails To Provide Adequate Occupational Therapy Programs.

Occupational therapy programs are aimed at increasing the level of functioning of Ebensburg residents. U.S. Exh. 617 (Graham Dep.) at 14.[24]/ Lois Graham, Ebensburg's Director of Occupational Therapy until August 1993, admitted that there are some Ebensburg residents who could be assisted through occupational therapy services who are not receiving them. U.S. Exh. 617 (Graham Dep.) at 17, 106. The last time there was a facility-wide effort to identify each Ebensburg resident who could benefit from occupational therapy services was in 1985 or 1986. U.S. Exh. 617 (Graham Dep.) at 20, 91. Ms. Graham does not believe that the assessment form she used to evaluate Ebensburg residents for occupational services is adequate. U.S. Exh. 617 (Graham Dep.) at 76-78. For example, she does not believe that she was able to adequately assess residents' physical limitations and motor abilities that are prerequisites to learning basic care skills. U.S. Exh. 617 (Graham Dep.) at 76, 77. She also is not satisfied that her assessments were adequate to evaluate residents' oral motor status. U.S. Exh. 617 (Graham Dep.) at 77. Her assessments did not identify particular deficits in various skill areas. U.S. Exh. 617 (Graham Dep.) at 77. She never revised the assessment form because she did not have the time. U.S. Exh. 617 (Graham Dep.) at 79. Ms. Graham would also like to have conducted comprehensive occupational therapy assessments more frequently but did not have the time to do so. U.S. Exh. 617 (Graham Dep.) at 90.

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[24]/ At Ebensburg, occupational therapy services include such programs as teaching prerequisite skills for activities of daily living, teaching a variety of motor skills, including hand manipulation, balance, protective extension, muscle strength, and coordination and working with clients who are tactilely defensive. U.S. Exh. 617 (Graham Dep.) at 91-92.

i. There Are Not Enough Occupational Therapists At Ebensburg.

At the point that she testified in her deposition in January 1993, Ms. Graham had been the Director of Occupational Therapy Services at Ebensburg since 1988. U.S. Exh. 617 (Graham Dep.) at 9. Moreover, she had been the only occupational therapist on staff at Ebensburg since 1984. U.S. Exh. 617 (Graham Dep.) at 10.[25]/ Up until August 1992, Ms. Graham was only at Ebensburg on a part-time basis. U.S. Exh. 617 (Graham Dep.) at 12. Between the fall of 1987 and August 1992, she only worked three days per week at Ebensburg. U.S. Exh. 617 (Graham Dep.) at 11. One of the reasons that Ms. Graham started to work full time in August 1992 was because she wanted to try and make changes within the occupational therapy department. U.S. Exh. 617 (Graham Dep.) at 13. In particular, she hoped to build up the quality of occupational therapy services, develop occupational therapy assessment tools, and develop and implement additional programs. U.S. Exh. 617 (Graham Dep.) at 13. She was not able to accomplish her goals and did not feel that Ebensburg management was responsive to her significant concerns in the area of occupational therapy. U.S. Exh. 617 (Graham Dep.) at 58, 59. She was very frustrated about this. U.S. Exh. 617 (Graham Dep.) at 61. Ms. Graham is no longer at Ebensburg. Tr. 10/13/93 (Arnall) at 8, 50; Tr. 10/15/93 (Bellomo) at 7.

As of January 8, 1993, there were five licensed occupational therapy assistants ("LOTA's") on staff at Ebensburg. U.S. Exh. 617 (Graham Dep.) at 32. All of the LOTA's work on the first shift during weekdays; none of the LOTA's work on the

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[25]/ Between 1984 and June 1985 there was an additional contract occupational therapist who worked at Ebensburg one day or a day and a half per week. U.S. Exh. 617 (Graham Dep.) at 21-22. Between June 1985 and June 1986, there were two contract occupational therapists who worked a total of one to two days. U.S. Exh. 617 (Graham Dep.) at 23.

weekends. U.S. Exh. 615 (Geriak Dep.) at 70. Sue Fagan works at Keystone and has a caseload of 23 clients. U.S. Exh. 617 (Graham Dep.) at 48. Jane Schneider also works at Keystone and has a caseload of 23 clients. U.S. Exh. 617 (Graham Dep.) at 49. Lana Geriak works in the JFK Learning Center and has a caseload of 48 clients. U.S. Exh. 617 (Graham Dep.) at 49. Sharon Zoskey works in the Old Main Learning Center and has a caseload of 24 clients. U.S. Exh. 617 (Graham Dep.) at 49. Mary Frye works in the Harmony Learning Center and has a caseload of 12 or 13 clients. U.S. Exh. 617 (Graham Dep.) at 49. The LOTA's caseloads are significantly higher than what Ms. Graham believes they should be. U.S. Exh. 617 (Graham Dep.) at 57. She believes that there should be two LOTA's working with a group of twelve to eight residents. U.S. Exh. 617 (Graham Dep.) at 56. Ms. Graham admits that a caseload of forty-eight clients does not meet accepted standards in the field of occupational therapy services. U.S. Exh. 618 (Graham Dep.) at 80. She also agrees that in some cases, the limited amount of occupational therapy services that clients receive is not within accepted professional standards. U.S. Exh. 618 (Graham Dep.) at 80.

Ms. Graham believes that in order to make necessary improvements in occupational therapy services at Ebensburg additional occupational therapists are needed. U.S. Exh. 617 (Graham Dep.) at 35. She feels that the "quality of OT services is basically dependent upon guidance and direction and assessment from a registered occupational therapist." U.S. Exh. 617 (Graham Dep.) at 23. She believes that Ebensburg needs two to three additional occupational therapists right now. U.S. Exh. 617 (Graham Dep.) at 24. Once these occupational therapists become established, Ebensburg can look more closely at individual

needs and determine whether even more occupational therapists are needed in order to provide programs to each resident who needs them. U.S. Exh. 617 (Graham Dep.) at 24-25.

Ms. Geriak, LOTA, agreed that one registered occupational therapist is insufficient for Ebensburg. U.S. Exh. 615 (Geriak Dep.) at 70. She thinks that there should be three or four occupational therapists. U.S. Exh. 615 (Geriak Dep.) at 70.

Every LOTA who works full time at Ebensburg and was deposed agreed that more LOTA's are necessary to provide needed services for residents and that Ebensburg residents would benefit from an additional number of LOTA's. U.S. Exh. 610 (Fagan Dep.) at 45; U.S. Exh. 613 (Frye Dep.) at 145; U.S. Exh. 615 (Geriak Dep.) at 70; U.S. Exh. 643 (Zoskey Dep.) at 70. With more LOTA's, occupational therapy programs could be provided in smaller groups and more time could be spent on programs. U.S. Exh. 610 (Fagan Dep.) at 45. Ms. Geriak agreed that Ebensburg residents would benefit from smaller caseloads and greater interaction with a LOTA. U.S. Exh. 615 (Geriak Dep.) at 57, 58. Ms. Geriak believes that a caseload of 10-12 clients would allow adequate occupational therapy programming.

Ms. Geriak currently is responsible for 24 clients in the morning and 24 in the afternoon. U.S. Exh. 615 (Geriak Dep.) at 34-35. Ms. Geriak admits that she is not able to give sufficient attention to all 24 clients. U.S. Exh. 615 (Geriak Dep.) at 36. She is only able to actually interact with nine of the twenty four individuals for approximately five to ten minutes each. U.S. Exh. 615 (Geriak Dep.) at 36. Ms. Geriak does not feel that five to ten minutes of occupational therapy is adequate. U.S. Exh. 615 (Geriak Dep.) at 40. She is not

able to perform her responsibilities as an occupational therapy assistant to her satisfaction. U.S. Exh. 615 (Geriak Dep.) at 71.

Ms. Zoskey has a caseload of 24 residents. U.S. Exh. 643 (Zoskey Dep.) at 8, 29. The residents are divided up into two groups of 12. U.S. Exh. 643 (Zoskey Dep.) at 29. She believes that in order to provide adequate occupational therapy services, there should be less than eight clients in a group. U.S. Exh. 643 (Zoskey Dep.) at 29. With a caseload of 24 individuals, Ms. Zoskey is only able to provide each individual with approximately five minutes of occupational therapy each day. U.S. Exh. 643 (Zoskey Dep.) at 35. She does not feel that this is an adequate amount of time for occupational therapy. U.S. Exh. 643 (Zoskey Dep.) at 35.

With improved occupational therapy services at Ebensburg, residents' functioning could be improved, residents would learn new skills to gain greater independence, there would be less loss of skills, and fewer residents would regress or deteriorate. U.S. Exh. 617 (Graham Dep.) at 35-36. In addition, with improved occupational therapy services, the overall ability of residents who are unresponsive, who have coordination problems, and who have difficulty attending to a task could be improved. U.S. Exh. 617 (Graham Dep.) at 37.

Ms. Graham was not able to provide the level of direct supervision that she believes necessary because she was the only occupational therapist at Ebensburg. U.S. Exh. 617 (Graham Dep.) at 55, 109. She also did not have sufficient time to monitor the efficacy of occupational therapy programs. U.S. Exh. 617 (Graham Dep.) at 110. If she were able to have monitored them, she believes that she could have identified behaviors that are not being addressed and could have ensured that occupational therapy programs were geared more

specifically to client needs. U.S. Exh. 617 (Graham Dep.) at 110-111. As a result, she believes that residents could potentially progress more quickly than they are. U.S. Exh. 617 (Graham Dep.) at 111. As of December 14, 1992, the Occupational Therapy Department at Ebensburg had not held any regular staff meetings since mid-1990. U.S. Exh. 610 (Fagan Dep.) at 16, 24.

If occupational therapy services were expanded at Ebensburg, residents could receive sensory integration programs for their self-stimulatory and self-abusive behaviors. U.S. Exh. 617 (Graham Dep.) at 63. Sensory integration programs provide necessary sensory input to individuals who have problems with central nervous system processing, tactile problems, and vestibular problems which result in poor balance and poor integration. U.S. Exh. 617 (Graham Dep.) at 64. By providing this sensory input, it assists individuals in developing more normal patterns of behavior. U.S. Exh. 617 (Graham Dep.) at 65.

Dr. Goldschmidt, the consulting psychiatrist at Ebensburg, agreed that Ebensburg needs more occupational therapists for two reasons: 1) occupational therapists can communicate with clients and pick up changes and early signs of side effects before they become apparent and communicate these observations to Dr. Goldschmidt; and 2) occupational therapists can teach clients how to express feelings and cut down on acting out by the clients. U.S. Exh. 616 (Goldschmidt Dep.) at 93-94. In addition, if occupational therapists helped clients learn how to communicate, the additional client communication skills would then help Dr. Goldschmidt with her diagnoses. U.S. Exh. 616 (Goldschmidt Dep.) at 94.

ii. Occupational Therapy Assistants Are Pulled From Their Occupational Therapy Responsibilities To Perform Other Functions.

In addition to their occupational therapy responsibilities, some of the LOTA's at Ebensburg have to serve as "monitors." A monitor is responsible for supervising a group of residents and direct care staff during day programs. U.S. Exh. 617 (Graham Dep.) at 39. While serving as monitor, the occupational therapist may also perform direct care staff functions, such as toileting and dressing clients. U.S. Exh. 615 (Geriak Dep.) at 54; U.S. Exh. 643 (Zoskey Dep.) at 30, 32. Two of the five LOTA's currently serve as monitors (Lana Geriak and Sharon Zoskey). U.S. Exh. 617 (Graham Dep.) at 44; Tr. 10/14/93 (Bellomo) at 55. The other LOTA's have also served as monitors at various times. U.S. Exh. 617 (Graham Dep.) at 44-45. Having to serve as a program monitor was one of the contributing factors for a LOTA leaving Ebensburg in October 1992. U.S. Exh. 617 (Graham Dep.) at 45.

In addition to her occupational therapy responsibilities, Ms. Geriak has had to serve as a monitor during day programs since 1990. U.S. Exh. 615 (Geriak Dep.) at 53. She serves as a monitor on a daily basis. U.S. Exh. 615 (Geriak Dep.) at 53. Serving as a monitor has impeded her ability to perform her occupational therapy responsibilities. U.S. Exh. 615 (Geriak Dep.) at 54. As a monitor, she is responsible for changing and escorting clients. U.S. Exh. 615 (Geriak Dep.) at 54. When she works as a monitor, no one else assumes her occupational therapy responsibilities. U.S. Exh. 615 (Geriak Dep.) at 56. The fact that she has to serve as a monitor is not satisfactory to her. U.S. Exh. 615 (Geriak Dep.) at 56. In fact, none of the LOTA's regard the responsibility of having to serve as a

monitor during day programs in addition to their occupational therapy responsibilities as satisfactory.

In addition to her occupational therapy responsibilities, Ms. Zoskey also serves as a monitor on a daily basis. U.S. Exh. 643 (Zoskey Dep.) at 29, 33. As a monitor, she is responsible for such things as busing clients, toileting, and changing clothes. U.S. Exh. 643 (Zoskey Dep.) at 30, 32. She spends about half of her time on monitoring duties. U.S. Exh. 643 (Zoskey Dep.) at 32. No one else assumes her occupational therapy duties and responsibilities while she is working as a monitor. U.S. Exh. 643 (Zoskey Dep.) at 37. Her monitoring responsibilities inhibit her ability to provide adequate occupational therapy and she does not believe that it is appropriate for her to work as a monitor. U.S. Exh. 643 (Zoskey Dep.) at 36.

Ms. Frye served as a monitor from July 1987 through September 1992. U.S. Exh. 613 (Frye Dep.) at 122. While serving as a monitor, she was responsible for performing some functions that are not related to occupational therapy. U.S. Exh. 613 (Frye Dep.) at 124. The duties that Ms. Frye had to perform as a monitor kept her from providing the occupational therapy services she felt the residents needed. U.S. Exh. 613 (Frye Dep.) at 124. It was impossible to even provide 15 minute occupational therapy programs to individuals. U.S. Exh. 613 (Frye Dep.) at 124. During the time that she was a monitor, Ms. Frye was only able to spend about an hour or an hour and a half each day on occupational therapy related services. U.S. Exh. 613 (Frye Dep.) at 125. Ms. Frye had a caseload of 68 clients for two-and-a half years between July 1987 and February 1990. U.S. Exh. 613 (Frye Dep.) at 125, 130. She was only able to provide services to approximately

15 to 16 clients each day for about ten minutes per client. U.S. Exh. 613 (Frye Dep.) at 126. Between February 1990 and January 1991, her caseload increased, reaching as high as 72. U.S. Exh. 613 (Frye Dep.) at 130.

During the time that she spent as a monitor, Ms. Frye stated that she was not able to provide meaningful occupational therapy because there were too many distractions, a high noise level, and constant interruptions. U.S. Exh. 613 (Frye Dep.) at 126. This whole situation was not satisfactory to Ms. Frye as a licensed occupational therapy assistant. U.S. Exh. 613 (Frye Dep.) at 127. For the entire five years that she spent as a monitor, Ms. Frye did not feel that she was able to provide Ebensburg residents with adequate occupational therapy services. U.S. Exh. 613 (Frye Dep.) at 128. Ms. Frye conveyed her concerns to her supervisor, Lois Graham beginning in 1987. U.S. Exh. 613 (Frye Dep.) at 127, 128. She informed Ms. Graham that she was "very unhappy with the situation." U.S. Exh. 613 (Frye Dep.) at 127, line 14. Despite the fact that she expressed her "dissatisfaction with the type of services" that she was providing, Ebensburg did "nothing" in response to Ms. Frye's complaints. U.S. Exh. 613 (Frye Dep.) at 132-133, lines 3, 9-10. Ms. Frye was not relieved of her monitoring responsibilities until 5 years after she first began expressing her concerns. U.S. Exh. 613 (Frye Dep.) at 127.

While working as a monitor, Ms. Frye had to wear many hats, including serving as a direct care staff person. U.S. Exh. 613 (Frye Dep.) at 132. She believes that she had to serve as a monitor because of a shortage of staff. U.S. Exh. 613 (Frye Dep.) at 132.

Ms. Frye thinks that Ebensburg residents "suffered" during the time that they she had to serve as a monitor and was not able to provide them with adequate occupational therapy

services. U.S. Exh. 613 (Frye Dep.) at 134. Individuals who needed occupational therapy services were simply not receiving them. U.S. Exh. 613 (Frye Dep.) at 135. If occupational therapy services had been provided, individuals' independence, self-help skills, dining skills, dressing skills, and grooming skills could have been improved. U.S. Exh. 613 (Frye Dep.) at 135.

Ms. Graham agrees that "having occupational therapists as monitors presents a problem." U.S. Exh. 617 (Graham Dep.) at 39. The LOTA's approached Ms. Graham when they were first assigned monitoring responsibilities in 1988 with their concerns that they could not carry out adequate occupational therapy programs while being a monitor. U.S. Exh. 617 (Graham Dep.) at 53. She tried, unsuccessfully, to rectify this situation. U.S. Exh. 617 (Graham Dep.) at 54. Ms. Graham believes that LOTA's continue to serve as monitors because there is an insufficient number of staff. U.S. Exh. 617 (Graham Dep.) at 55.

d. Ebensburg Fails To Provide Adequate Speech And Communication Training To Meet Residents' Needs.

There are six speech and hearing staff at Ebensburg. U.S. Exh. 620 (Huber Dep.) at 84. The case load for each staff person ranges from 24 to approximately 54 residents, with the exception of the one staff person, Kathy Wagner, who also functions as head of the Dysphagia Team. U.S. Exh. 620 (Huber Dep.) at 84-85. Mr. Huber, the Coordinator of Speech and Hearing Services at Ebensburg, believes that residents would benefit from additional speech and hearing staff because they would be able to provide programs in smaller groups and provide more direct services. U.S. Exh. 620 (Huber Dep.) at 65, 88. In addition, with more speech and hearing staff at Ebensburg there would be more "hands on"

one-to-one attention. U.S. Exh. 620 (Huber Dep.) at 64. He believes that everyone learns better one-to-one. U.S. Exh. 620 (Huber Dep.) at 65.

Mr. Huber agrees that acquisition of communication skills is important to the well-being of Ebensburg residents. U.S. Exh. 620 (Huber Dep.) at 100. Teaching residents communication skills can enhance their safety by enabling them to better understand unsafe situations and communicate that they are in an unsafe situation. U.S. Exh. 620 (Huber Dep.) at 99. Acquisition of communication skills can also enable individuals to better protect themselves from harm. U.S. Exh. 620 (Huber Dep.) at 100. It can also enhance residents' health by teaching them to communicate when something hurts, they fell sick, or have suffered an injury. U.S. Exh. 620 (Huber Dep.) at 100. For example, staff have heard Christine G. say the word "cold" whenever the environment around her appeared to be cold. U.S. Exh. 363; see also United States' Exhibit 671, which is a picture of Christine. Although Christine's inter-disciplinary team noted this during her 1993 annual review and recognized that she is aware of her environment and recognizes staff, Ebensburg does not provide her with any communication training. U.S. Exh. 363.

A number of devices have been developed for people with disabilities to assist them in being independent and in making learning more efficient, including clothing with velcro fasteners, feeding machines, communication boards using pictures, and switches that turn things on and off. Tr. 8/4/93 (Amado) at 40-42. These devices have been available for many years and are not new to the field. Tr. 8/4/93 (Amado) at 42. During his tours of Ebensburg, Dr. Amado saw only one or two switching devices, and was told that only one

person had a lap board for communication. Tr. 8/4/93 (Amado) at 42-43, 89.[26]/ Practically every single individual at Ebensburg who does not presently communicate could learn to communicate using some communication device. Tr. 8/4/93 (Amado) at 43. In many cases, the cost of electro-mechanical and augmentative communication devices will be borne by Medicaid, and does not become a direct cost of the agency providing services. Tr. 8/4/93 (Amado) at 83. Ebensburg's failure to provide electro-mechanical and augmentative communication devices to its resident is depriving these residents of the opportunity to control their environments and experience independence and self-satisfaction. Tr. 8/4/93 (Amado) at 42-43. Dr. Sneed concurred that a number of people can benefit from facilitated communication techniques. U.S. Exh. 635 (Sneed Dep.) at 61. Dr. Goldschmidt also agreed that Ebensburg needs more speech therapists to help clients who are able to learn sign language. U.S. Exh. 616 (Goldschmidt Dep.) at 94.

Despite his title as Coordinator of Speech and Hearing Services at Ebensburg, Mr. Huber does not have control over the deployment of the speech and hearing staff at Ebensburg. U.S. Exh. 620 (Huber Dep.) at 9, 95. Three of the speech and hearing staff work as monitors in addition to their speech and hearing responsibilities. U.S. Exh. 620 (Huber Dep.) at 84-85. Up until late November 1992, two additional speech and hearing staff were also working as monitors. U.S. Exh. 620 (Huber Dep.) at 85.

When the speech therapists work as monitors at Ebensburg, they do not have enough time to carry out all their speech and language programmatic responsibilities. U.S. Exh. 620

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[26]/ In October 1993, according to Mr. Bellomo, six individuals at Ebensburg have either communication boards or books. Tr. 10/14/93 (Bellomo) at 17.

(Huber Dep.) at 91. While working as monitors there are too many distractions that pull them away from their responsibilities and prohibit them from doing their job properly. U.S. Exh. 620 (Huber Dep.) at 93. Consequently, they do not have enough time to devote to providing speech and language programs to resident. U.S. Exh. 620 (Huber Dep.) at 97. The fact that speech and hearing staff have to work as program monitors is not satisfactory to Mr. Huber as a licensed professional in the field. U.S. Exh. 620 (Huber Dep.) at 95. He believes that it is a misutilization of "a lot of professional talent in utilizing these people as monitors in the learning center." U.S. Exh. 620 (Huber Dep.) at 95, lines 18-20.

The speech and hearing staff at Ebensburg are frustrated about their inability to provide programmatic services and have expressed their concerns about being taken away from their programmatic responsibilities. U.S. Exh. 620 (Huber Dep.) at 92, 97. Mr. Huber, in turn, has conveyed these concerns to Mr. Devine but feels that his hands are tied to remedy the situation. U.S. Exh. 620 (Huber Dep.) at 92, 97. He has felt so strongly that the speech and hearing staff should not have to serve as program monitors that he has had confrontations with Mr. Devine over this issue which he has not been able to resolve. Mr. Huber stated:

> I have a tendency to have a very violent temper. I have it in my job performance standards from Mr. O'Brien that I will not have anymore violent disagreements with the director of residential services [Mr. Devine]. That says enough for itself right there.

U.S. Exh. 620 (Huber Dep.) at 93, lines 4-8. Mr. Huber admitted that because Ebensburg's speech therapists have to function as monitors, it impedes their ability to design and implement programs that would allow residents to reach their potential with respect to the

acquisition of communication skills. U.S. Exh. 620 (Huber Dep.) at 116-117. Communication skills are necessary to ensure safety, allow individuals to protect themselves from harm, and enhance health. U.S. Exh. 620 (Huber Dep.) at 99-100. Mr. Huber also thinks that the manner in which speech and language services are provided to Ebensburg residents greatly reduces the benefits of the programs. U.S. Exh. 620 (Huber Dep.) at 126-127. This is because there are too many distractions in the learning center. U.S. Exh. 620 (Huber Dep.) at 127. This is particularly problematic with the individuals that the speech and hearing staff are trying to serve because in many cases they have "very short attention spans. They are easily distracted with extraneous visual and auditory stimulus. They look around. And you lose the attention that you've gained." U.S. Exh. 620 (Huber Dep.) at 126, lines 20-23.

As recently as October 1993, State surveyors cited Ebensburg for its failure to follow up on recommended re-tests for hearing evaluations on ten out of ten residents in the surveyors' sample. U.S. Exh. 1103 at 1. None of these residents had a hearing evaluation within the past year. Id. at 2.

VII. EBENSBURG IS FAILING TO PROVIDE ADEQUATE BEHAVIOR MANAGEMENT SERVICES.

A. Injuries Due To Behaviors Are Dramatically Increasing.

A significant percentage of all incidents and injuries at Ebensburg are caused by residents' behaviors.[1]/ There was a dramatic increase in the number of injuries due to behaviors between 1991 and 1992. Tr. 7/26/93 (Stark) at 105. In 1991, 625 incidents were caused by behaviors; in 1992, 904 were caused by behaviors. U.S. Exh. 91. This represent an increase of 45%. Tr. 7/26/93 (Stark) at 105. Between February 10, 1992 to February 10, 1993, 34% of all incidents and injuries at Ebensburg were attributable to residents' behaviors. Tr. 10/15/93 (O'Brien) at 76; Def. Exh. FF. For the period February 10, 1993 to August 25, 1993, 38.4% were due to behaviors. Tr. 10/15/93 (O'Brien) at 76; Def. Exh. GG. The percentage of injuries due to behaviors therefore continues to increase at Ebensburg.

Ebensburg has never attempted to identify individuals whose behaviors pose the greatest risk in terms of injury to themselves or to other people. U.S. Exh. 639 (Stratton Dep.) at 67. Ebensburg also does not compile information that shows aggregate numbers of injuries due to behaviors. U.S. Exh. 640 (Stratton Dep.) at 195. In fact, at the time of his deposition in January 1993, Dr. Stratton thought that Ebensburg was "getting close" to the point where there were no injuries due to behaviors. U.S. Exh. 640 (Stratton Dep.) at 209-210.

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[1]/ Behavior related occurrences include the following types of incidents, based upon Ebensburg's coding system as set forth in U.S. Exh. 73: assaults, fights (04) (05); "individual to individual interaction" (09); "individual to staff interaction" (10); ingestion of foreign matter (11); self-injurious act (14); and unacceptable absence (15). U.S. Exh. 90.

B. Ebensburg's Behavior Management Services Do Not Comport With Accepted Professional Standards.

Based upon their tours of Ebensburg, their interviews with both direct care and professional Ebensburg staff, their attendance at Behavior Intervention Committee meetings and/or drug reviews, and their extensive review of complete resident records and other Ebensburg documents, both psychology experts for the United States who testified about the adequacy of psychology services at Ebensburg found that they substantially depart from accepted professional standards. Tr. 8/2/93 (Russo) at 9-11; Tr. 8/4/93 (Amado) at 10, 12-13. Similarly, Dr. Stark found many deficient practices at Ebensburg in behavior management services. Tr. 7/27/93 (Stark) at 129-135, 139, 147, 148, 163. The United States' psychology experts identified a wide range of deficiencies in Ebensburg's behavior management practices, including failure to provide behavior programs in cases where maladaptive behaviors are causing repeated and serious injuries, Tr. 8/2/93 (Russo) at 75-77, 89-90; Tr. 7/26/93 (Stark) at 134; failure to provide effective behavior programs, Tr. 8/2/93 (Russo) at 59; failure to revise behavior programs where behaviors increase or do not change, Tr. 8/2/93 (Russo) at 68; Tr. 7/26/93 (Stark) at 134; and failure to provide behavior programs that comport with generally accepted standards. Tr. 8/2/93 (Russo) at 20, 59. The Psychology Discipline Coordinator at Ebensburg, Dr. Stratton, admits that there are not enough psychologists at Ebensburg to deliver services that meet accepted professional standards of care. U.S. Exh. 640 (Stratton Dep.) at 211. Dr. Stratton also acknowledges that the kinds of psychology issues that the Department of Justice has identified are issues that other people have identified at Ebensburg and talked about for some years. U.S. Exh. 640 (Stratton Dep.) at 225-226.

The Department of Justice itself identified these very same issues at Ebensburg as far back as 1987. In 1987, the Department of Justice notified defendants that injuries due to behaviors at Ebensburg were excessive. U.S. Exh. 638 (Sponsky Dep.) Exh. 49 at 3. Defendants were notified that Ebensburg was failing to provide its residents with minimally adequate training programs, and, as a result, its residents were being unduly restrained and injured. Id. at 2-3. Defendants were notified that Ebensburg was failing to provide behavior programs for residents with self-injurious and physically abusive or destructive behaviors. Id. at 2, 5. Defendants were also notified that where behavior programs existed, they were "so deficient as to fall below the level of any acceptable professional standard." Id. at 2. Defendants were notified that Ebensburg had insufficient numbers of direct care staff and that this was leading to preventable injuries and failures to implement behavior programs. Id. at 3. Finally, defendants were notified that Ebensburg must develop adequate behavior management programs and integrate these with the use of psychotropic medications in order to reduce the use of chemical restraint at Ebensburg. Id. at 2.

In 1990, defendants were again notified by the Department of Justice that Ebensburg's behavior management services remained deficient. U.S. Exh. 638 (Sponsky Dep.) Exh. 50. Again, defendants were notified that injuries due to behaviors were excessive and that Ebensburg was failing to provide professionally designed and implemented behavior programs. Id. at 5. Defendants were notified that "most of the existing [behavior] plans are too similar to reflect the individual needs of the resident, and, as such, do not reflect the judgment of a qualified professional as to the necessary steps needed to address the individual needs of the resident for whom the program was ostensibly designed." Id. Finally,

defendants were notified that Ebensburg was using physical and chemical restraints as substitutes for behavior programs. Id.

The only psychology expert to testify that Ebensburg's psychology services comport with accepted professional standards was Dr. Reid, and even then, Dr. Reid's testimony was equivocal. Dr. Reid carefully worded his response when asked whether Ebensburg's psychology services met accepted professional standards. Instead of a forthright yes, Dr. Reid equivocated, stating that "they're within the realm of what's considered accepted professional standards." Tr. 9/16/93 (Reid) at 12. Dr. Reid's opinion about Ebensburg's behavior management practices was similarly equivocal. See Tr. 9/16/93 (Reid) at 9 ("treatment of severe behavior disorders at Ebensburg is within the realm of standard professional services").

1. Dr. Reid Performed A Superficial Review Of Ebensburg's Behavior Management Services.

As compared to the three psychology experts for the United States, defendants' psychology expert, Dr. Reid, performed a very limited review of Ebensburg's behavior management services, and, as a result, failed to offer testimony on several aspects of Ebensburg's behavior management services. Experts for the United States, on the other hand, conducted extensive reviews of all of Ebensburg's psychology services, with particular emphasis on Ebensburg's behavior management services. A complete discussion of the qualifications and methodology of the three psychology experts for the United States can be found in the Appendix.

In order to form his opinion, Dr. Reid chose to conduct a limited review of Ebensburg's behavior management services although he had the same access to information

at Ebensburg as the United States' experts. Tr. 9/16/93 (Reid) at 114. The only part of residents' records that Dr. Reid reviewed were the behavior programs for those individuals with Class III interventions, which are the most restrictive interventions at Ebensburg. Dr. Reid did not review the comprehensive record of a single individual at Ebensburg. Tr. 9/16/93 (Reid) at 8.[2/] The two primary things that Dr. Reid did to evaluate the adequacy of the behavior programs at Ebensburg were to look at 15 behavior programs to see if they contained basic components and then observed 13 of the 15 individuals with those programs to see whether the programs were being implemented. Tr. 9/16/93 (Reid) at 106; U.S. Exh. 966. Dr. Reid did not look at a single record to determine whether Ebensburg revises behavior programs when individuals make no progress on the program or when behaviors increase. Tr. 9/16/93 (Reid) at 119. Instead, Dr. Reid relied on Ebensburg's representations that a process was in place to review the programs. Tr. 9/16/93 (Reid) at 119. Dr. Reid did not look at a single record to determine whether Ebensburg revises behavior programs when individuals hurt themselves or hurt others due to behaviors. Tr. 9/16/93 (Reid) at 123. Instead, Dr. Reid only determined that there was a structure in place to review injuries. He did not determine whether prompt follow up action was taken. Tr. 9/16/93 (Reid) at 123. Dr. Reid made no effort to determine whether Ebensburg had behavior programs in place for all individuals with maladaptive behaviors. Tr. 9/16/93 (Reid) at 126. Dr. Reid does not know if there is any individual at Ebensburg who has more

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[2/] Dr. Reid, in answering questions about particular cases commented on by United States' experts, was merely stating general principles in his field; he did not review any records or evaluate the individuals at issue before providing his comments about deficiencies the United States' experts identified. Tr. 9/16/93 (Reid) at 145, 155.

than one behavior program. Tr. 9/16/93 (Reid) at 153. Dr. Reid was told that Ebensburg individualizes data collection systems beyond its interval data collection system; he relied on this representation and made no attempt to independently verify it. Dr. Reid has not seen any individualized data collection system at Ebensburg. Tr. 9/16/93 (Reid) at 100. Dr. Reid did not sit in on any Behavior Intervention Committee meetings or attend any drug reviews. Tr. 9/16/93 (Reid) at 158. Dr. Reid did not evaluate whether any of the review processes in place at Ebensburg are effective or not. Tr. 9/16/93 (Reid) at 154-155. In forming his opinion about the adequacy of Ebensburg's behavior management practices, Dr. Reid did not study the 1988 Statewide Behavior Management Policy thoroughly. Tr. 9/16/93 (Reid) at 100.

2. Defendants Failed To Rebut Testimony On Deficient Behavior Management Practices At Ebensburg.

Dr. Reid was the only psychology expert called by defendants at trial. Ebensburg's Psychology Discipline Coordinator did not testify. Topics about which Dr. Reid did not testify include:

- Ebensburg's psychology services prior to his visit to Ebensburg in February 1993;
- Whether every individual at Ebensburg with a severe behavior disorder has a behavior program in place;
- Whether Ebensburg is addressing biting or pica behaviors in a professionally acceptable manner;
- The adequacy of behavior programs other than the 15 Class III programs at Ebensburg as of February 1993 -- and for these 15 individuals, because Dr. Reid had not reviewed their records, he could not even state whether the programs adequately addressed the behaviors of the individuals or whether the programs were effective;
- The effectiveness of the review and revision of behavior programs at Ebensburg;

- The effectiveness of any of the review processes that are in place at Ebensburg; and;

- Dr. Reid did not mention a single individual residing at Ebensburg during his direct testimony.

C. Ebensburg Does Not Have Sufficient Psychologists To Provide Services That Meet Accepted Standards.

Both Dr. Russo and Dr. Stratton agree that there are not enough psychologists at Ebensburg to deliver services that meet accepted professional standards of care. Tr. 8/2/93 (Russo) at 16; U.S. Exh. 640 (Stratton Dep.) at 211. Dr. Russo testified that the insufficiency of the number of PSA's at Ebensburg is resulting in harm to the residents. Tr. 8/2/93 (Russo) at 16.

James Stratton, Ph.D., has been the psychology discipline coordinator at Ebensburg Center for about 10 years. U.S. Exh. 639 (Stratton Dep.) at 11. Dr. Stratton has worked at Ebensburg since 1976. U.S. Exh. 639 (Stratton Dep.) at 15. He has never worked at any other facilities for mentally retarded people. U.S. Exh. 639 (Stratton Dep.) at 15.

The psychology department at Ebensburg includes Dr. Stratton, the only psychologist with a Ph.D., and eight other individuals called psychology services associates (PSA's). Six of the eight PSA's have masters degrees, and the remaining two PSA's have bachelor's degrees. Tr. 8/2/93 (Russo) at 15-16; U.S. Exh. 639 (Stratton Dep.) at 19-20.[3]/ The educational background of the PSA's is not taken into consideration when assigning caseloads

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[3]/ Ebensburg does not require that PSA's have training in behavior management before beginning work at Ebensburg. U.S. Exh. 640 (Stratton Dep.) at 215.

to the PSA's. U.S. Exh. 639 (Stratton Dep.) at 22-23. The bachelor's level PSA's have the same responsibilities as the master's level PSA's. U.S. Exh. 639 (Stratton Dep.) at 23.

Five PSA's at Ebensburg have caseloads of 48. Two PSA's (for Horizon and Laurel) have caseloads of 72. One PSA (for Keystone) has a caseload of 96. Tr. 8/2/93 (Russo) at 15; U.S. Exh. 639 (Stratton Dep.) at 20-21. Dr. Stratton believes that caseloads of 96 and 72 are not appropriate for the type of client that Ebensburg serves and are too large for the provision of effective services. U.S. Exh. 640 (Stratton Dep.) at 207-208. Dr. Stratton also believes that a caseload of 48 is large, and, depending upon the clients in the caseload, could be inappropriate. U.S. Exh. 640 (Stratton Dep.) at 210. Dr. Stratton testified that a caseload of 35 or 40 would be very manageable. U.S. Exh. 640 (Stratton Dep.) at 215.

Dr. Stratton does not think there are sufficient psychology staff to provide behavior programs that teach functional alternative behaviors to harmful behaviors. U.S. Exh. 640 (Stratton Dep.) at 211. Dr. Stratton does not think there are sufficient psychology staff to conduct adequate functional analyses for individuals at Ebensburg who need them. U.S. Exh. 640 (Stratton Dep.) at 211. Dr. Stratton testified that if there were smaller caseloads at Ebensburg, psychologists could provide more hands-on interventions with alternative stimulations and activities of daily living skills and do more sophisticated assessments of reinforcers and teach individuals to use assistive devices and teach replacement behaviors for challenging behaviors. U.S. Exh. 640 (Stratton Dep.) at 208-209.

Dr. Stratton is not the only manager or professional at Ebensburg that thinks more psychology staff are needed. For instance, Dr. Goldschmidt, Ebensburg's consultant psychiatrist, believes that Ebensburg needs more PSA's. U.S. Exh. 616 (Goldschmidt Dep.)

at 95. Mr. Seymour, the unit manager of Laurel House, believes that there should be "at least one PSA per living area" at Laurel. U.S. Exh. 630 (Seymour Dep.) at 85, lines 22-23. This equals four PSA's for 96 individuals, or a ratio of 1:24. If there were more PSA's assigned to Laurel House, Mr. Seymour feels confident that conditions would be improved. U.S. Exh. 630 (Seymour Dep.) at 84. In particular, Mr. Seymour believes that having a PSA present to demonstrate or model appropriate interventions when behaviors occur is "extremely important." U.S. Exh. 630 (Seymour Dep.) at 26, lines 23-25; 27, line 1. Moreover, having a PSA available at program sites and accessible to all shifts is also "extremely important" and would result in "an enhancement for training." U.S. Exh. 631 (Seymour Dep.) at 27, lines 3-10. Mr. Seymour believes that every individual at Laurel House has some form of maladaptive behavior. U.S. Exh. 631 (Seymour Dep.) at 28. Despite this, nearly one half of the total population at Laurel House do not even have a formal behavior program for their behaviors. Tr. 8/2/93 (Russo) at 59; U.S. Exh. 154. Even though Mr. Seymour believes that a PSA should be assigned to monitor behaviors at all meals at which Laurel House residents are eating, a PSA is not assigned or present at all meals. U.S. Exh. 631 (Seymour Dep.) at 91. When Mr. Seymour requested an additional PSA for Laurel House during July 1992, a PSA was only assigned on a quarter-time basis to Laurel house. U.S. Exh. 630 (Seymour Dep.) at 86, 87.

Staff have repeatedly requested increased availability of psychologists, particularly on evenings and weekends, when there are no psychologists on campus to help with behavior problems. Tr. 8/2/93 (Russo) at 16; U.S. Exh. 105 (examples of incident reports where staff request PSA availability on weekends and evenings). Staff at day programming have

also requested PSA availability. For instance, in March 1993, when Franklin B. had a severe behavior disturbance at the Gary Bain Center, in which he was throwing large wooden boxes, flipping tables, attempting to smash his chair and hit other clients, and eventually ended up breaking the loading dock door with his head, staff requested that a PSA intervene, but no PSA was available. U.S. Exh. 105; Tr. 8/2/93 (Russo) at 16-18.

The only witness who testified that Ebensburg has a sufficient number of psychologists was Dr. Reid. Tr. 9/16/93 (Reid) at 19-20. In forming his opinion, Dr. Reid was not aware that one psychologist at Ebensburg has a caseload of 96 and another has a caseload of 72. Tr. 9/16/93 (Reid) at 134. Dr. Reid did allow, however, that if you compare the number of psychologists at Ebensburg with other facilities, Ebensburg would look relatively low. Tr. 9/16/93 (Reid) at 135.[4]/ He also allowed that he had "no doubt that the likelihood of improving services could be improved if [Ebensburg] had more [psychologists]." Tr. 9/16/93 (Reid) at 129, lines 11-13.

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[4]/ Comparing Ebensburg to Western Carolina, a state-run residential facility where Dr. Reid is the Director of Psychology, is instructive. At Western Carolina, where the population is of similar size and with a similar range of disabilities as the population of Ebensburg, the psychology department includes three Ph.D. psychologists in addition to Dr. Reid, ten masters level psychologists, two special educators, and nine psychology technicians with bachelor's degrees. Tr. 9/16/93 (Reid) at 135-137, 140. Western Carolina's numbers reflect about seven FTE to do applied research and to perform work in the community that Ebensburg does not do. Tr. 9/16/93 (Reid) at 140-142. Putting aside these seven additional FTE, Western Carolina still has about 18 FTE psychology staff to work exclusively with the individuals living at Western Carolina -- double the 9 psychologists working at Ebensburg.

At Western Carolina, the caseload for the ambulatory population is about 32 and for the non-ambulatory population, about 43. Tr. 9/16/93 (Reid) at 138-140, 142. A Ph.D. psychologist supervises every 5 psychologists. Tr. 9/16/93 (Reid) at 139. In addition, Western Carolina also has one master's level psychologist, 2 special educators, and five bachelor's level psychology technicians who are not assigned particular caseloads, but instead work with the entire population. Tr. 9/16/93 (Reid) at 139-140.

In order to provide psychology services that meet accepted professional standards of care, Ebensburg needs about four more Ph.D. psychologists and about twice the number of psychologists that presently work at Ebensburg. Tr. 8/2/93 (Russo) at 138-139. In order to provide psychology services that meet accepted professional standards of care, Dr. Stratton testified that he would need one more Ph.D. in psychology and at least two more psychologists with masters degrees. U.S. Exh. 640 (Stratton Dep.) at 212-213. Dr. Stratton made it clear that he was testifying about providing adequate -- not ideal -- services. U.S. Exh. 640 (Stratton Dep.) at 212-213. In order to provide psychology services that train individuals most efficiently and with the least restrictive interventions, in Dr. Stratton's opinion, Ebensburg needs two more Ph.D. psychologists and three additional masters level psychologists. U.S. Exh. 640 (Stratton Dep.) at 214.

Mr. O'Brien is concerned about the competency and quality of some of the PSA's at Ebensburg. U.S. Exh. 624 (O'Brien Dep.) at 136. Although Mr. O'Brien feels that there is a need to train all staff at Ebensburg, he feels that there may be more of a need to train the PSA's than others. U.S. Exh. 624 (O'Brien Dep.) at 212-213. Ebensburg staff have also indicated their desire for competent psychologists. For example, following a July 1992 incident in which Winfield M. was struck by a chair thrown by his peer, a direct care staff recommended that behavior programs be set up "by a competent psychologist." U.S. Exh. 105 at 4. Dr. Stratton believes that the Ebensburg PSA's have the greatest training needs in overall assessment skills and in hands-on training of clients on self-care skills. U.S. Exh. 639 (Stratton Dep.) at 49.

In spite of these perceived training needs, the only formal in-house training for the PSA's at Ebensburg consists of a monthly meeting with Dr. Stratton that lasts approximately 2 hours. Attendance at this meeting is not mandatory. U.S. Exh. 639 (Stratton Dep.) at 43-44. There is no budget marked for out-service training for the psychologists at Ebensburg. U.S. Exh. 639 (Stratton Dep.) at 45. PSA's have not in all cases received training that they needed as identified on prior years' evaluations either because in-house training was not provided or because out-service training requests were denied. U.S. Exh. 639 (Stratton Dep.) at 48.

1. The Role Of Ebensburg's Psychology Discipline Coordinator Is Too Limited.

Ebensburg's Psychology Discipline Coordinator, Dr. Stratton, is not responsible for the hiring, firing, or disciplining of the Ebensburg PSA's. Tr. 8/2/93 (Russo) at 18. Mr. Devine, who is in charge of residential services at Ebensburg -- not Dr. Stratton -- is ultimately responsible for assigning, and is directly involved in deciding, the caseload for each PSA. U.S. Exh. 639 (Stratton Dep.) at 21. The PSA's do not report to Dr. Stratton, but to their respective unit managers. Tr. 8/2/93 (Russo) at 18; U.S. Exh. 639 (Stratton Dep.) at 30-32. As far as Dr. Stratton knows, none of the unit managers have any background in psychology. U.S. Exh. 639 (Stratton Dep.) at 31. Given their lack of background and training in psychology, their inability to provide oversight of the PSA's' work, and their frequent use of psychology staff for non-psychology functions, the unit directors are ill-equipped and inappropriate to supervise psychology services at Ebensburg. Tr. 8/2/93 (Russo) at 80-81.

Dr. Stratton has no authority to require PSA's to attend the monthly in-house training sessions that he provides. U.S. Exh. 639 (Stratton Dep.) at 45. Dr. Stratton thinks he should have the authority to require PSA's to attend these monthly training meetings. U.S. Exh. 639 (Stratton Dep.) at 45. Dr. Stratton has no formal budget to support the continuing education and professional development of the Ebensburg PSA's. Tr. 8/2/93 (Russo) at 18.

Dr. Stratton is not responsible for ensuring the adequacy of the skills training programs at Ebensburg. U.S. Exh. 639 (Stratton Dep.) at 51.

Dr. Stratton is not responsible for ensuring that every individual who lives at Ebensburg who has self-injurious behavior has an adequate behavior program to address the behavior. That responsibility falls to the individual QMRP's and ultimately to Mr. Bellomo. U.S. Exh. 640 (Stratton Dep.) at 193-194. Dr. Stratton is not responsible for ensuring that all staff who carry out behavior programs are sufficiently trained to carry them out. U.S. Exh. 639 (Stratton Dep.) at 54. Dr. Stratton is not responsible to ensure that behavior programs are consistently and correctly implemented. U.S. Exh. 639 (Stratton Dep.) at 55.

Dr. Stratton is not the chairperson of the Behavior Intervention Committee ("BIC"). Mr. O'Brien, the chair of the BIC, has no background in psychology. U.S. Exh. 640 (Stratton Dep.) at 198.

2. Psychologists At Ebensburg Perform Non-Psychology Functions Due To Staff Shortages.

Psychologists providing services to individuals with mental retardation in a residential setting like Ebensburg must work on positive, skill-oriented programming and develop skills training programs for positive skills training as well as behavior programs for difficult behaviors. Tr. 8/2/93 (Russo) at 11. Psychologists should observe their clients in all

environments, and it is appropriate that psychologists accompany their clients to day programs as long as the psychologist is acting based on the needs of individual clients, and not due to staffing shortages. Tr. 8/2/93 (Russo) at 111-112.

However, psychologists at Ebensburg, who have huge caseloads, are pulled away from their duties due to staffing shortages to do ancillary tasks, including driving buses and suctioning during dental procedures; functioning as program monitors;[5]/ and performing direct care responsibilities. Tr. 8/2/93 (Russo) at 12-14; U.S. Exh. 639 (Stratton Dep.) at 34, 37-39; see also U.S. Exh. 182 (psychologist Zubal's grievance that instead of performing psychology duties, he was acting as a program monitor); U.S. Exh. 639 (Stratton Dep.) at 38-39 (psychologist Phillips acted as program monitor for approximately a year due to staff shortages); U.S. Exh. 639 (Stratton Dep.) at 34-36 (psychologists Hanagan and Lamar act as program monitors one half of one day each week, and on an as-needed basis the rest of the time, depending upon staff shortages). The Ebensburg psychologists uniformly expressed their concerns about being pulled away from their duties as psychologists to both Dr. Russo and to Dr. Stratton. Tr. 8/2/93 (Russo) at 15. In fact, Dr. Stratton encouraged psychologists Hanagan and Lamar to keep a diary of the time they spent acting as program monitors because he agreed with their concerns. U.S. Exh. 639 (Stratton Dep.) at 35-36; Tr. 8/2/93 (Russo) at 15. In addition, Dr. Stratton has discussed his concern that PSA's are made to act as program monitors with the supervisors who make those assignments, but the practice continues due to staff shortages. U.S. Exh. 639 (Stratton Dep.) at 38-39.

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[5]/ A program monitor is responsible for supervising a group of residents and direct care staff during day programs. U.S. Exh. 617 (Graham Dep.) at 39.

Dr. Reid agreed that the time spent by psychologists in non-psychology functions "needs to be relatively limited." Tr. 9/16/93 (Reid) at 17. However, Dr. Reid did not evaluate how much time psychologists at Ebensburg are engaged in direct service or support activities versus clinical time. Tr. 9/16/93 (Reid) at 149.

D. Behavior Management Standards Are Clear And Are Generally Set Forth In The Commonwealth's 1988 Statewide Behavior Management Policy.

Over the past thirty or forty years, an enormous body of scientific literature has been developed in the field of behavioral psychology that shows how to work effectively with mentally retarded clients. Tr. 8/2/93 (Russo) at 27-28; Tr. 8/4/93 (Amado) at 9-10. This literature sets forth the methodology by which a behavior like aggression or self-injurious behavior can be assessed, how that assessment is used to develop a treatment prescription, and how an adequate evaluation of progress can be made. Tr. 8/2/93 (Russo) at 27-28. The value of understanding the function of a behavior is well developed in the scientific literature, which links the identification of a problem behavior with its successful treatment. Tr. 8/2/93 (Russo) at 28.

The standards for behavior management techniques for people with mental retardation are written not only in the literature, but also have been written by many states, including the Commonwealth of Pennsylvania. Tr. 8/2/93 (Russo) at 118. U.S. Exh. 30 is Pennsylvania's 1988 Statewide Behavior Management Policy ("Commonwealth's 1988 Behavior Management Policy"). The Commonwealth's 1988 Behavior Management Policy is the current policy in effect at Ebensburg setting forth requirements for behavior management. Tr. 8/2/93 (Russo) at 18-19; U.S. Exh. 640 (Stratton Dep.) at 6; U.S. Exh. 870 (Thaler Dep.) at 53.

Experts for both the United States and the Commonwealth agree that the requirements of the Commonwealth's 1988 Behavior Management Policy comport with generally accepted practices in the field. Tr. 8/2/93 (Russo) at 19; Tr. 8/4/93 (Amado) at 9-10; Tr. 9/16/93 (Reid) at 83. The practices embodied in the 1988 policy have been generally accepted principles in the field for at least the past decade, and probably for the past 15 to 20 years. Tr. 8/2/93 (Russo) at 19-20.

E. Ebensburg Is Failing To Provide Behavior Programs For Every Individual Exhibiting Serious Behaviors Resulting In Severe And Repeated Injuries.

Residential facilities like Ebensburg must provide a behavior program for every individual with a serious behavior problem. Tr. 8/2/93 (Russo) at 11, 21. Dr. Stratton acknowledges that every individual who exhibits a behavior that is potentially harmful to that person or to another person needs to have a behavior program. U.S. Exh. 639 (Stratton Dep.) at 79-80. However, Ebensburg has never made an attempt to identify individuals whose behaviors pose the greatest risk in terms of injuries to themselves or to other people. U.S. Exh. 639 (Stratton) at 67.

Dr. Russo, Dr. Stark and Dr. Fahs concluded that there are a number of individuals at Ebensburg exhibiting serious behaviors that are causing severe and repeated injuries for whom Ebensburg has instituted no behavior program to treat the serious behaviors. Tr. 8/2/93 (Russo) at 75-77, 89-90; Tr. 7/26/93 (Stark) at 134; Tr. 8/3/93 (Fahs) at 93-96. During their review of samples of Ebensburg records, Drs. Russo and Stark discovered that individuals exhibiting such very serious and dangerous behaviors as aggression, self-injurious behaviors, pica, biting, and inappropriate sexual behaviors had no behavior programs to

address these behaviors. Tr. 8/2/93 (Russo) at 25, 75-77, 89-90; Tr. 7/26/93 (Stark) at 134. Dr. Russo testified about 17 such cases he identified during his record review -- fully a third of the records he reviewed. Tr. 8/2/93 (Russo) at 75-77, 89-90. During his record review, Dr. Stark identified many such cases and prepared a summary chart containing 14 examples that was entered into evidence as U.S. Exh. 780 (attached). Tr. 7/26/93 (Stark) at 134. Since at least 1983, Ebensburg has been aware that it is failing to provide behavior programs to many residents with severe maladaptive behaviors. U.S. Exh. 793. Since 1983, State surveyors have repeatedly cited Ebensburg for its failure to provide behavior programs to residents with severe maladaptive behaviors. U.S. Exh. 793; U.S. Exh. 60 at 503756-503757. The Commonwealth's psychology expert, Dr. Reid, made no effort to determine whether Ebensburg had behavior programs in place for all individuals with maladaptive behaviors. Tr. 9/16/93 (Reid) at 126. Dr. Reid, therefore, could not refute testimony by experts for the United States that some Ebensburg clients who need behavior programs do not have them because Dr. Reid only reviewed cases wherein behavior programs had been developed. Tr. 9/16/93 (Reid) at 15-16.

The Commonwealth did not rebut a single case cited by either Dr. Russo or Dr. Stark, either by providing evidence that a behavior program was in place, or had been considered and rejected, or was not necessary.[6]/ Each individual at Ebensburg who is

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[6]/ The sole possible exception to this statement may be the case of Rosemary W. Ebensburg finally provided a behavior program for Rosemary following Dr. Russo's deposition in February 1993. However, at the time that Dr. Russo toured Ebensburg in the fall of 1992 and copied Rosemary's record, Rosemary was wearing a helmet for her behavior and had no behavior plan for her self-injurious behavior of throwing herself to the ground and injuring herself. Tr. 8/2/93 (Russo) at 59, 76. Ebensburg failed to provide a behavior program for Rosemary in spite of the fact that IOC surveyors had cited Ebensburg for its failure to provide a behavior program for Rosemary during

(continued...)

exhibiting serious behaviors in the absence of an appropriate behavior program is not receiving the benefit of appropriate psychology services and has experienced harm as a result of Ebensburg's failure to provide these services. These individuals are at risk to themselves and others at Ebensburg on a continuing basis. Tr. 8/2/93 (Russo) at 77, 90. The kinds of serious behaviors that Ebensburg is failing to address with behavior programs fall into four general categories: 1) aggression and self-injurious behaviors; 2) pica; 3) biting; and 4) inappropriate sexual behaviors.

1. Ebensburg Is Failing To Provide Behavior Programs For Aggression And Self-Injurious Behaviors.

Both Dr. Russo and Dr. Stark identified cases where Ebensburg is failing to provide behavior programs for individuals with aggressive and/or self-injurious behaviors who are causing severe and repeated injuries to themselves or others. Tr. 8/2/93 (Russo) at 75-77; Tr. 7/26/93 (Stark) at 134; U.S. Exh. 780. Examples of such cases include:

- Denise V., who does not have a behavior program for her severe self-injurious behavior, even though she has suffered serious and repeated injuries due to her behavior of

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[6]/(...continued)
their August 1992 survey. U.S. Exh. 1100. Dr. Stratton recalls that during Dr. Russo's tour in October 1992, staff reported that Rosemary wears a helmet because she has a behavior of throwing herself on the floor. U.S. Exh. 640 (Stratton Dep.) at 123.

Mr. Bellomo's testimony on the topic of Rosemary's helmet usage and whether he was aware of the need for a behavior program was quite contradictory. During cross-examination on October 14, 1993, Mr. Bellomo emphatically stated that he was unaware that Rosemary was wearing a helmet due to behaviors, including head banging, until Dr. Russo's deposition in February 1993. Tr. 10/14/93 (Bellomo) at 149-150. He maintained this position, even when shown the August 1992 IOC report citing Rosemary's helmet without a behavior plan as a deficiency some six months earlier. He stated again, that "[t]he first time I learned of it was Dr. Russo's deposition." Tr. 10/14/93 (Bellomo) at 150.

The next day, in re-direct testimony, he stated "the behavior and the problem of the helmet has been to my attention for quite some time." Tr. 10/15/93 (Bellomo) at 51, lines 16-17. When asked whether it was before Dr. Russo's deposition, he replied "Oh, my, yes. It was long before that deposition" and proceeded to describe the deficiency cited by the IOC survey team. Id. at 51, line 19.

banging her head on walls, floors, and windows. Tr. 8/2/93 (Russo) at 75; see also U.S. Exh. 493(aa)(1992 and 1993 incident reports documenting instances where Denise has injured herself while banging her head). Denise's mother, Marian Dekowski, testified that since she placed Denise at Ebensburg when Denise was five, Denise's head has become indented and she walks now with a limp. Mrs. Dekowski thinks that both have been caused by Denise's head-banging. Tr. 7/26/93 (Dekowski) at 173-174. On July 24, 1993, two days before Mrs. Dekowski testified, Denise was found injured, and Ebensburg suspects that her injuries were due to her self-injurious behaviors. U.S. Exh. 958.

- James S., who does not have a behavior program for self-injurious behavior. Tr. 8/2/93 (Russo) at 75. James S.'s annual psychological evaluation identifies several behavior deficits, including aggression, punching, kicking, biting, scratching, or throwing objects, and aggression to the environment, and self-injurious behavior such as head banging, stabbing himself with a utensil, or falling backwards. U.S. Exh. 640 (Stratton Dep.) at 144. The only target behaviors included in James' behavior program are for aggression, which is defined as "hitting, slapping, kicking, and spitting." Stratton Dep. Exh. 3. Although James does have a behavior program for aggression that purports to also address his self-injurious behaviors, there is insufficient documentation in James' record to suggest that James' self-injurious behavior and his aggression are related and amenable to the same treatment. Tr. 8/2/93 (Russo) at 75, 112-113; Tr. 8/3/93 (Fahs) at 130-131 (James' self-injurious behaviors are inappropriately "lumped together" for treatment purposes with other distinct unrelated behaviors).[7]/ In November 1992, when Ebensburg approved the use of Sinequan on an emergency basis for treatment of James' depression, James' team was instructed to submit a behavior program addressing James' self-injurious behavior together with a restrictive procedure request to the Behavior Intervention Committee. U.S. Exh. 922. The December 1992 minutes of the Behavior Intervention Committee, when a restrictive procedure request for James (client #806) was submitted, reflect no discussion of a behavior program for James for his self-injurious behavior. U.S. Exh. 42(c) at 541414. One month later when the Psychology Discipline Coordinator, Dr. Stratton, was deposed, he admitted that James' behavior program could be expanded and may be confusing to staff about how to respond to James' self-injurious behavior. U.S. Exh. 640 (Stratton Dep.) at 153, 168. This aspect of James' behavior program is still the same. U.S. Exh. 856. James has suffered many, many injuries due to his self-injurious behaviors. U.S. Exh. 479. James' injuries from self-abuse continued even at the time of trial. U.S. Exh. 958. For the period May through mid-August 1993, James engaged in self-injurious behavior four times, including breaking two mirrors and using the glass to cut his head open, hitting his head on the door causing four cuts to his

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[7]/ Ebensburg has been repeated cited by State surveyors for its behavior programs, which inappropriately "lump together" more than one than one maladaptive behavior. U.S. Exh. 793; U.S. Exh. 66 at 2A (a "significant number" of Ebensburg behavior programs are "unacceptable" because, among other things, only one behavior program is provided for "multi-targeted behaviors").

forehead, hitting his head on a metal desk and lacerating his scalp, and removing his toenail. No change was made in his behavior program. U.S. Exh. 958.[8]/

- Winfield M., who has no behavior plan for his aggression. Tr. 8/2/93 (Russo) at 77. Ebensburg restrained Winfield for his behavior twice in 1991; 14 times between June and November 1992 (including three instances of restraint in a papoose board); and 3 times during the first seven and a half months of 1993. U.S. Exh. 993.

- Eileen G. Both Dr. Russo and Dr. Stark reviewed Eileen's record and both concluded that she has no behavior program for her "long history" of aggressive behavior of pushing clients off of furniture and pulling them out of their wheelchairs. Tr. 8/2/93 (Russo) at 76; U.S. Exh. 780. During the seven months from August 1991 until February 1992, Eileen, on at least 23 occasions, pushed, shoved, punched, slapped, and hit other residents, including knocking them to the floor from their wheelchairs, stepping on them, sitting on top of them, and pulling their arms and hair. U.S. Exh. 360. Both experts also concluded that Eileen has no behavior program for her self-injurious behavior, which includes biting and hitting herself. Tr. 8/2/93 (Russo) at 76; U.S. Exh. 780.

- Ruth J. Both Dr. Russo and Dr. Stark reviewed Ruth's record, and both concluded that Ruth has no behavior program for her aggression and self-injurious behaviors. Tr. 8/2/93 (Russo) at 76-77; U.S. Exh. 780. Dr. Russo testified that when Ruth struck her mouth on a railing, resulting in the extraction of Ruth's tooth, staff commented that Ruth "is known for this type of behavior." Tr. 8/2/93 (Russo) at 76-77. The regression analysis for Ruth shows that her aggressive behavior significantly increased during the period from January 1992 through March 1993. U.S. Exh. 783.

- Eugene B. The videotape taken by Dr. Russo during his tours of Ebensburg shows Eugene with each finger bandaged due to his severe self-injurious finger picking that results in bleeding. Tr. 8/2/93 (Russo) at 88; U.S. Exh. 260. Ebensburg has not provided a behavior program for Eugene, in spite of the fact that Eugene chronically injures his fingers in a self-injurious ritual. Tr. 8/2/93 (Russo) at 77, 88.

- Mark K., who has no behavior program for his self-injurious behaviors despite repeated episodes of slapping, pounding and scratching his face to the point of causing bruising, swelling, and abrasions. Dr. Stark noted that Mark has now begun to also bite himself. U.S. Exh. 780.

- Estelle M., who has no behavior program for her self-injurious behavior of inserting objects into her vaginal and rectal areas, in spite of repeated instances of this

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[8]/ See also infra § IX.A.7 (discussion of the inadequate psychiatric care that Ebensburg has provided to James).

behavior with such objects as a chair leg, a pencil, a hair brush, and a spoon. Tr. 7/26/93 (Stark) at 134-135; U.S. Exh. 780.

- James W., who has no behavior program for his self-injurious behavior of tearing off his fingernails and toenails. Tr. 7/26/93 (Stark) at 135; U.S. Exh. 780. James has exhibited this behavior on a number of occasions. U.S. Exh. 135, 136.

- Rosemary W., who has no behavior program for her self-injurious behavior of throwing herself on the floor and injuring herself, in spite of the fact that she wears a restraint helmet for this behavior. Tr. 8/2/93 (Russo) at 59, 76.

2. Ebensburg Is Failing To Provide Behavior Programs For Pica.

There is a wealth of information that is well-established in the literature about the treatment of individuals with pica, the behavior of eating inedibles. Tr. 8/2/93 (Russo) at 73-74. Experts for both the United States and the Commonwealth agree that individuals who exhibit pica behavior need to be provided a behavior program to treat that behavior. Tr. 8/2/93 (Russo) at 74, 104-106; U.S. Exh. 639 (Stratton Dep.) at 71. In every single case of pica he has treated, Dr. Russo has been able to identify strategies that reduce the pica behavior. Tr. 8/2/93 (Russo) at 108-109. Although pica is a behavior that, in some cases, is "stunningly amenable to treatment," Tr. 8/2/93 (Russo) at 107, line 13, the chances of treatment success decrease the longer the behavior is not treated in a professionally acceptable manner. Tr. 8/2/93 (Russo) at 107-108.

Individuals with known pica behaviors at Ebensburg do not have behavior programs to address the pica. Tr. 8/2/93 (Russo) at 75-77, 89-90; Tr. 7/26/93 (Stark) at 134; U.S. Exh. 780. Dr. Stark identified three individuals who exhibit pica behavior, yet have no behavior program for pica. Tr. 7/26/93 (Stark) at 134; U.S. Exh. 780. For instance, Dale J. has no behavior program for pica even though he has swallowed parts of zippers, screws, a key and other metallic objects, and pieces of rug and paper, and has been hospitalized

several times due to a GI bleed. Tr. 7/26/93 (Stark) at 134; U.S. Exh. 780 (attached). In October 1992, Dale's team met and decided he did not have pica and concluded that the items must have entered him through a "contaminated food item or accidental ingestion." Tr. 7/26/93 (Stark) at 134; U.S. Exh. 780. In addition to Dale, Dr. Stark found that Michael B., who eats Attends, toilet paper and toothpaste, does not have a behavior program for pica even though his pica behavior is noted in Michael's annual review. U.S. Exh. 780. Dr. Stark also found that Vincent P. does not have behavior program for pica, even though foreign objects have been found in his vomit. U.S. Exh. 780.

Dr. Russo testified about seven additional individuals who exhibit serious pica behavior, yet have no behavior program for pica. Tr. 8/2/93 (Russo) at 75-76, 90. For example, Brian B. has been hospitalized for ingestion of a piece of wood, and has eaten chalk, a crayon, and an ear tip from a thermometer. Tr. 8/2/93 (Russo) at 76. David W. has had several surgical procedures to remove objects he has swallowed and has a psychiatric diagnosis of pica, but has no behavior program for pica. Tr. 8/2/93 (Russo) at 90.[9]/ In addition to Brian and David, Dr. Russo noted that Darren W., George C., Lawrence D., Brenda M., and John B. all exhibit pica behaviors, yet have no behavior programs for pica. Tr. 8/2/93 (Russo) at 76-77.

The psychology expert for the Commonwealth did not know whether all of the Ebensburg clients with serious pica behaviors have a behavior program for pica, but he would be "surprised" if they did not. Tr. 9/16/93 (Reid) at 127-128.

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[9]/ Stratton Dep. Exh. 10 is a computer printout of the eight individuals at Ebensburg who have a psychiatric diagnosis of pica. U.S. Exh. 639 (Stratton Dep.) at 69-70. The list includes David W.

3. Ebensburg Is Failing To Provide Behavior Programs For Biting.

Ebensburg is failing to provide behavior programs to individuals who bite others, and these individuals are inflicting serious and painful repeated bites on the residents at Ebensburg. Tr. 7/26/93 (Stark) at 134; U.S. Exh. 780. Ebensburg has taken inadequate action both to protect the person being bitten and to address the behaviors of the biter. Tr. 7/26/93 (Stark) at 129. George M. is an individual identified by Dr. Stark as having no behavior program for biting even though George has inflicted many serious bites. U.S. Exh. 780. Ebensburg has failed to provide George with a behavior program for biting despite the fact that in August 1992, the IOC surveyors identified George as an individual who needed a behavior program for biting. In their 1992 survey, the IOC reviewers specifically cited Ebensburg's failure to identify biting as a problem behavior for George, especially given the fact that George is a Hepatitis B carrier. U.S. Exh. 67 at 8D.

The evidence shows that in 1992, George bit or was suspected to have bitten Larry D. on seven different occasions, inflicting at least 28 bites. U.S. Exh. 267(c). On March 30, George was suspected to have caused seven bite wounds on Larry's shoulder and arm. On April 1, George was suspected to have bitten Larry twice on the chest. On April 22, direct care staff heard Larry scream and he came running over to staff with bite marks on both hands. The incident report notes that although the bites were not witnessed, that George was near Larry and "has bitten [Larry] repeatedly in the past." On September 18, George bit Larry on the upper arm. On September 21, direct care staff heard a loud scream from the bedroom, ran in and discovered George biting Larry on the arm. Five fresh bites were found on Larry. On September 22, George bit Larry again -- twice on the forearm, once on

the finger, and once on the upper arm. On December 10, staff heard Larry scream and turned to see George biting Larry; this time George bit Larry seven times, including both wrists, on the forearm and between the eyebrows. U.S. Exh. 267(c).

Dr. Stark also found that Andrew H. has no behavior program for biting. U.S. Exh. 780. Andrew bit his peers six times between July and November 1992. Tr. 7/26/93 (Stark) at 129; U.S. Exh. 267(c). Ebensburg staff noted the need to develop a behavior program for Andrew's biting during July 1992. Tr. 7/26/93 (Stark) at 129; U.S. Exh. 780, 267(c). Instead of treating Andrew's biting with a behavior program, Ebensburg is treating Andrew's biting by giving him psychotropic medications. U.S. Exh. 780.[10]/

Dr. Stark found that George F., an individual with a long history of serious biting behaviors, has no behavior program for biting. U.S. Exh. 780. Ebensburg has failed to provide a behavior program for George's biting even though Dr. Sneed asked Ebensburg to provide one in 1991 due to Dr. Sneed's concern that "client will continue to bite (attack) other relatively defenseless individuals." U.S. Exh. 780; see also supra § V.F.3 (discussion of Ebensburg's failure to protect its residents from George's biting even when told to do so).

Some Ebensburg residents are being repeatedly bitten by the same person. Tr. 7/26/93 (Stark) at 129. For example, Mary Ann R. was bitten five times by Bonnie R. in a five month period between late 1992 and early 1993. Tr. 7/26/93 (Stark) at 129. Bonnie does not have a behavior program to address her biting. Tr. 7/26/93 (Stark) at 129; U.S. Exh. 780. Dr. Stark calls this "disturbing" and stresses that "You've got to address biting;

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[10]/ For a discussion of the inadequate psychiatric care that Ebensburg provides Andrew, including its failure to consider non-medication alternatives for Andrew's behavior, see infra § IX.A.7.

this is a very severe, high priority type behavior that needs to be addressed." Tr. 7/26/93 (Stark) at 129. In Larry D.'s case, when staff have identified the biter, it is most frequently the same person (George M.), who does not have a behavior plan for his biting and is a Hepatitis B carrier. U.S. Exhs. 780, 267(c).

The psychology expert for the Commonwealth agreed that biting is a very serious problem, that biting is very painful, and that biting behavior can be eliminated in certain cases. Tr. 9/16/93 (Reid) at 14.[11]/ Dr. Reid did not review whether individuals at Ebensburg who bite have appropriate behavior programs for biting. Tr. 9/16/93 (Reid) at 146.

4. Ebensburg Is Failing To Provide Behavior Programs For Inappropriate Sexual Behavior.

Ebensburg has also failed to provide behavior programs to residents with inappropriate sexual behaviors. Tr. 7/26/93 (Stark) at 134; U.S. Exh. 780. There are many individuals at Ebensburg who engage in inappropriate sexual behaviors. U.S. Exh. 615 (Goldschmidt Dep.) at 97. Ebensburg's failure to provide behavior programs for inappropriate sexual behaviors is particularly harmful in light of the fact that Ebensburg has no sexuality counselor. Tr. 10/14/93 (Bellomo) at 112-113. Ebensburg's psychiatric consultant, Dr. Goldschmidt, thinks that Ebensburg should have a sexuality counselor. In her opinion, if Ebensburg had a sexuality counselor, a lot of the sexual acting out might be eliminated. U.S. Exh. 615 (Goldschmidt Dep.) at 97. Dr. Stark found that James W. does not have a behavior program for his inappropriate sexual behavior. U.S. Exh. 780. Mr.

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[11]/ Dr. Hauser, one of the Commonwealth's psychiatry experts, testified that, in every single case of his, biting behavior was improved by his treatment. Tr. 9/15/93 (Hauser) at 141-142.

Bellomo knew as far back as December 1991 that James W. was sexually aggressive. Tr. 10/14/93 (Bellomo) at 108. In spite of this knowledge, Mr. Bellomo placed James in Keystone House to recuperate from his fractured jaw. A few weeks later, in January 1992, James was found in a Keystone bathroom stall with Keystone resident Vincent V., Vincent's underwear was down, and James was straddling him.[12]/ Following three more incidents in 1992 where James was engaged in a sexual activity with another client, James' team met on October 28, 1992. James' team decided to acquire a private bedroom for James and to contact a certified sex therapist for James. U.S. Exh. 501 (summary chart of Ebensburg's response to James W.'s sexual behaviors). James' sexual behaviors continued. After six such incidents, on November 12, 1992, Mr. Bellomo issued a memo stating that James should be moved to a private bedroom "immediately." On Thursday, November 19 at 5:10 a.m., James was found in bed with another individual disrobed from the waist down. Later that same day, at 10:00 a.m., James was found in the bathroom on his living unit engaging in anal intercourse with Michael W., a Hepatitis B carrier. U.S. Exh. 501. James was not moved to a private bedroom until more than two weeks after Mr. Bellomo's memo, on November 27, 1992, nearly a month after James' team recommended that he be moved to a private bedroom. Tr. 10/13/93 (Bellomo) at 169.[13]/ An evaluation of James' sexual

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[12]/ This evidence directly contradicts Mr. Bellomo's testimony that no sexual occurrences occurred in Keystone House in either 1992 or 1993. Tr. 10/13/93 (Bellomo) at 152-153.

[13]/ U.S. Exh. 501 lists November 24, 1993 as the date that James was moved to his private bedroom. This was based upon his 11/19/92 occurrence report where he was engaged in anal sex with a Hepatitis B carrier. On the back of his occurrence report, the supervisor notes that he is "slated to move to private bedroom on 11/24/92." U.S. Exh. 501(a) at 00540663. Mr. Bellomo testified at trial, however, that James was not actually moved until November 27, 1992. Tr. 10/13/93 (Bellomo) at 169.

indicated that George was "too low functioning" for a behavior problem. Id. at 104. Dr. Fahs was struck by this notion, given that George is no different than the other profoundly mentally retarded individuals at Ebensburg. Id. Defendants' psychiatric expert, Dr. Hauser, admitted that it would obviously be a problem if Ebensburg staff routinely concluded that individuals were too low functioning to benefit from programming. Tr. 9/15/93 (Hauser) at 97. Instead of providing George with a behavior program, Ebensburg is treating George's behavior of masturbating at inappropriate places and times with psychotropic medication. Id. 103-105; see also infra § IX.A.7 (discussion of Ebensburg's failure to provide George with adequate psychiatric care).

5. Ebensburg Fails To Provide Behavior Programs Even When The Facility Director Requests Them.

Even where Mr. Bellomo has directed staff to address "obviously" "dangerous" kinds of behaviors with a behavior program, Tr. 10/14/93 (Bellomo) at 12, the behaviors have not been addressed and the residents have suffered harm. For instance, in October 1992, Mr. Bellomo observed Marian M. spinning around in a self-stimulatory behavior during day programming. Staff indicated that Marian often spins and will do so for prolonged periods of time. Mr. Bellomo walked with Marian for awhile and found that she did not spin. Tr. 10/14/93 (Bellomo) at 123-124. He asked why Ebensburg staff could not engage her in similar types of activities. Id.; U.S. Exh. 207. A month later, during November 1992, Mr. Bellomo again observed Marian M. twirling with no staff intervention. He wrote a memo asking Mr. McGuire, the unit manager, to advise him of whether Marian had any program to discourage her twirling behavior. U.S. Exh. 209.

Mr. Bellomo admits that Marian's twirling behavior "obviously" is "a very dangerous kind of behavior, because once you start that twirling, if you come in contact with a piece of furniture or lose your balance, you're liable to fall down and be injured." Tr. 10/14/93 (Bellomo) at 12. When Mr. Bellomo testified at trial in October 1993 -- almost a full year after he asked whether Marian had a behavior program to discourage her twirling behavior -- Mr. Bellomo admitted that Marian still did not have a behavior program for her spinning and twirling behavior. Tr. 10/14/93 (Bellomo) at 131. He also admitted "perhaps I should have followed up again after that last memo on Marion [sic]. That may be something that I should have done." Tr. 10/14/93 (Bellomo) at 132, lines 12-14.[14]/

Marian has suffered significant injuries since Mr. Bellomo first inquired about Marian's twirling behavior. In April 1993, Marian was spinning in her bedroom without staff intervention while staff engaged in morning care. U.S. Exh. 209. Marian tripped and hit her mouth on her bed when she fell, lacerating her lip, cheek and gums. U.S. Exh. 209. Six sutures were required to close the two lacerations, and Marian had to be restrained in a papoose board in order to suture her mouth. Tr. 10/14/93 (Bellomo) at 127. Marian had to take medication for pain and wear mitten restraints for seven days to allow the wounds to heal. Id.; U.S. Exh. 413.

On June 3, 1993, Marian "was awake most of the night spinning." A bruise on Marian's eye was discovered during morning care, a bruise on Marian's elbow was found later on, and there was some drainage from Marian's eye. U.S. Exh. 413. These injuries

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[14]/ In fact, Mr. Bellomo admits that he does not always follow up on concerns that he has identified. Tr. 10/14/93 (Bellomo) at 131.

were thought to be due to Marian's bumping into something while spinning in the night. U.S. Exh. 413. Marian's psychologist was asked to perform a functional analysis of her spinning behavior. U.S. Exh. 413. On August 8, 1993, Marian was sitting on the wooden arm rest of a chair, and when she got up, "she made a motion as [if] to twirl but fell striking the arm rest of the chair." Marian's eyelid was lacerated and had to be closed with four sutures. Again, her psychologist was told to conduct a functional analysis of Marian's spinning behavior. U.S. Exh. 413.

Instead of instituting a behavior program to decrease Marian's spinning behavior and replace it with a less risky behavior, staff note on the incident report of Marian's April injury that a private nanny paid for by Marian's parents will be hired soon and Ebensburg will rely on the nanny to intervene every time Marian starts to spin. U.S. Exh. 209. By the time Mr. Bellomo testified in October 1993, Marian's parents were paying for a nanny who is with Marian five hours a day. Tr. 10/14/93 (Bellomo) at 124.

Dr. Amado testified that the incidents for Marian demonstrate Ebensburg's lack of responsiveness to an identified problem, which is resulting in harm to Marian. Tr. 8/4/93 (Amado) at 68-69. Marian's parents' hiring of a nanny to provide services to protect Marian does not speak highly of Ebensburg. Tr. 8/4/93 (Amado) at 92. Moreover, Ebensburg's solution of simply letting the parents provide nanny supervision in the absence of Ebensburg's provision of an adequate habilitative program for Marian will simply lead to Marian being nanny dependent for the rest of her life without habilitative opportunities. Tr. 8/4/93 (Amado) at 92.

F. **Ebensburg's Behavior Programs Are Not Effective.**

Where they do exist, behavior programs at Ebensburg are not effective. Tr. 8/2/93 (Russo) at 59. Staff at Ebensburg agree. For instance, the unit manager of Sunset House admits that there are several Sunset House individuals for whom behavioral programs are not working. U.S. Exh. 642 (Weimer Dep.) at 150-151. Ebensburg's behavior management services have been cited for lack of effectiveness by State surveyors. U.S. Exh. 793. Dr. Reid did not evaluate whether the behavior programs at Ebensburg are effective. He did not look at the data concerning an individual's behavior before, during and after implementation of a behavior program. Tr. 9/16/93 (Reid) at 104, 113.

The standard convention in the field to determine whether a behavior program is effective is to represent behavior data graphically over time and determine the trend. Tr. 8/2/93 (Russo) at 61. U.S. Exh. 783 represents such graphs of Ebensburg behavior data taken from 38 records, and includes graphs for 45 aggressive and self-injurious behaviors. The behavior data was taken from any record reviewed by Dr. Russo for whom behavior data is collected by Ebensburg and for whom at least a year of recent data was available in the record. For each resident's set of data, a regression analysis produced the straight line that best described the data. Tr. 8/2/93 (Russo) at 61-62. Behavior data from adequate behavior programs would show orderly reductions in the behaviors. Tr. 8/2/93 (Russo) at 64. Instead of showing such orderly behavior reductions, the "great majority" of graphs show that serious aggressive and self-injurious behaviors of the residents at Ebensburg have either stayed the same or have actually gotten worse in spite of Ebensburg's behavior management services. Tr. 8/2/93 (Russo) at 67, line 23.

For instance, the data show that, for Sandy W., there has been no change in her aggressive behavior over time. For Irvin B., from April 1991 through January 1993, his rate of aggression not only increased, but the variability of his data increased, suggesting that Ebensburg does not understand and is unable to manage his behavior. Tr. 8/2/93 (Russo) at 64; U.S. Exh. 783. In spite of the fact that psychologists should detect trends in behavior data when treating clients, staff at Ebensburg are not using the data they collect on behaviors to inform their clinical decisions. Tr. 8/2/93 (Russo) at 64-65.

Although Dr. Reid expects that behavior programs at Ebensburg are effective, he does not know whether they are. Tr. 9/16/93 (Reid) at 113. The regression analysis performed by Dr. Russo proves Dr. Reid's expectation to be mistaken. Regression analyses of behavior data for 14 of the 15 clients whose behavior programs Dr. Reid reviewed reveals that for four of the 15 clients (Ann B., Franklin B., Irvin B., and Jeffrey C.), maladaptive behaviors are increasing, and for six of the 15 clients (Gary E., Thomas E., Veedia H., John G., Betty Jean H., and Sandra W.), there has been no improvement in behavior. U.S. Exh. 783.

Ann B. is an example of an Ebensburg resident on a behavior program whose behaviors are getting worse. U.S. Exh. 783. In early 1986, Ebensburg was restraining Ann for her self-injurious behavior with a papoose board or helmet at a rate of less than two hours per month. Tr. 8/2/93 (Russo) at 65; U.S. Exh. 93. In April 1986, Ebensburg introduced the restraint chair as part of Ann's behavior program for self-injurious behavior, which resulted in an immediate and significant increase in Ann's rate of restraint. Tr. 8/2/93 (Russo) at 65; U.S. Exh. 93. Instead of making informed clinical judgments and recognizing that Ann was one of a whole class of individuals who self-injure in order to obtain restraint,

extra-pyramidal symptoms. Id. In spite of the fact that Ann took psychotropic medications for her self-injurious behavior for many years, Dr. Goldschmidt only saw Ann five times between April 1986 and January 1992. Id.

The significant amount of time that Ann spends in her restraint chair is also causing Ann much harm. While in restraint, she is not receiving positive habilitation and skills development training and there is an indication in Ann's chart that she has suffered a bowel obstruction and has had a colostomy as a result of prolonged inactivity in her chair. Tr. 8/2/93 (Russo) at 66, 92. See also Tr. 7/29/93 (McGowan) at 181-182.

Dr. Reid reviewed Ann's behavior program and observed her. Dr. Reid thought that Ebensburg should be doing more for Ann, and he is not satisfied with her case. Tr. 9/16/93 (Reid) at 117. Dr. Reid relied on Ebensburg's representations that they had sought outside consultation from the Kennedy Institute, but he was not aware that the Kennedy Institute consultation occurred five years ago. Tr. 9/16/93 (Reid) at 159. Dr. Reid is not aware of any other outside consultations that Ebensburg arranged for Ann. Tr. 9/16/93 (Reid) at 159. At the time Ann received a consultation from the Kennedy Institute in 1988, she had been in her chair for about two years. The Kennedy Institute recognized that Ann's chair was serving a protective function, but cautioned that the chair must be considered as only a way station, and not as a final goal for Ann. Tr. 8/2/93 (Russo) at 101. The Kennedy Institute provided valuable information to Ebensburg concerning Ann's motivation for her self-injury, but Ebensburg failed to use that information to change its treatment for her. Tr. 8/2/93 (Russo) at 101, 103-104. Ebensburg did not do its own functional analysis of Ann's behavior until March 9, 1993. U.S. Exh. 964.

G. Ebensburg Is Failing to Revise Its Behavior Programs When Necessary.

Ebensburg does not revise behavior programs when necessary. Tr. 8/2/93 (Russo) at 68; Tr. 7/26/93 (Stark) at 134; U.S. Exh. 780. Dr. Stratton agrees that not all of the behavior programs at Ebensburg are reviewed and revised with sufficient frequency. U.S. Exh. 640 (Stratton Dep.) at 138-139. Dr. Stratton admits that Ebensburg has not adjusted behavior programs as promptly as they should have in some cases where behavior does not improve or is getting worse. U.S. Exh. 640 (Stratton Dep.) at 139. There is no individual responsible on a facility-wide basis for ensuring the appropriate review and timely revision of behavior programs except for the approximately 15 Class III behavior programs. U.S. Exh. 639 (Stratton Dep.) at 57-58. For behavior programs that are not Class III, an individual's QMRP --not the individual's psychologist -- is primarily responsible for ensuring that the behavior program is reviewed, revised and is currently appropriate. U.S. Exh. 639 (Stratton Dep.) at 56-57. Ebensburg has been repeatedly cited for its failure to revise its behavior programs. U.S. Exh. 793.

1. Ebensburg's Failure To Revise Behavior Programs Is Resulting In Harm.

Based upon his review, Dr. Russo concluded that the residents of Ebensburg are suffering significant harm as a result of Ebensburg's failure to revise behavior programs in a timely manner. Tr. 8/2/93 (Russo) at 68. In almost all cases that he reviewed, Ebensburg continued the same non-individualized behavior programs year after year even though clients continued to exhibit significant behavior problems resulting in injuries. Tr. 8/2/93 (Russo) at 74-75.

Dr. Russo testified in detail about three individuals who are being significantly harmed by Ebensburg's failure to revise behavior programs in a timely manner -- Irvin B., Sandra W., and Winfield M. Tr. 8/2/93 (Russo) at 68-74.

- Irvin B.: In less than a three month period between August and October 1992, clients attacked Irvin B.[16]/ at least eight times. During these attacks, Irvin was punched in the eye twice, bitten on the arm, bitten on the back by a Hepatitis B carrier, bitten on the hand, pushed and fell, lacerating his lip, and was found with a razor extension cord that another individual had wrapped around his neck. Tr. 8/2/93 (Russo) at 69. Ebensburg documents indicate that these incidents were due to Irvin's pesty and teasing behaviors, yet Ebensburg did not revise Irvin's behavior program to train Irvin not to engage in such behaviors. Tr. 8/2/93 (Russo) at 69.[17]/ It is Ebensburg's responsibility in a case like Irvin's to provide adequate social skills behavior programs to decrease maladaptive antisocial behaviors to protect Irvin from harm and to provide a safe environment from others. Tr. 8/2/93 (Russo) at 69-70. Ebensburg's failure to revise Irvin's behavior program in a timely and appropriate manner has resulted in great harm to Irvin. Tr. 8/2/93 (Russo) at 70.

- Sandra W.: Sandra W. has a behavior program for aggression and biting that has not been revised since January 1989. U.S. Exh. 93. Between January 1989 and September 1992, Sandra was bitten by her peers on 47 occasions (more than half of these bites were inflicted by Loretta A.); was sent to the emergency room three times because her shoulder was dislocated due to unknown causes; fractured her finger due to unknown causes; banged her face on the floor while being placed in floor control due to her behaviors, and lost three teeth; was pushed, resulting in 12 sutures to her head; was kicked several times in the face; and tore off five of her toenails. Tr. 8/2/93 (Russo) at 70; U.S. Exh. 135, 136. Between January 1991 and September 1992, Sandra bit her peers on 11 occasions, including biting off a piece of Debra S.'s nose. U.S. Exh. 267(c). On September 9, 1992, Sandy's PSA reviewed her behavior program and concluded that it needed no adjustment. Tr. 8/2/93 (Russo) at 70. Since that time, she has caused eight injuries, including biting Evelyn D. on the upper arm, Gwen C. on the breast, and Mary Rose B. on the forearm three times, and has been injured eight times, including being bitten on three occasions, and being kicked in the face on three separate occasions and punched in the face once by Denise V. U.S. Exh. 958; U.S. Exh. 267(c); U.S. Exhs. 135, 136. Sandra W. is a hepatitis B carrier. U.S. Exh. 501. Ebensburg's failure to timely revise Sandra's behavior program to effectively decrease her aggressive behavior and teach her appropriate social skills has resulted in significant harm to Sandra's peers as well as to Sandra. Tr. 8/2/93 (Russo) at 70-71.

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[16]/ Irvin's name is incorrectly transcribed in the trial transcript as Aaron. Tr. 8/2/93 (Russo) at 69.

[17]/ In October 1993, Mr. Bellomo suggested that Irvin has been provided counselling in the last few months. Tr. 10/13/93 (Bellomo) at 230.

- Winfield M.: Winfield has a behavior program for pica, written in 1987, that is little more than a safety procedure to prevent ingestion of inedibles. Tr. 8/2/93 (Russo) at 72. Even this procedure has been ineffective in protecting Winfield. Except to change his medications, Winfield's program has not been significantly revised since 1987, even though his behavior program is not working. Tr. 8/2/93 (Russo) at 72. In 1987, Winfield had surgery for a perforated bowel and foreign body removal; in 1988, he was again hospitalized for pica; in 1990, he ate a tack, and when he was x-rayed to see where it was, a conglomerate of screws and nails were seen in his abdomen; in June 1992, he vomited up rubber bands, clothing labels and cigarette butts; in July 1992 he vomited clothing labels again; in August 1992, he ate two buttons from his shirt; in October 1992, he ate cigarette butts, including one that may have been lit; in October 1992, he took apart a cupboard door and ate a screw; in November 1992, he ate paper off the floor and ate a clothing label; in February 1993, he was hospitalized for abdominal pain, an x-ray showing numerous metal objects, but surgery to remove the objects was unsuccessful; and in March 1993, because Winfield was limping, an x-ray was done which revealed a zipper and numerous screws in his abdomen. Tr. 8/2/93 (Russo) at 72-73. Following the March 1993 incident, Ebensburg removed Winfield from his day program at Gary Bain because there are nuts and bolts at Gary Bain instead of revising his behavior program to aggressively manage Winfield's pica behavior. Tr. 8/2/93 (Russo) at 73.[18]/

Dr. Stark provided five additional examples of behavior programs that had not been revised despite continued injuries to the individual or to others. U.S. Exh. 780. For example, although Ronnie B. has had a behavior program for her pica behavior since 1990, her behavior program has not been revised despite a 1992 Ebensburg staff recommendation that a new program be implemented to "adequately deal with her pica." In November 1992, a two inch wooden peg was found in her stool. U.S. Exh. 780. Similarly, although Gary K. has had a behavior program for biting since 1988, Gary's plan has not been revised since then in spite of frequent biting episodes, including a March 1992 incident in which Gary bit James P. on the scrotum, requiring sutures, and in spite of a note on an incident report following that bite that Gary's program needs to be reviewed and/or revised. U.S. Exh.

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[18]/ Winfield missed three months of work at Gary Bain. He was not returned to Gary Bain until June 15, 1993. Tr. 10/13/93 (Bellomo) at 225.

267(c); U.S. Exh. 780. There was no psychologist at Gary's 1992 annual review. U.S. Exh. 780.[19]/

Raymond H. has been injured 94 times in the 50 months in the period January 1989 through February 1993. U.S. Exh. 777, 1034. Ebensburg has not revised Raymond H.'s behavior program for aggression and self-injurious behavior since April 1991, except to eliminate restraints from his program in late 1992 and a living area restriction in December 1991. U.S. Exh. 856, 42(c) at 4860, 4890, 4911, 541439, 541418. In the 22 months from July 1991 to April 1993, Raymond was injured 34 times. U.S. Exh. 369, 1043. Fourteen of these 34 injuries were due to his self-injurious behavior, including, in May 1992, throwing himself over a railing, striking his face on a ramp edge, fracturing and abrading a deep piece of flesh from his nose. Raymond was sent to the emergency room via ambulance for six sutures to the bridge of his nose. In August 1992, Raymond slammed his head into the floor when he was told he did not have a paycheck, requiring four sutures, and in November 1992, he smashed his head into a window, lacerating his scalp, requiring three sutures. In November 1992, Raymond pulled out his tooth. Of the remaining 20 injuries Raymond sustained between July 1991 and April 1993, Raymond was injured five times during fights with his peers, five times when his peers hurt him without provocation, seven times due to falls, and three times due to falls relating to seizures. U.S. Exh. 369, 1034. The evidence demonstrates that Ebensburg has failed to revise Raymond H.'s behavior program even though Raymond suffers repeated injuries due to his behaviors and was restrained for his

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[19]/ See also infra § IX.A.7 (discussion of Ebensburg's failure to timely treat Gary with appropriate antidepressant medication, resulting in harm because Gary was forced to suffer agitation and aggression in the absence of adequate psychiatric care).

behaviors 18 times during the period January 1990 through November 1992. U.S. Exh. 369, 42(c) at 4860, 4890, 4911, 541439, 541418. The regression analysis of Raymond's behavior data shows that Raymond's behavior is not improving. U.S. Exh. 783.

Dr. Reid agreed that it is not professionally acceptable to continue an individual on a behavior program that is not working without revising it in a timely manner. Tr. 9/16/93 (Reid) at 122. Dr. Reid, however, did not look at a single record to determine whether Ebensburg revises behavior programs when individuals make no progress on the program or when behaviors increase. Tr. 9/16/93 (Reid) at 119. Instead, Dr. Reid relied on Ebensburg's representations that a process was in place to review the behavior programs. Tr. 9/16/93 (Reid) at 119. U.S. Exh. 93 contains the restrictive procedure requests for the 15 individuals whose behavior programs Dr. Reid reviewed. Dr. Reid did not review these restrictive procedure requests in order to form his opinion. Tr. 9/16/93 (Reid) at 8. These restrictive procedure requests demonstrate virtually no revisions in behavior programs over prolonged periods of time, except for changes in psychotropic medication and elimination of the use of the papoose board in late 1992.

Dr. Reid did not evaluate the injuries that occur at Ebensburg. Tr. 9/16/93 (Reid) at 123. In the three and a half months between May 1, 1993 and August 18, 1993, the 15 individuals whose behavior programs Dr. Reid reviewed caused 54 injuries to themselves or others due to their behaviors. U.S. Exh. 958. A review of the underlying incident reports corresponding to these injuries confirms that Ebensburg has failed to revise behavior programs in spite of repeated injuries caused by behaviors. For instance, between May and August 1993:

- Franklin B. caused 11 injuries to himself or others, including causing Dennis B.'s temple to bleed; slapping Eric S. in the mouth, resulting in the extraction of Eric's front tooth; and biting Elliot G. twice. In spite of the fact that Ebensburg acknowledged that Franklin was presenting a severe behavior disruption, his behavior program was not modified and only his medications were adjusted. During this same time period, Ebensburg chemically restrained Franklin B. on an emergency basis on 11 separate occasions. U.S. Exh. 993.[20]/

- James S. engaged in self-injurious behavior four times, including breaking two mirrors and using the glass to cut hit head open, hitting his head on the door, causing four cuts to his forehead, hitting his head on a metal desk and lacerating his scalp, and removing his own toenail. No change was made in his program.

- Ann B. hurt herself four times through self-abuse; there were no changes in her program.

- John G. bit Paul M., hit and may have bitten Deron E., and engaged in self-injurious behavior three times, including raking his face and biting himself. There was no change in John's behavior program.

- Betty Jean H. engaged in self-abuse on four occasions and hurt others twice. Although Tegretol was added to her medications in July 1993, her behavior program was continued as written.

- Denise V. engaged in self-injurious behavior on at least four occasions, including lacerating her scalp from hitting her head on a wooden divider. Ebensburg recommended that no changes be made to Denise's current behavior program.

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[20]/ See also infra § IX.A.7 (discussion of Ebensburg's inadequate psychiatric care for Franklin including: 1) improper assessment and diagnosis of Franklin's aggression, which has caused harm to Franklin and others because Franklin's aggression has increased over time, 2) inability to rely on behavior data and functional analyses of Franklin's behavior, 3) failure to implement the consulting psychiatrist's recommendations, and 4) inadequate review of Franklin's medications by Ebensburg's Behavior Intervention Committee).

that behavior programs continue year after year without change. Tr. 8/2/93 (Russo) at 57-58. For instance, in spite of 106 episodes of restraint in a two year period, James S.'s behavior program for aggression was recommended to continue without change by the BIC during the period January 1990 through February 1993 except to approve changes to his psychotropic medications and approve replacement of the use of the papoose board with use of floor control in late 1992. U.S. Exh. 42(c) at 4863, 4891, 4910, 4825, 4830, 4937, 541441, 541426, 541416. Similarly, in the more than three years between January 1990 and February 1993 when Sandra W. was restrained more than 70 times, the BIC recommended that her behavior program be continued without change except for changes in her drugs and replacement of the papoose board with floor control in late 1992. U.S. Exh. 42(c) at 4856, 4881, 4902, 4930, 4846, 541439, 76626, 541421-22. The BIC even recommended continuation of Sandra's behavior program in January 1992, after noting that Sandra had been restrained a record number of times (20) in one month, alone, in December 1991. Id. at 4940. Between January 1990 and February 1993, the BIC recommended that Denise V.'s behavior program be continued without change except to change her drugs and replace use of the papoose board with use of floor control in late 1992. U.S. Exh. 42(c) at 4879, 4895, 4919, 4836, 541460, 541433, 541421-22.

The Commonwealth's 1988 Behavior Management Policy requires that members of Ebensburg's Behavior Intervention Committee have expertise in psychopharmacology. U.S. Exh. 30 at 53; Tr. 10/19/93 (O'Brien) at 88. When he toured Ebensburg in September 1992, Dr. Fahs asked Mr. Fris whether his attendance at the behavior management committee was a priority, and Mr. Fris agreed that it was a priority. U.S. Exh. 612 (Fris

Dep.) at 131. However, according to Mr. Fris, there are not enough staff for Mr. Fris to regularly attend the meeting. U.S. Exh. 612 (Fris Dep.) at 131. Mr. Fris admits that before he spoke with Dr. Fahs, he had not been attending the BIC meetings regularly. U.S. Exh. 612 (Fris Dep.) at 131. U.S. Exh. 42 shows that before Dr. Fahs attended the September 1992 BIC meeting, pharmacists only attended BIC meetings 17% of the time. Since Dr. Fahs toured Ebensburg, pharmacist participation at BIC meetings has increased to 56%. Tr. 10/19/93 (O'Brien) at 91.

H. Direct Care Staff Are Failing To Implement Behavior Programs.

Based on their observations of staff at Ebensburg, Drs. Russo and Amado testified that direct care staff at Ebensburg are failing to implement behavior programs. Tr. 8/2/93 (Russo) at 78; Tr. 8/4/93 (Amado) at 44-45. Ebensburg's own documents also demonstrate that direct care staff are failing to implement behavior programs. For instance, an Ebensburg nurse making rounds at 4:30 a.m. found Nathaniel W. being restrained in a papoose board with a stool over his head, covering his face, and no staff in the immediate area. Use of the stool in conjunction with the papoose board was not part of Nat's behavior program. U.S. Exh. 126. An abuse investigation of the incident uncovered the fact that only one staff person on the third shift had ever been inserviced on Nat's behavior program, and the training had occurred when that staff worked the daylight shift. U.S. Exh. 126. Nat's psychologist could not remember specific times that he had conducted inservice training on the third shift. U.S. Exh. 126. In another incident, on February 13, 1992, a direct care trainee witnessed staff place a pillow case over Jeff K.'s head while drawing blood, and when he asked why, staff replied that "we always do that." U.S. Exh. 133 at

6658. Jeff's behavior program did not permit such a procedure. Id. at 6679. An abuse investigation revealed that of the four regular staff in Jeff's living area, only one had been inserviced on Jeff's behavior program. Id. at 6673. In September 1992, Mr. Devine toured day programming in Harmony House Learning Center. A direct care staff on overtime revealed to Mr. Devine that she did not know the clients and did not know their behavioral characteristics. U.S. Exh. 212. On September 26, 1992, Richard M. had been engaging in self-injurious behavior since about 3:00 p.m., and at 6:10 p.m., Richard was discovered with part of his finger amputated. U.S. Exh. 107. Following the amputation, Richard's psychologist was asked to in-service his "new" staff on his behavior program. U.S. Exh. 107. Moreover, Ebensburg has been repeatedly cited by State surveyors for its failures to implement behavior programs. U.S. Exh. 793. For instance, in August 1992, Ebensburg was cited for failing to implement James B.'s behavior program during day programs. U.S. Exh. 67 at 8A.

Dr. Reid was the only witness to conclude that Ebensburg staff are implementing components of behavior programs. Tr. 9/16/93 (Reid) at 39. However, Dr. Reid's conclusion is based on observations of a small number of individuals (13) for short periods of time (an average of about eighteen and a half minutes each). Tr. 9/16/93 (Reid) at 108; U.S. Exh. 966. As is evident from his data, in many cases, Dr. Reid was simply unable to evaluate whether Ebensburg implemented its behavior programs because the behaviors at issue did not occur during his observation periods. Tr. 9/16/93 (Reid) at 108-109. For instance, Dr. Reid could not evaluate whether Ebensburg implemented the negative consequence behavior components of its behavior programs in 17 of his 22 observations

because of non-occurrence of behaviors. U.S. Exh. 966. In addition, Dr. Reid's data collection methodology is flawed. For instance, if Dr. Reid did not see a reinforcer being given, he scored it as insufficient time rather than as non-implementation of the program. Tr. 9/16/93 (Reid) at 109-110. Dr. Reid scored more than half of his tangible reinforcement observation periods as "insufficient time". U.S. Exh. 966. Dr. Reid concedes that there is a possibility that he was witnessing non-implementation and scoring it incorrectly as "insufficient time". Tr. 9/16/93 (Reid) at 110. Given the fact that Dr. Reid did not observe individuals for the full length of the individual's reinforcement schedule of either 30 or 60 minutes, Dr. Reid obviously could not, and did not, score a single observation as non-implementation of a DRO reinforcer. U.S. Exh. 966.

All three psychology experts for the United States and Dr. Stratton testified that direct care staff at Ebensburg are not adequately trained to provide necessary implementation of behavior management services. Tr. 7/26/93 (Stark) at 119; Tr. 8/2/93 (Russo) at 78; Tr. 8/4/93 (Amado) at 44-45; U.S. Exh. 640 (Stratton Dep.) at 19-20, 185-186, 218. Dr. Goldschmidt admits that she has not conducted in-service training sessions for all staff at least semi-annually regarding treatment of individuals with both behavior and psychiatric problems even though this training is required by her contract. U.S. Exh. 615 (Goldschmidt Dep.) at 105. Dr. Russo testified that there is a systemic failure to teach direct care staff to conduct the technical requirements of treating and protecting the individuals at Ebensburg. Tr. 8/2/93 (Russo) at 79.[22]/

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[22]/ Supervisory staff, as well as direct care staff, need training. Tr. 8/2/93 (Russo) at 79-81. U.S. Exh. 183 is an October 1992 memo from a residential services manager to the facility director, stating that the supervisors at Ebensburg are plagued by a general lack of knowledge pertaining to their job function, and requesting competency based training for supervisory staff at Ebensburg.

Dr. Stratton admits that it is not possible to ensure consistency in implementation of behavior programs without adequate training. U.S. Exh. 640 (Stratton Dep.) at 189. Mr. Bellomo admits the critical importance of consistently implementing behavior programs, stating that "programs are only going to be effective if they are consistently implemented." U.S. Exh. 603 (Bellomo Dep.) at 54, lines 5-9. The unit manager of Keystone House admits that staff do not consistently implement behavior programs for individuals in Keystone who have such programs. U.S. Exh. 604 (Bonfanti Dep.) at 115-116.

It is critical that all staff who work with an individual know how to work with that individual. Tr. 8/4/93 (Amado) at 48. Over 25% of the direct care staff -- those staff hired before the current training protocol was started -- have not received full training. Tr. 8/2/93 (Russo) at 78. Ebensburg provides no competency based training to direct care staff for implementation of behavior programs. Tr. 8/2/93 (Russo) at 78-79. Little, if any, training is provided to residential staff concerning appropriate materials and activities for profoundly and severely mentally retarded clients. Tr. 8/2/93 (Russo) at 79. Until recently, there was no procedure at Ebensburg for in-servicing staff on the 11:15 p.m. until 7:30 a.m. shift on the behavior programs for the clients living on their assigned units. U.S. Exh. 181.

Ebensburg does not have a policy that requires staff newly assigned to an area to have training in the behavior programs of the individuals living in that area before working with the individuals. U.S. Exh. 640 (Stratton Dep.) at 181. Similarly, as the incident involving the amputation of Richard M.'s finger tip indicates, Ebensburg also fails to train staff when a new resident is transferred to their unit. U.S. Exh. 107. Dr. Stratton admits that Ebensburg staff interact with clients before they are fully trained on their behavior programs. U.S.

Exh. 640 (Stratton Dep.) at 181. Staff who are temporarily pulled to a building from another building are not trained in the behavior programs of the individuals living there. U.S. Exh. 640 (Stratton Dep.) at 182. Both direct care staff trainees who testified at trial, Damian Tackett and Robin Hebenthal, testified that Ebensburg assigned them to work with individuals but failed to provide any training concerning the programs of the individuals. Tr. 8/3/93 (Tackett) at 7, 13; Tr. 8/3/93 (Hebenthal) at 198-199.

Ebensburg does not require PSA's to train all direct care staff who work with a client whenever that client's behavior program is revised. U.S. Exh. 640 (Stratton Dep.) at 186. Ebensburg does not systematically evaluate whether appropriate staff are being inserviced on a timely basis when behavior programs are revised. U.S. Exh. 640 (Stratton Dep.) at 187-188.

Direct care staff at Ebensburg are also inadequately trained to operate under their own direction and initiative. "In the absence of supervision, they are at a loss." Tr. 8/4/93 (Amado) at 53, lines 7-8; U.S. Exh. 212, 214. As a result, services are not provided to residents when supervisors are absent, resulting in harm to the residents due to lack of meaningful activity. Tr. 8/4/93 (Amado) at 53.

I. Ebensburg's Behavior Programs Do Not Comport With Generally Accepted Standards.

Behavior programs at Ebensburg substantially depart from appropriate professional practice and these inadequate programs are resulting in harm to the residents of Ebensburg. Tr. 8/2/93 (Russo) at 20, 59. Dr. Reid testified that Ebensburg's "treatment programs for severe behavior problems could be improved." Tr. 9/16/93 (Reid) at 12. Dr. Reid testified that effort should be made to improve the programs to get them as close as possible to state

of the art. Tr. 9/16/93 (Reid) at 12. "State of the art," according to Dr. Reid, means the technology represented in the professional literature, but it does not mean optimal. Tr. 9/16/93 (Reid) at 9. Mr. O'Brien characterizes the behavior programs at Ebensburg as "low tech". U.S. Exh. 624 (O'Brien Dep.) at 137.

1. Ebensburg's Behavior Programs Are Not Individualized.

The field, in general, and the Commonwealth's 1988 Behavior Management Policy, in particular, require that behavior programs be individualized. Tr. 8/2/93 (Russo) at 19, 22; U.S. Exh. 30 at 2. In Dr. Russo's opinion, "in almost all cases, the [behavior] programs are essentially canned. There is very little in the way of individualization. There is very little in the way of differential programming for individuals with these very serious and dangerous behaviors." Tr. 8/2/93 (Russo) at 25, lines 20-24. Ebensburg's canned behavior programs, according to Dr. Russo, show no evidence that the enormous body of scientific methodology that has developed during the past thirty or forty years as to what constitutes appropriate practice in the field of behavioral psychology as applied to individuals with mental retardation is being applied. Tr. 8/2/93 (Russo) at 27-28, 104. State surveyors have cited Ebensburg for its failure to provide individualized behavior programs, at various times calling Ebensburg's behavior programs "canned" and "prepackaged," and stating that "the facility appears to have a generalized approach to behavioral management." U.S. Exh. 793.

U.S. Exh. 592 contains blank behavior programs for Class II and Class III Ebensburg behavior programs. Most of the Class II and all of the Class III training programs for residents of Ebensburg follow the canned programs that comprise U.S. Exh. 592. Tr. 8/2/93 (Russo) at 23-25. According to Dr. Stratton, all of the Class III behavior programs at

Ebensburg have followed the blank Class III behavior program contained in U.S. Exh. 592 for the past four or five years. U.S. Exh. 639 (Stratton Dep.) at 89.

U.S. Exh. 856 is a compilation of the 37 behavior programs that had been written for the approximately 50 cases that Dr. Russo reviewed. The plans in Exhibit 856 demonstrate Ebensburg's strong reliance on the masters and use of their canned definitions, methodologies, and standard sequence of behavioral programming. Tr. 8/2/93 (Russo) at 24-25.

Dr. Reid only reviewed 15 Ebensburg behavior programs, and concluded that "there were a lot of similarities across the programs." Tr. 9/16/93 (Reid) at 21. Dr. Reid does not know whether Ebensburg is just filling in the blanks in the behavior programs. Tr. 9/16/93 (Reid) at 21.

2. Ebensburg's Behavior Programs Do Not Teach Alternative Behaviors.

The field, in general, and the Commonwealth's 1988 Behavior Management Policy, in particular, require Ebensburg to develop behavior programs that emphasize developing adaptive, alternative behaviors rather than merely eliminating or suppressing undesirable behaviors. Tr. 8/2/93 (Russo) at 19, 29; U.S. Exh. 30 at 3. This requirement is critical because many maladaptive behaviors that people with mental retardation exhibit are really an attempt to communicate something. Tr. 7/26/93 (Stark) at 57; Tr. 8/2/93 (Russo) at 29. In providing a positive, alternative method of communication, the individual can communicate without resort to an undesirable behavior. Tr. 8/2/93 (Russo) at 29.

Dr. Stratton acknowledges that the purpose of a behavior program is to increase the frequency of desired behaviors and to decrease the frequency and/or intensity of challenging

behaviors. U.S. Exh. 640 (Stratton Dep.) at 9-10. Time and time again, the literature demonstrates that if you suppress an undesired behavior without teaching a desired behavior to replace it, you not only have decreased the ability of a mentally retarded individual to communicate, but the minute you take away the suppression program, the undesired behavior returns. Tr. 8/4/93 (Amado) at 116-120. The mission of a psychologist is not to suppress clients' behaviors, thereby diminishing the breadth of their behaviors and leaving them with fewer skills than when the psychologist found them. Instead, the mission of a psychologist is to increase clients' independence and increase the breadth of their abilities. Tr. 8/4/93 (Amado) at 118-119.

Dr. Stratton admits that the educational component of most of Ebensburg's behavior programs, in which alternative functional behaviors are supposed to be taught, follow the blank behavior programs entered into evidence as U.S. Exh. 592. U.S. Exh. 639 (Stratton Dep.) at 90. Almost exclusively, the only method that Ebensburg uses to fulfill the requirement that it teach alternative behaviors in its behavior programs is the use of a procedure called a "differential reinforcement of other behavior ("DRO"). Tr. 8/2/93 (Russo) at 29-30. Dr. Stratton further admits that more than 95% of Ebensburg's behavior programs involve the use of DRO's. U.S. Exh. 640 (Stratton Dep.) at 17-18. A DRO rewards behaviors other than the undesirable behavior. If an individual does not exhibit an undesirable behavior for a specified period of time, the individual will receive something that he likes. Dr. Stratton admits that DRO's do not necessarily teach an individual positive behaviors (although they may inadvertently do that). DRO's do not teach

the person what to do. They only teach the individual what not to do. U.S. Exh. 640 (Stratton Dep.) at 18.

In almost all cases, use of a DRO is not an adequate positive educational adaptive component of a behavior program. Tr. 8/2/93 (Russo) at 31. Ebensburg's only attempt to teach adaptive, alternative behaviors is to provide a reinforcer once every 30 or 60 minutes. Tr. 8/2/93 (Russo) at 30. In Dr. Russo's words, "about every sixty minutes on the average they walk in, they pat the guy on the back, say something to him. They may or may not deliver something tangible like an edible and say 'Good job,' or 'You're being appropriate." Tr. 8/2/93 (Russo) at 30, lines 15-20. As Dr. Russo explained, DRO's are generally ineffective with severely or profoundly retarded individuals who find it very difficult to figure out what they have done right in the past thirty or sixty minutes in order to deserve a reward. Tr. 8/2/93 (Russo) at 31.

Dr. Reid agrees with Dr. Russo that behavior programs must emphasize developing adaptive behaviors rather than merely eliminating undesirable behaviors. Tr. 9/16/93 (Reid) at 21. According to Dr. Reid, Ebensburg needs to improve the component of their behavior programs that emphasize developing adaptive behaviors. Tr. 9/16/93 (Reid) at 21.

3. Reinforcers Are Not Given Out Consistently.

Other than occasional verbal rewards, Dr. Russo did not observe any individualized, tangible reinforcers being given to individuals while they were on the living units. Tr. 8/2/93 (Russo) at 37. Dr. Stratton admits that the tangible reinforcements for the DRO's are not always consistently implemented. U.S. Exh. 640 (Stratton Dep.) at 22.

According to Dr. Stratton, in order to determine whether Ebensburg staff are delivering reinforcements according to the DRO schedules set up in the behavior programs, observers would generally have to observe for at least an hour. U.S. Exh. 640 (Stratton Dep.) at 23. The psychology expert for the Commonwealth did not do this. Tr. 9/16/93 (Reid) at 109-110.

4. Ebensburg Has Failed To Conduct Functional Analyses.

Ebensburg's failure to conduct functional analyses until only very recently substantially departs from accepted general practices in the field. Tr. 8/2/93 (Russo) at 47.[23]/ It is a generally accepted standard in the field that psychologists must conduct a functional analysis of behaviors addressed in behavior programs. Tr. 8/2/93 (Russo) at 21; U.S. Exh. 640 (Stratton Dep.) at 27-28. The Commonwealth's Behavior Management Policy, which was adopted by the Commonwealth in 1988, requires that facilities conduct a functional analysis of each undesirable behavior before treatment programs are designed. U.S. Exh. 30 at 8-9, 14. Dr. Stratton admits that it is important that a formal document identified as a functional analysis be present in the record of each individual with a behavior program. U.S. Exh. 640 (Stratton Dep.) at 27.

At the time of Dr. Russo's first tour of Ebensburg in September 1992, Ebensburg had not completed a single formal functional analysis. Tr. 8/2/93 (Russo) at 45-46. By his

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[23]/ Functional analysis is a term that describes the investigative process that looks at the medical, physiological, and environmental aspects to determine what the function of the behavior is, why the behavior occurs, and what the purpose of the behavior is. U.S. Exh. 639 (Stratton Dep.) at 75. Functional analysis can provide information on what steps should be taken to resolve challenging behaviors and can give a psychologist clues, or, in some cases, direct evidence, as to what should be done to establish behavior that will serve the same function but will be potentially less harmful to the person and to those around the person. U.S. Exh. 639 (Stratton Dep.) at 75.

second tour in October 1992, Ebensburg had completed only two functional analyses, despite the fact that the Commonwealth's Behavior Policy had mandated that functional analyses be performed for each individual with a behavior suppression program since 1988. Tr. 8/2/93 (Russo) at 46.[24]/ Ebensburg completed three additional functional analyses during the two days that Dr. Russo toured the facility in October 1992. Tr. 8/2/93 (Russo) at 46. In October 1992, Mr. Bellomo asked Dr. Stratton to give him specific details about how to incorporate suggestions made by the Department of Justice regarding functional analysis into the psychology services at Ebensburg. Bellomo Dep. Exh. 10 at 2.[25]/

When he was deposed in January 1993, Dr. Stratton admitted that not every individual with a behavior program at Ebensburg had an adequate functional analysis. U.S. Exh. 640 (Stratton Dep.) at 26. At that time, Dr. Stratton also admitted that not even every individual at Ebensburg with a Class III program had an adequate functional analysis. U.S. Exh. 640 (Stratton Dep.) at 26-27. Dr. Stratton also admitted that not every individual who is taking a behavior modifying medication had an adequate functional analysis of their behaviors. U.S. Exh. 640 (Stratton Dep.) at 111-112. Dr. Stratton brought to his

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[24]/ Western Carolina, a state-run institution for the mentally retarded, was doing functional analyses in 1988. Tr. 9/16/93 (Reid) at 104-105.

[25]/ After Dr. Russo's October 1992 tour of Ebensburg, Ebensburg completed one functional analysis in December 1992, none in January 1993, and four in February 1993. Tr. 8/2/93 (Russo) at 46-47. Ebensburg did not begin to actually conduct functional analyses with any concerted effort until after the United States filed a formal discovery request in January 1993 asking defendants to identify all functional analyses conducted by Ebensburg and the dates the functional analyses had been conducted. U.S. Exh. 1021 at 4-5. Defendants did not answer those interrogatories until May 7, 1993. Id. at 13. In the interim, Ebensburg conducted 34 functional analyses. Id. at 4-5. Ebensburg, however, never produced in discovery documents requested by Dr. Russo that would evidence changes in behavior programs made as a result of the functional analyses. Tr. 8/2/93 (Russo) at 47.

deposition, as requested, a list he generated of individuals at Ebensburg having the most serious behavior problems. U.S. Exh. 639 (Stratton Dep.) at 8; Stratton Dep. Exh. 1. Only two of the eight individuals identified by Dr. Stratton as having the most serious behavior problems at Ebensburg had a functional analyses at the time of Dr. Stratton's deposition. U.S. Exh. 640 (Stratton Dep.) at 177. It took Ebensburg another five months to complete functional analyses for the remaining six individuals on Dr. Stratton's list. U.S. Exh. 964; Stratton Dep. Exh. 1.

At the time of Dr. Stratton's deposition, James S. did not have an adequate functional analysis. U.S. Exh. 640 (Stratton Dep.) at 175. Dr. Stratton admitted that the seriousness of James' behavior warranted a comprehensive written functional analysis before 1993. U.S. Exh. 640 (Stratton Dep.) at 176. It took Ebensburg another two and a half months to complete a functional analysis of James' behaviors. U.S. Exh. 964. During this time period, James tore off one of his toenails and one of his fingernails, hit his head on the wall hard enough to cause a scalp laceration, and hit another client on the head so hard it reopened a wound on James' hand. United States' Exh. 479. The incident where James hit his head on the wall occurred on February 17, 1993 -- one month after Dr. Stratton's deposition. On the occurrence report documenting that injury, the supervisor in James' living area was unable to make any recommendations for prevention of recurrence of James' self-abuse because there was no knowledge of what causes James' behaviors, despite the fact that his behaviors seemed to be getting worse. U.S. Exh. 479. It still took Ebensburg another 6 weeks to perform a functional analysis for James.

Dr. Russo did not see any evidence in any of the over 50 records that he reviewed nor did he hear evidence during any of the staff interviews that he conducted that Ebensburg was relying on oral communications with staff regarding the function of a behavior for an individual in order to develop its behavior programs. Tr. 8/2/93 (Russo) at 136-137. Dr. Reid claimed that he saw such evidence in the few Ebensburg behavior programs that he reviewed, but he admitted that he had never evaluated the effectiveness of a behavior program that included such an oral functional analysis. Tr. 9/16/93 (Reid) at 104.

Dr. Stratton admits that injuries due to behaviors would be reduced if every individual at Ebensburg with challenging behaviors had an adequate functional analysis. U.S. Exh. 640 (Stratton Dep.) at 30; Tr. 8/2/93 (Russo) at 45. He further admits that there would probably be fewer restrictive interventions at Ebensburg if every individual with challenging behaviors had an adequate functional analysis. U.S. Exh. 640 (Stratton Dep.) at 30.[26]/

It is part of the job of a psychologist to be able to predict when one of his clients will engage in a dangerous act. Tr. 8/4/93 (Amado) at 93. The psychologist fulfills that responsibility by doing a comprehensive functional analysis of his clients' behaviors. Tr. 8/4/93 (Amado) at 93. Dr. Amado is able to make predictions about when his clients will engage in dangerous behaviors because he does comprehensive functional analyses. Tr. 8/4/93 (Amado) at 93.

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[26]/ Although he is not a psychologist, Dr. Kastner reported that there is a controversy in the literature about the use of functional analyses. Dr. Kastner specifically cited articles by Linscheld and Landau in the summer 1993 edition of the Journal on Mental Retardation, testifying that the articles raised significant questions for the readership as to the subjectivity of functional analysis as a treatment option. Tr. 9/13/93 (Kastner) at 169-170. The articles that Dr. Kastner cites have nothing at all to do with the use of functional analysis; rather, they are a debate on the treatment of behaviors using electro-shock therapy.

To implement behavioral suppression programs without completing a comprehensive functional analysis is malpractice. Tr. 8/4/93 (Amado) at 116-120. Even though it is inappropriate to treat undesirable behavior without a functional analysis, Ebensburg treats a particular resident's inappropriate behavior with a "standard package," without really understanding why the individual is behaving that way. Tr. 8/2/93 (Russo) at 28, 43.

5. Ebensburg's Data Collection System Is Not Individualized And Does Not Measure Frequency, Intensity, And Duration Of Behavior.

Ebensburg's data collection system substantially departs from generally accepted professional standards. Tr. 8/2/93 (Russo) at 53; Tr. 8/3/93 (Fahs) at 76. The field, in general, and the Commonwealth's 1988 Behavior Management Policy, in particular, require Ebensburg to collect behavior data that measures the frequency, intensity and duration of a behavior that is the target of a behavior program. Tr. 8/2/93 (Russo) at 47-48; Tr. 8/3/93 (Fahs) at 76; U.S. Exh. 30 at 16, 28, 33. Dr. Reid agrees that the Commonwealth's 1988 Behavior Management Policy requires Ebensburg to collect data on the frequency, intensity and duration of behaviors that are the subject matter of behavior programs. Tr. 9/16/93 (Reid) at 98. Ebensburg's interval data collection system records whether a particular behavior occurred on an hourly basis. Tr. 8/2/93 (Russo) at 48; Tr. 8/3/93 (Fahs) at 76; U.S. Exh. 640 (Stratton Dep.) at 46. In response to the question whether the interval data collection system at Ebensburg provides sufficient information to meet professional standards, instead of providing a responsive answer, Dr. Reid answered "it can." Tr. 9/16/93 (Reid) at 29. According to Dr. Reid, the interval data collection system that Ebensburg uses is "relatively gross." Tr. 9/16/93 (Reid) at 28-29.

Ebensburg's interval data system does not measure the duration or intensity of a behavior at all, and is only a rough measure of the frequency of a behavior. Tr. 8/2/93 (Russo) at 49; Tr. 8/3/93 (Fahs) at 76; Tr. 9/16/93 (Reid) at 98-99. That is, whether a behavior occurred fifty times or one time during an hour, Ebensburg's data system would only reflect the behavior's occurrence once during that hour. Tr. 8/2/93 (Russo) at 49. Dr. Stratton agrees that Ebensburg's 24 hour data collection sheets just record whether or not the behavior occurred at all during a one hour interval and do not measure the frequency of a behavior. U.S. Exh. 640 (Stratton Dep.) at 62.

For each year between 1989 and 1992, state surveyors have found deficiencies with Ebensburg's data collection system, including data that was incomplete, uninformative, and at times, absent, and a lack of data regarding the frequency and severity of a behavior. U.S. Exh. 779. Ebensburg does not do any formal reliability checks on its 24 hour behavior data collection. U.S. Exh. 640 (Stratton Dep.) at 22. In October 1992, Mr. Bellomo asked Dr. Stratton to review the data collection system in place at Ebensburg and provide specific details about how to improve the data collection system. Bellomo Dep. Exh. 10 at 2. The same data system was in effect, however, as of April 1993 when Dr. Reid toured Ebensburg. Tr. 9/16/93 (Reid) at 28-29.

Ebensburg's interval data collection system is not sufficiently individualized. Tr. 8/2/93 (Russo) at 48; Tr. 8/3/93 (Fahs) at 73, 76. It is used in virtually all cases at Ebensburg. Tr. 8/2/93 (Russo) at 48; U.S. Exh. 640 (Stratton Dep.) at 46.[27]/ Dr. Fahs

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[27]/ At his deposition, the only example of an individualized data collection system that Dr. Stratton could think of was the system instituted in December 1992 for data collection for Dean F., where data is collected at half hourly intervals and there is greater specification of the events he is involved in (continued...)

concluded that Ebensburg's blanket use of its "universal data collection sheet" for any and all behaviors, no matter what they are, for any and all individuals, was "entirely inappropriate." Tr. 8/3/93 (Fahs) at 76. Dr. Stratton admits that in some cases it would be better if Ebensburg's data collection system were more individualized. U.S. Exh. 640 (Stratton Dep.) at 65.

Dr. Russo has very serious concerns regarding the reliability and validity of the data collected by Ebensburg. Tr. 8/2/93 (Russo) at 52. When he reviewed behavior data sheets during his tours of Ebensburg, Dr. Russo found significant gaps and missing data. Tr. 8/2/93 (Russo) at 52. For instance, on October 23, 1993, no data had yet been filled out for any of the individuals at Laurel House when he toured there about 3:10 p.m., and staff indicated that often data would be filled out later. Tr. 8/2/93 (Russo) at 152-153; see also U.S. Exh. 607 (Degretto Dep.) at 154-155 (unit manager of Villa states that staff sometime fill out behavior data sheets at the end of the shift instead of at the end of each elapsed hour); U.S. Exh. 642 (Weimer Dep. at 155) (unit manager of Sunset House recalls instances when behavior data was not filled out for recurring periods of time). Dr. Russo testified that interviews with Ebensburg staff indicated that Ebensburg routinely fills in behavior data after the fact -- sometimes days after the fact. Tr. 8/2/93 (Russo) at 52; see also U.S. Exh. 640 (Stratton Dep.) at 58-61 (describing routine used by PSA's to get missing data filled in days

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[27]/(...continued)
throughout the day. U.S. Exh. 640 (Stratton Dep.) at 57-58.

after behavior occurred). Dr. Stratton admitted that data filled in days after it occurred is not as reliable or valid. U.S. Exh. 640 (Stratton Dep.) at 60.[28]/

In addition, Dr. Russo found instances where data had been filled out before the fact during his review of records after his tours. Tr. 8/2/93 (Russo) at 68, 133, 148-149. For instance, staff investigating the incident in which Betty Jean H.'s arm was broken during an attempt to place her in floor control found that data on Betty Jean's 24 hour behavior sheet had been filled out in advance of the occurrence, and the sheets indicated that Betty Jean was sleeping at the time of the incident. U.S. Exh. 134 at 3; see also U.S. Exh. 607 (Degretto Dep.) at 155 (unit manager of Villa thinks that data sheets have been filled out before they were supposed to be); Degretto Dep. Exh. 13 (memo dated May 11, 1992 from Degretto to Villa supervisors asks that staff be trained to complete behavior sheets hourly -- "not for periods before or after"); U.S. Exh. 642 (Weimer Dep.) at 156-157 (unit manager of Sunset House recalls an instance where behavior data was filled out before the shift was completed and states that there "definitely" could be other instances that he is not recalling at the moment).

Dr. Russo also is concerned with the reliability of Ebensburg's data because Ebensburg only collects behavior data two days a week at the program sites. Tr. 8/2/93 (Russo) at 50; U.S. Exh. 640 (Stratton Dep.) at 50-51. In Dr. Russo's opinion, where

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[28]/ U.S. Exh. 97 shows that on September 4, 1992, Ebensburg approved the emergency use of Mellaril for Brenda M. Tr. 10/19/93 (O'Brien) at 77. At that time, Ebensburg specifically requested that behavior data be collected on her behavior of hyperactivity. Tr. 10/19/93 (O'Brien) at 77. In fact, Ebensburg did not begin taking data on Brenda's behavior, other than her pica behavior, until September 14, 1992. Tr. 10/19/93 (O'Brien) at 78-79. In spite of the absence of any behavior data, Ebensburg extended its approval for the emergency use of Mellaril for Brenda M. on September 14, 1992. U.S. Exh. 97.

Ebensburg has established behavior programming at the facility based on continuous data, it makes no sense to only collect data at program sites two days per week. Tr. 8/2/93 (Russo) at 51. Dr. Stratton admits that it is important to consistently collect information about behaviors in program areas because that is the basis upon which decisions are made about what to do with and for an individual. U.S. Exh. 640 (Stratton Dep.) at 52-53. Although Dr. Reid testified that it can be appropriate to sometimes collect data only a few days a week rather than every day during the week, he added that "it could easily be that two days a week is not sufficient." Tr. 9/16/93 (Reid) at 29. Dr. Reid did not evaluate whether Ebensburg's practice of collecting data only two days a week in its day program is effective. Tr. 9/16/93 (Reid) at 153.

According to Dr. Stratton, if there were more direct care staff at Ebensburg, it would be easier to individualize the data collection process. U.S. Exh. 640 (Stratton Dep.) at 66. If there were more psychology staff at Ebensburg, Ebensburg would be better able to train direct care staff to collect behavior data. U.S. Exh. 640 (Stratton Dep.) at 66. When training on use of the data collection sheet is given, it generally only lasts 10 to 15 minutes. U.S. Exh. 640 (Stratton Dep.) at 49.

VIII. EBENSBURG USES UNDUE BODILY RESTRAINTS.

A. Ebensburg Is Chemically Restraining Its Residents.

1. Ebensburg Is Using Behavior Modifying Medications As A Substitute For Behavior Programs.

Dr. Russo, Dr. Stark, and Dr. Fahs all found that Ebensburg is using behavior modifying medications as substitutes for behavior programs. Tr. 8/2/93 (Russo) at 54; Tr. 7/26/93 (Stark) at 130-131; Tr. 8/3/93 (Fahs) at 93, 96. Dr. Stark, who has edited two books on people who have a dual diagnosis of mental retardation and mental illness, is critical of Ebensburg's practice of resorting to medications as a way of responding to behaviors. Tr. 7/26/93 (Stark) at 130; U.S. Exh. 7 at 13-14. In his review of thousands of occurrence reports, Dr. Stark found that frequently Ebensburg's response to behaviors and injuries was "changing medication, upping the doses, switching to something else. As if -- and I work in this area -- as if something magic is going to happen with medication." Tr. 7/26/93 (Stark) at 130, lines 11-14. He emphasizes that "you've got to have a behavior program. Medication can be helpful sometimes, but you need behavior programs." Tr. 7/26/93 (Stark) at 131. As such, Ebensburg's use of medications in lieu of adequate behavior programs substantially departs from generally accepted practices in the field. Tr. 8/2/93 (Russo) at 57. Defendants' psychiatric expert, Dr. Hauser, agreed that individuals who are persistently and chronically given medication for behavior problems are being chemically restrained. Tr. 9/15/93 (Hauser) at 122.

The field, in general, and the Commonwealth's 1988 Behavior Management Policy, in particular, require that behavior modifying medications not be used as a substitute for a

behavior program. Tr. 8/2/93 (Russo) at 53; Tr. 8/3/93 (Fahs) at 90-91, 113; U.S. Exh. 30 at 36. This means that psychotropic medications may not be used solely to control behaviors; instead, a behavior program must be implemented. Tr. 8/2/93 (Russo) at 53; Tr. 8/3/93 (Fahs) at 90-91.[1]/ Dr. Goldschmidt believes if Ebensburg had more direct care staff, residents could take less psychotropic medications because there would be more staff to work with agitated and potentially dangerous individuals. U.S. Exh. 615 (Goldschmidt Dep.) at 87-90.

As far back as 1987, the Department of Justice notified defendants that Ebensburg was unconstitutionally chemically restraining residents due to its failures to integrate adequate behavior programs with the use of psychotropic medications. U.S. Exh. 638 (Sponsky Dep.) Exh. 49. In 1990, the Justice Department notified defendants that Ebensburg continued to use psychotropic medications as substitutes for behavior programs and was thus continuing to unconstitutionally chemically restrain its residents. U.S. Exh. 638 (Sponksy Dep.) Exh. 50.

Since 1988, Title XIX regulations prohibit the use of medications without a behavior program to address the behaviors for which the medications are used. Def. Exh. T; 42 CFR 483.450(e)(2). State surveyors through both the Inspection of Care and Medical Assistance review processes have repeatedly cited Ebensburg for violating this requirement. Tr. 8/3/93 (Fahs) at 89-90, 95-99. In October 1991, the IOC surveyors cited Ebensburg for its failure

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[1]/ Behavior programs must be used in conjunction with the use of psychotropic medications even where a behavior occurs as a result of some psychiatric disorder, because the behavior becomes functionally related to other factors in the environment, such as avoidance or escape. Tr. 8/2/93 (Russo) at 53-54. As such, psychotropic medications can only control part of the reasons that a behavior is occurring. By not having adequate individualized behavior programs for clients on psychotropics, Ebensburg is exposing its residents to years and years of protracted risk of harm with little likelihood of eliminating their behavioral difficulties. Tr. 8/2/93 (Russo) at 54.

to provide behavior programs for individuals taking psychotropic medication. Tr. 8/3/93 (Fahs) at 89-90; U.S. Exh. 66 at 2B. In November 1992, State surveyors found that Ebensburg was still failing to provide behavior programs to residents on psychotropic medications. Tr. 8/3/93 (Fahs) at 97-99; U.S. Exh. 60 at 00503762. In January 1993, IOC surveyors cited Ebensburg for treating Michael M.'s self injurious behaviors with anafranil in the absence of a behavior program. Tr. 8/3/93 (Fahs) at 95-96; U.S. Exh. 67 at 8B. That same group of surveyors also cited Ebensburg for its failure to provide a behavior program for James O., who is being treated instead with Prolixin. Tr. 8/3/93 (Fahs) at 97; U.S. Exh. 67 at 8D.

Dr. Russo testified about 14 individuals who have been chronically maintained on psychoactive medications for years without receiving adequate responsive individualized behavioral treatment. Tr. 8/2/93 (Russo) at 54-55. For instance, Betty Jean H., who is taking psychotropic medication, has had a chronic problem with maladaptive behaviors since 1988 and she has had no significant changes to her behavior program for the last five years, despite a continuation and actual increase in the rate of her maladaptive behaviors. Tr. 8/2/93 (Russo) at 56; U.S. Exh. 783. For five years, Ebensburg's failure to provide an adequate, effective behavior program for Betty Jean has caused harm to Betty Jean and to others as a result of her inadequately addressed behaviors, including an incident wherein Betty Jean's arm was broken during a restraint procedure. Tr. 8/2/93 (Russo) at 56-57. In another example, Andrew H. has no behavior program for his behaviors of biting and tearing bed clothes. Instead, he is prescribed anafranil for these behaviors. U.S. Exh. 780. Between July 1992 and April 1993, Andrew bit his peers on nine different occasions. U.S.

Exh. 135, 267. Dr. Stratton was supposed to evaluate Andrew and come up with recommendations by July 1992, but as of November 1992, this had not been done. Id. Dr. Stratton was also supposed to attend a mini-staffing for Andrew in August 1992 to problem solve, but he did not attend the meeting, and Andrew's Haldol was increased. Id. Lorna K. is prescribed Mellaril for "exhibiting inappropriate behavior." Fris Dep. Exh. 2. Lorna has no behavior program. U.S. Exh. 154. Dr. Fahs testified that Darren W. had no behavior program to address his behaviors caused by the turmoil of adding more clients to his living area and these behaviors were resulting in injuries to Darren. Tr. 8/3/93 (Fahs) at 128. Dr. Fahs found that Darren was being treated with only medications for his behaviors. Id. Dr. Fahs also testified that George F. had no behavior program to address his inappropriate sexual behaviors, but was prescribed psychotropic medications to control his masturbation. Id. at 103-104.

According to Dr. Goldschmidt, certain PSA's at Ebensburg sometimes rely on psychotropic medications before they try a behavior program. U.S. Exh. 615 (Goldschmidt Dep.) at 59. She also admitted that there is sometimes an over-deference to medications for treatment of behavior problems at Ebensburg. U.S. Exh. 615 (Goldschmidt Dep.) at 58-60.

In addition, as evidenced by Ebensburg's own incident reports, the psychologists at Ebensburg often directly call for the use of medication in the treatment of a behavior by automatically attributing it to mental illness, rather than considering other underlying factors and alternative treatments.[2]/ Tr. 8/2/93 (Russo) at 55; U.S. Exh. 117. For instance:

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[2]/ The psychologists attribute behaviors to psychiatric symptoms, despite the fact that they have not conducted functional analyses to actually determine the underlying causes. See discussion infra § VII.I.4.

- On June 13, 1992, Randall L. grabbed Joe C.'s shirt "for no apparent reason." Randall's eye and nose were injured during the ensuing fight. Randall's PSA notes that "Randall's infrequent, unpredictable outbursts are related to his schizophrenia. Generally well managed with Serentil. Data may suggest a slight increase of dosage."

- On December 19, 1992 at about 4:40 p.m., Roberta V. starting slapping other individuals and herself and pounding windows. Roberta "was very agitated and self abusive throughout the evening." At 9:20 p.m., a contusion was discovered on Roberta's forearm. Her PSA states "because of Roberta's OCD [obsessive-compulsive disorder], she can become agitated. Perhaps there is a need to increase her Rx."

- On December 29, 1992, Denise V. "had been kicking at others all evening." When she kicked Kathy W., Kathy "grabbed Denise by the shoulders and pushed her head first to the floor." Denise struck her face and head on chair legs. Denise's psychologist states "Denise's problems are mainly due to her psychiatric diagnosis. Will recommend an increase in Tegretol next drug review."

- On March 22, 1993, James S. pulled his toenail off. James' PSA states that "he continues to receive medication to address his depression. No changes are recommended to his current programming."

The number of requests by psychologists to the behavior management committee to begin residents on psychotropic medications as a "restrictive procedure" increased from a total of 16 in 1990, 22 in 1991, to 36 in 1992. U.S. Exhs. 36, 37, 640 (Stratton Dep.), Stratton Dep. Exh.17. The number of Ebensburg residents on multiple psychotropic medications as well as "new starts" of psychotropic medications also increased between 1990 and 1992. In both 1990 and 1991, there were 12 residents on more than one psychotropic medication and 24 new starts, as compared to 1992, where there were 26 residents on more than one psychotropic medication and 54 new starts of medications. Id.

Dr. Sneed,[3]/ who has a Ph.D. in psychology, would like to see all use of psychotropic medication used to control behaviors eliminated at Ebensburg because every

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[3]/ Dr. Sneed was the Director of the Bureau of Direct Program Operations in the Office of Mental Retardation within the Department of Public Welfare between 1989 and 1993.

medication has an effect on the body. U.S. Exh. 635 (Sneed Dep.) at 15, 28-30. In Dr. Sneed's opinion, options other than psychotropic medications need to be considered such as "changing the environment, the noise level, the opportunity for privacy, changing the roommate." U.S. Exh. 635 (Sneed Dep.) at 30, lines 23-24. Dr. Sneed believes that positive approaches should be used to replace restrictive or punitive procedures. U.S. Exh. 635 (Sneed Dep.) at 47. By positive approaches, he means practices that "recognize the needs of persons, their needs, their dreams, their aspirations." U.S. Exh. 635 (Sneed Dep.) at 47, lines 16-17. Dr. Sneed believes that "restraints are the least desirable of several options." U.S. Exh. 635 (Sneed Dep.) at 47, lines 24-25.

2. Ebensburg Uses Psychotropic Medications Where They Are Not Indicated And Where They Are Not Effective.

Residents at Ebensburg are unnecessarily given psychotropic medications. Tr. 8/3/93 (Fahs) at 94-95. Ebensburg residents take psychotropic medications that are not indicated and are not effective. Id. at 79, 89, 100-101. This type of chemical restraint is "quite common" at Ebensburg. Id. at 94-95.

In 100% of the records that he reviewed, Dr. Fahs found that Ebensburg failed to appropriately assess the behavior of concern. Tr. 8/3/93 (Fahs) at 79, 88.[4]/ Similarly, Dr. Fahs did not review a single record that documented why a particular diagnosis was selected over other possibilities. Id. at 86. As a result of Ebensburg's "inadequate and disorganized, undisciplined" psychiatric assessments, which are probably leading to improper diagnoses, there is a "high probability" that unnecessary psychotropic medications are prescribed. Id. at

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[4]/ For a detailed discussion of the inadequacy of Ebensburg's psychiatric services, see infra § IX.

79, 89. The process of providing overall psychiatric care to the residents of Ebensburg Center and assessing residents for the need for psychotropic medication is "so deficient," that Dr. Fahs was not able to form an opinion about particular diagnoses or the correctness of particular drug treatments. Id. at 114.

Once prescribed, Ebensburg is seriously deficient in appropriately and adequately monitoring whether its residents are benefiting from the psychotropic medications they are taking. Tr. 8/3/93 (Fahs) at 100. Dr. Fahs concluded that in 100% of the records he reviewed, treatment monitoring was inadequate. Id. at 101. Dr. Fahs could offer no opinion on whether particular individuals were benefiting from particular medications because Ebensburg's monitoring was so bad. Id. at 119. Thus, Ebensburg residents who fail to benefit from medications are left on medications that do not address the behavior of concern while being exposed to serious side effects. Id. at 101. In Dr. Fahs' words, "[t]hat's real harm." Id.

The field requires psychiatrists to use psychotropic medications only where indicated and to avoid using them where they are not indicated. Tr. 8/3/93 (Fahs) at 65. Ebensburg residents are harmed by taking drugs without adequate justification and proper monitoring because individuals continue to suffer from their on-going self-injurious and/or aggressive behaviors, and they suffer needless serious side effects from the administration of medications that are not beneficial. Id. at 67, 69, 93.

B. Ebensburg Is Mechanically And Physically Restraining Individuals Without Providing Adequate Treatment Plans.

In addition to chemical restraints, Ebensburg is also using mechanical and physical restraints on individuals without providing adequate treatment plans. The evidence shows

that Ebensburg fails to provide effective behavior programs to its residents. Tr. 8/2/93 (Russo) at 67; U.S. Exh. 669, 783. Ebensburg fails to revise these ineffective behavior programs even though behaviors do not improve and individuals are being restrained due to the very behaviors purportedly addressed in the behavior programs, which should be improving instead of requiring continued restraint. Id.; U.S. Exh 993. For instance:

- Ann B. has been on the same behavior program for her self-injurious behavior since 1990. U.S. Exh. 93. Ann is spending increasing amounts of time restrained in her restraint chair for her self-injurious behavior. Tr. 8/2/93 (Russo) at 65; U.S. Exh. 783. The evidence shows that, except for a period of hospitalization in April 1993, Ann has been spending over 250 hours per month in her restraint chair since February 1991. U.S. Exh. 286, 783. In May 1993, Ann spent more time in her restraint chair (351 hours) than during any previous month at Ebensburg. Id. Dr. Russo testified that Ann's behavior program is not effective. Tr. 8/2/93 (Russo) at 65-66; U.S. Exh. 783.

- Betty Jean H. has had no significant changes to her behavior program for aggression and self-injurious behavior for the last five years, despite a continuation and actual worsening of her maladaptive behaviors. Tr. 8/2/93 (Russo) at 56; U.S. Exh. 783. Ebensburg's failure to provide an adequate effective behavior program is causing Betty Jean harm, including an incident in April 1992 wherein Betty Jean's arm was fractured while staff were attempting to restrain her. Tr. 8/2/93 (Russo) at 56-57. Ebensburg restrained Betty Jean for her aggression and self-injurious behavior 40 times in 1991, 45 times in 1992, and 22 times, including one emergency chemical restraint, during the first seven and a half months of 1993. U.S. Exh. 993.

- Sandra W. has a behavior program for aggression and biting that has not been revised since January 1989. U.S. Exh. 93. Dr. Russo testified that Sandra has been subjected to significant harm as a result of Ebensburg's failure to provide her with an effective behavior program. Tr. 8/2/93 (Russo) at 68, 70-71. In the more than three years between January 1990 and February 1993, during which time Sandra was restrained more than 70 times, her behavior program was continued without change except for changes in her drugs and replacement of the papoose board with floor control in late 1992. U.S. Exh. 42(c) at 4856, 4881, 4902, 4930, 4846, 541439, 76626, 541421-22. Ebensburg even recommended continuation of Sandra's behavior program in January 1992, after noting that Sandra had been restrained a record number of times (20) in one month, alone, in December 1991. Id. at 4940.

- In spite of 106 episodes of restraint in a two year period, James S.'s behavior program for aggression was continued without change by Ebensburg during the period January 1990 through February 1993, except to change his drugs and replace use of the

papoose board with use of floor control in late 1992. U.S. Exh. 42(c) at 4863, 4891, 4910, 4825, 4830, 4937, 541441, 541426, 541416.

- Veedia H. has been on the same behavior program for aggression since January 1992. U.S. Exh. 856. Between January 1, 1992 and July 28, 1993, Ebensburg restrained Veedia 87 times. U.S. Exh. 993.

- In October 1991, Ebensburg's Behavior Intervention Committee noted that Franklin B. "seems to want to be restrained." U.S. Exh. 42(c) at 4843. In spite of this knowledge, Ebensburg's use of restraints with Franklin dramatically increased in the succeeding years. In 1992, Franklin was restrained 15 times in the papoose board and 11 times in floor control. U.S. Exh. 993. In the first eight and a half months of 1993, Franklin was restrained using floor control 31 times, and in a little over ten months in 1993, Franklin was restrained 24 times with an emergency chemical restraint. U.S. Exh. 993, defendants' Brief in Opposition to United States' Motion for Rebuttal Testimony at 35, fn. 13 (filed 11/12/93).

- Ruth J. has no behavior program for her aggression and self-injurious behaviors. U.S. Exh. 780. The regression analysis for Ruth shows that her aggressive behavior significantly increased during the period January 1992 and March 1993. U.S. Exh. 783. Since January 1, 1991, Ruth has been restrained 13 times due to her aggressive and self-injurious behaviors. U.S. Exh. 993.

- Denise V. does not have a behavior program for her severe self-injurious behavior, even though she has suffered serious and repeated injuries due to her behavior of banging her head on walls, floors, and windows. Tr. 8/2/93 (Russo) at 75. Between January 1990 and February 1993, Denise V.'s behavior program for aggression was continued without change, except to change her drugs and replace use of the papoose board with use of floor control in late 1992. U.S. Exh. 42(c) at 4879, 4895, 4919, 4836, 541460, 541433, 541421-22. Since January 1, 1991, Denise has been restrained 11 times due to her aggression or her self-injurious behaviors. U.S. Exh. 993.

- Ebensburg has not revised Raymond H.'s behavior program for aggression and self-injurious behavior since April 1991, except to eliminate restraints from his program in late 1992 and a living area restriction in December 1991. U.S. Exh. 856, 42(c) at 4860, 4890, 4911, 541439, 541418. Raymond was restrained for his behaviors 6 times in 1991, 6 times in 1992, and 3 times in the first seven and a half months of 1993. U.S. Exh. 993. The regression analysis of Raymond's behavior data shows that Raymond's behavior is not improving. U.S. Exh. 783.

- Except for elimination of a living area restriction in late 1991 and replacement of the papoose board with floor control in late 1992, Ebensburg had not revised Eliot G.'s behavior program for aggression as of January 1993. Stratton Dep. Exh. 2; U.S. Exh. 42(c) at 4895, 4919, 4837, 541460, 541434. In August 1991, Ebensburg's Behavior Intervention

Committee (BIC) recommended continuing Eliot's behavior program in spite of noting that "he has not been doing well when compared to last year at this time." Id. at 4837. In 1991, Ebensburg restrained Eliot 20 times, in 1992, 32 times, and in the first seven and a half months of 1993, 19 times. U.S. Exh. 993.

- Winfield M. has no behavior plan for his aggression. Tr. 8/2/93 (Russo) at 77. Ebensburg restrained Winfield for his behavior twice in 1991; 14 times between June and November 1992 (including three instances of restraint in a papoose board); and 3 times during the first seven and a half months of 1993. U.S. Exh. 993.

C. Ebensburg Used The Papoose Board In Violation of State Policy Until Late 1992.

Ebensburg used the papoose board as a restrictive mechanical restraint through late 1992. U.S. Exh. 993; see also U.S. Exh. 222 (photographs of the application of a papoose board). Most of the individuals who had behavior programs that included use of the papoose board still had such a program in September 1992; planned use of the papoose board was primarily eliminated between September and December of 1992. U.S. Exh. 640 (Stratton Dep.) at 98-100. In Dr. Russo's opinion, Ebensburg continued to use the papoose board in violation of the Commonwealth's 1988 Behavior Management Policy which requires that use of a particular Class III treatment methodology, like the papoose board, be grounded in professional literature. Tr. 8/2/93 (Russo) at 26; U.S. Exh. 30 at 33. In his own reviews and in his discussions with Dr. Stratton, Dr. Russo could find no sufficient literature base to support the use of the papoose board as an effective restrictive measure. Tr. 8/2/93 (Russo) at 26. Dr. Stratton is not aware of anything in the literature that supports using papoose boards on a clinical basis, despite the fact that they were being routinely used at Ebensburg through November 1992. U.S. Exh. 640 (Stratton Dep.) at 95.

In Dr. Russo's opinion, Ebensburg should have eliminated the use of the papoose board long before the end of 1992. A standard treatment design in the field of psychology

requires that Ebensburg eliminate restraint in the behavior programs of clients with long restraint histories to see whether the use of restraint is actually needed. Tr. 8/2/93 (Russo) at 145-146.

As Dr. Stratton recognized, there are dangers inherent in any kind of physical restraint because staff must exert force on a person that is trying to hurt himself or others, and there is always a risk of injury. U.S. Exh. 640 (Stratton Dep.) at 87-88. Use of the papoose board to restrain Ebensburg residents has resulted in injuries. For instance, on January 15, 1992, at 8:15 a.m. in Horizon House, in the words of one of the two supervisors who reported to work there that morning, "the staff pattern was a mess." U.S. Exh. 132 at 40544. In West II, where Ibrahim D. was fighting with Franklin B., "there was total chaos." Id. Ibrahim was restrained in a papoose board. As Ibrahim was completely immobilized in the papoose board, Franklin continued aggressing toward Ibrahim and kicked him in the face, in spite of staff monitoring during the restraint use. Ibrahim suffered a lacerated lip and a "foot print on the bridge of his nose." For the next fifteen minutes, while Ibrahim remained in the papoose board, Franklin stayed in the room with Ibrahim, and Franklin kept lunging at the staff guarding Ibrahim. Staff could not remove Franklin from the area due to lack of staff. Id. at 40544(a).

Dr. Reid only reviewed recent levels of use of mechanical restraint during his February 1993 visit and did not review data from the last several years. Tr. 9/16/93 (Reid) at 15. As the evidence shows, throughout 1991 and into 1992, until the United States filed this lawsuit in February 1992, Ebensburg's use of mechanical restraint was significantly higher than the levels of mechanical or physical restraint reviewed by Dr. Reid. Def. Exh.

Q (which does not include the time that Ann B. spends restrained in her restraint chair). Within a month of filing of the lawsuit, Ebensburg cut its use of restraints in half. Def. Exh. Q. The number of individuals mechanically or physically restrained by Ebensburg on a monthly basis also dropped by about half in the months following February 1992, when this lawsuit was filed. See Def. Exh. R.

The evidence also shows that Ebensburg is underreporting its use of mechanical restraints. For instance, the evidence demonstrates that Rosemary W. wears a helmet for her behavior of throwing herself to the ground. U.S. Exh. 67 at 8F, 1100. There is no dispute that such a use of a helmet constitutes mechanical restraint. Tr. 8/2/93 (Russo) at 59; Tr. 9/16/93 (Reid) at 157-158. State surveyors also noted it to be a restraint in August 1992. U.S. Exh. 1100. However, not a single minute of time that Rosemary has spent in her helmet is recorded on Ebensburg's log of restraint use or reflected in Def. Exh. Q or S. See U.S. Exh. 993. Mr. O'Brien testified, incorrectly, that no one at Ebensburg wore a helmet for restraint purposes until February 1993, but Def. Exh. S does not show one minute of time for mechanical restraints in February, March or April 1993. Tr. 10/19/93 (O'Brien) at 100, 104-105.

Dr. Russo, Dr. Stratton, and Dr. Reid also agree that use of a jumpsuit to prevent rectal digging is a restraint. Tr. 8/2/93 (Russo) at 41-42; U.S. Exh. 640 (Stratton Dep.) at 124; Tr. 9/16/93 (Reid) at 158. Not a single minute of time that Darren W. spent wearing a jumpsuit to prevent his behavior of rectal digging is recorded on Ebensburg's log of restraint usage or reflected in Def. Exh. Q. See U.S. Exh. 993.

D. Ebensburg Is Replacing Its Use Of Mechanical Restraints With Floor Control And Emergency Chemical Restraints.

Although two witnesses for defendants testified that elimination of mechanical restraints at Ebensburg did not result in a corresponding increase in other types of restraints, Tr. 9/13/93 (Kastner) at 171; Tr. 10/15/93 (O'Brien) at 122-123, the evidence demonstrates otherwise. Defendants' Exhibit S purports to show that there has been no increase in the use of physical restraints at Ebensburg since Ebensburg supposedly eliminated the use of mechanical restraint in December 1992. However, defendants' chart only includes data through April 1993. Tr. 10/19/93 (O'Brien) at 96.

United States' Exhibit 998 (attached) demonstrates that after the papoose board was eliminated at Ebensburg, the use of floor control has grown significantly. The number of times that Ebensburg used floor control during the period May to July 1993 is almost double the number of times used in the three months following elimination of use of the papoose board. U.S. Exh. 998. During the use of floor control, an individual is held by staff on the floor. Tr. 10/19/93 (O'Brien) at 107.

The evidence also demonstrates that since Ebensburg discontinued use of the papoose board, use of emergency chemical restraints has grown significantly. U.S. Exh. 993.[5]/ A chart comparing the use of the papoose board for behavior with the use of emergency chemical restraints at Ebensburg is attached as Attachment E. This evidence shows that in the eight months before Ebensburg eliminated use of the papoose board, Ebensburg never

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[5]/ U.S. Exh. 993 includes Ebensburg restraint data, including emergency chemical restraint data, through August 10, 1993. Tr. 10/19/93 (O'Brien) at 101, 103. Data on U.S. Exh. 993 that are noted as "chemical" or "valium" or "Mellaril" means that an emergency chemical restraint was used at Ebensburg. Tr. 10/19/93 (O'Brien) at 103.

used an emergency chemical restraint. However, since elimination of use of the papoose board, Ebensburg used emergency chemical restraints on 34 occasions through November 12, 1993. U.S. Exh. 993; Def. Brief in Opposition to United States' Motion for Rebuttal Testimony at 35, fn. 13 (filed 11/12/93). Since July 1993, when Dr. Goldschmidt resigned, Ebensburg has had no psychiatrist. Tr. 10/19/93 (O'Brien) at 81-82.

E. **Ebensburg's Use Of Floor Control Is Resulting In Injuries.**

Mr. O'Brien admits that when an individual is restrained, there is a possibility that the individual will get injured. Tr. 10/19/93 (O'Brien) at 107. Examples of people who have been injured at Ebensburg while being placed in "required relaxation" or floor control include:

- Sandra W. -- While being put in floor control in January 1991, Sandra banged her face on the floor, knocking one tooth out. The dentist extracted two other teeth loosened during the floor control episode. U.S. Exh. 510.

- Raymond H. -- On February 25, 1992, while staff were attempting to put Raymond in floor control, Raymond became more agitated and banged his head against the floor several times, causing a laceration to his eyebrow that had to be closed with four ethistrips. U.S. Exh. 369.

- Betty Jean H. -- In April 1992, Betty Jean's arm was fractured while staff were attempting to put her in floor control. U.S. Exh. 134.

- James W. -- In July 1992, Ebensburg used required relaxation to control James. While being held on the carpeted floor, James received multiple abrasions on both knees, on his forehead, right cheek, both wrists, both temporal areas and on both shoulders. U.S. Exh. 992.

- Raymond H. -- On October 15, 1992, Ebensburg put Raymond in floor control for "swinging at staff." Raymond banged his head on the floor, sustaining an abrasion on his cheek. U.S. Exh. 369.

- Franklin B. -- On October 20, 1992, Franklin banged his face on the floor during floor control procedures. As a result of the trauma, Franklin's right upper central incisor became loosened and was bleeding. U.S. Exh. 992.

- Joe C. -- At 11:15 p.m. on May 14, 1993, Joe was found in the bathroom engaging in a sexual behavior with Clifford P. When staff intervened, Joe became aggressive and staff put Joe in emergency floor control. Joe held onto the pipes under the sink, and hurt the ride side of his face. When the doctor checked Joe at 9:15 the next morning, she noted that Joe had two swollen fingers and edema under his eye. U.S. Exh. 992.

- Franklin B. -- On May 27, 1993, Donald P. tried to bite Franklin. Franklin ran away, hitting others. Floor control was used, causing an abrasion to Franklin's back. U.S. Exh. 992.

- Franklin B. -- On June 3, 1993, Franklin was tearing his clothing. Staff used floor control on Franklin. During floor control, Franklin's lower lip was injured and there were two open areas on Franklin's right forearm. Franklin also had blood all over his face. U.S. Exh. 992.

IX. EBENSBURG FAILS TO PROVIDE ADEQUATE AND APPROPRIATE PSYCHIATRIC SERVICES IN VIOLATION OF GENERALLY ACCEPTED PROFESSIONAL STANDARDS.

A. Ebensburg Does Not Provide Its Residents With Adequate Psychiatric Services.

There are a large number of Ebensburg residents with severe psychiatric difficulties and severe behavioral problems; thus, the provision of psychiatric services to people at Ebensburg is a very important part of medical care at the facility. Tr. 8/3/93 (Fahs) at 62-3. The proper approach to providing psychiatric care to individuals with mental retardation is the same approach one takes in providing sound medical care in general: assessment, diagnosis, treatment, and monitoring. Tr. 8/3/93 (Fahs) at 63-4.[1]/ Dr. Fahs consistently found pervasive deficiencies at Ebensburg in each one of these core areas that are "universally accepted in the psychiatric profession and in the medical profession entirely." Tr. 8/3/93 (Fahs) at 75. In fact, he found problems in the psychiatric care and treatment of each and every Ebensburg record he reviewed. Id. at 88, 101. The facility's practices are so substandard in all four areas, that Dr. Fahs concluded Ebensburg does not provide its residents with adequate and appropriate treatment of their psychiatric disorders, in violation of generally accepted standards in the medical community. Tr. 8/3/93 (Fahs) at 92. The

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[1]/ Generally, in the assessment phase, the doctor tries to determine what the particular difficulty may be, usually by collecting a range of information. Tr. 8/3/93 (Fahs) at 63. Careful consideration of the information gathered in the assessment phase results in a diagnosis of the disorder. Tr. 8/3/93 (Fahs) at 63. After the diagnosis is made, appropriate treatment is to be provided to the individual, and then, the treatment must be monitored to see whether or not it is, in fact, helpful. Tr. 8/3/93 (Fahs) at 64. Dr. Fahs testified that all of medicine hinges on this approach which is "completely non-controversial" and it "is really fundamental to medicine, not just psychiatric care of mentally retarded people." Tr. 8/3/93 (Fahs) at 65. This classic approach merely involves the "rational application of principles of medicine." Tr. 8/3/93 (Fahs) at 162.

harm resulting from these deficient practices includes inappropriate and/or inadequate medication, the risk of serious drug side effects, continuing behavior problems and the potential that they pose for injury, and needless, prolonged psychiatric suffering from inadequate treatment. Tr. 8/3/93 (Fahs) at 69, 79, 93, 118; accord Tr. 9/14/93 (Lubetsky) at 152.

Each one of the experts for the Commonwealth who testified about psychiatric care also found weaknesses in Ebensburg's psychiatric practices or agreed that there was a need for improvement. See, e.g., Tr. 9/15/93 (Hauser) at 58, 63, 140, 146 (data collection, psychiatric consults); Tr. 9/14/93 (Lubetsky) at 115, 149, 154, 157 (data collection, diagnoses, assessments, treatment, consults); Tr. 9/14/93 (Kastner) at 9 (general psychiatric care). Ebensburg's consulting psychiatrist, Dr. Goldschmidt, readily admits, as well, to problems in psychiatric care at Ebensburg. Tr. 8/3/93 (Fahs) at 82; U.S. Exh. 615 (Goldschmidt) 29-30) (need for more consult time and better data on which to make decisions). In addition, State surveyors have repeatedly found deficiencies in psychiatric practices at Ebensburg. See, e.g., U.S. Exhs. 60, 66, 67; Tr. 8/3/93 (Fahs) at 90, 96-7, 98. As far back as 1990, the Department of Justice notified defendants that Ebensburg was providing inadequate psychiatric care to its residents. In particular, the United States specifically advised the Commonwealth that Ebensburg's failure to adequately evaluate and diagnose residents (which is essential to selecting appropriate treatment) as well as its failure to adequately monitor psychotropic medications departed from generally accepted professional standards. U.S. Exh. 638 (Sponsky Dep.) Exh. 50.

Dr. Kastner admitted that the level of psychiatric care provided to the residents at Ebensburg could be improved. Tr. 9/14/93 (Kastner) at 9. He testified that the Ebensburg psychiatrist could benefit from the assistance of someone with a specific training background in developmental disabilities. Tr. 9/14/93 (Kastner) at 9. He further added that there are experts available to Ebensburg who live only an hour and a half away and "it makes sense to bring one of them in to provide some consultation." Tr. 9/14/93 (Kastner) at 10. Dr. Kastner indicated that Ebensburg should also consider having a psychopharmacologist on site for several hours per month of consultation. Tr. 9/14/93 (Kastner) at 11.

1. A Disciplined Medical Approach Is Necessary In Providing Dependent Individuals With Psychiatric Services.

Obtaining accurate information in the assessment phase, and engaging in a carefully disciplined consideration of the diagnosis is especially important when providing psychiatric care to individuals with developmental disabilities and mental retardation. Tr. 8/3/93 (Fahs) at 88. It is important because most of these individuals have severe intellectual impairment, most are unable to speak for themselves, and most cannot report feelings or thinking. Tr. 8/3/93 (Fahs) at 88, 161-2. For example, people with mental retardation who have no speech cannot report how uncomfortable they are. Tr. 8/3/93 (Fahs) at 122.[2]/ As a result, the psychiatrist is robbed of important and necessary information that is normally available when providing psychiatric care to individuals outside this population. Tr. 8/3/93 (Fahs) at

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[2]/ Dr. Fahs testified "mentally retarded people, like mentally retarded people at Ebensburg, by and large are ... severely intellectually impaired. They often can't talk about their difficulties. And the people who are talking about their difficulties may not have to suffer the consequences of an incorrect decision." Tr. 8/3/93 (Fahs) at 162.

88.[3]/ Consequently, there is even more of a premium placed on a careful, rigorous, disciplined, thoughtful approach when providing psychiatric care to a mentally retarded population. Tr. 8/3/93 (Fahs) at 88-9, 162. Dr. Fahs testified that in dealing with this population, "even more care needs to be exercised ... [e]ven more rigor, even more discipline needs to be exercised in order to assure that reasonable treatment programs are implemented." Tr. 8/3/93 (Fahs) at 88-9.[4]/

Because many of these individuals have chronic and/or recurrent behavioral problems, the psychiatric assessment, diagnosis, treatment, and monitoring process needs to become a continuous "loop" where the monitoring information naturally flows back into the assessment process. Tr. 8/3/93 (Fahs) at 133. Dr. Fahs stressed that if an individual does not respond to a certain treatment, then the assessment, diagnosis, treatment, and monitoring process must be undertaken again, but always "in a disciplined fashion." Id. Dr. Fahs did not see this process reflected in Ebensburg charts at Ebensburg. Id.

2. Ebensburg Is Failing To Provide Its Residents With Adequate, Disciplined Psychiatric Assessments In Violation Of Generally Accepted Standards.

The psychiatric assessments completed at Ebensburg are inadequate and do not meet generally accepted standards in the field. Tr. 8/3/93 (Fahs) at 75.[5]/ Dr. Fahs concluded

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[3]/ Dr. Fahs stressed that a psychiatrist's job is exceedingly difficult even when treating a verbal, intellectually normal population. Tr. 8/3/93 (Fahs) at 88.

[4]/ Dr. Hauser acknowledged that the nonverbal patient in this population is unable to come forward and report what is bothering him or to describe his inner thoughts and feelings. Tr. 9/15/93 (Hauser) at 37. As a result, Dr. Hauser indicated that with this nonverbal population, one has to pursue with greater effort the alternatives that could be leading to the problem. Tr. 9/15/93 (Hauser) at 39.

[5]/ For a discussion of detailed examples of inadequate psychiatric assessments at Ebensburg, see infra § IX.7.

that 100% of the Ebensburg resident records he reviewed were deficient with respect to containing adequate and accurate psychiatric assessment information. Tr. 8/3/93 (Fahs) at 79, 85, 88. Dr. Fahs concluded that the inadequacy of the psychiatric assessments at Ebensburg was "a pervasive problem." Tr. 8/3/93 (Fahs) at 79. Dr. Lubetsky agreed that there is room for improvement in Ebensburg's clinical assessments. Tr. 9/14/93 (Lubetsky) at 149.

As a result of the inadequate psychiatric processes at Ebensburg, Dr. Fahs concluded that "inadequate and disorganized, undisciplined assessment is likely going to lead to the prescription of medication which is either unnecessary or the withholding of medication which ought to be given." Tr. 8/3/93 (Fahs) at 79. This has a tangible effect on the Ebensburg residents who require psychiatric treatment. Id.

A proper psychiatric assessment involves the collection of information from staff, doctors and other interdisciplinary team members in a cooperative effort with the psychiatrist to gain a clear understanding about an individual's particular behavior of concern. Tr. 8/3/93 (Fahs) at 71. All the psychiatric experts in this case agreed that an adequate and proper assessment must be provided to people with mental retardation, particularly when psychotropic medications are prescribed. Tr. 8/3/93 (Fahs) at 63-4, 71-2; Tr. 9/15/93 (Hauser) at 143; Tr. 9/14/93 (Lubetsky) at 144.[6]/

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[6]/ Dr. Hauser agreed that it is important to provide a proper psychiatric assessment in every case when psychotropic medications are being prescribed. Tr. 9/15/93 (Hauser) at 144. Dr. Hauser testified that psychotropic medications should never be prescribed for anyone without an adequate assessment. Tr. 9/15/93 (Hauser) at 144. Dr. Lubetsky also testified that before psychotropic medications are prescribed for a mentally retarded individual, an adequate assessment needs to be performed. Tr. 9/14/93 (Lubetsky) at 144.

Dr. Lubetsky agreed that in assessing a mentally retarded individual, it is important to have careful staff observations of the mentally retarded individual's behavior and interactions. Tr. 9/14/93 (Lubetsky) at 144. These observations are important because they provide the psychiatrist with information about the individual's symptoms, his behavior, and his functioning with others. Tr. 9/14/93 (Lubetsky) at 144-5. Dr. Lubetsky indicated that this observational information helps the psychiatrist in his assessment of the individual's condition. Tr. 9/14/93 (Lubetsky) at 145. He acknowledged that these observations by staff are even more important for someone who is unable or quite limited in his ability to communicate verbally or is functioning on a lower cognitive level, and as a result, is largely unable to self-report. Id.

a. The Behavioral Data And Information Collected By Ebensburg For Use In Psychiatric Assessments Is Either Non-Existent Or Inadequate.

Dr. Fahs concluded that he had "overwhelming reservations" about the behavioral data used in the psychiatric assessment and diagnosis process at Ebensburg. Tr. 8/3/93 (Fahs) at 104. Dr. Hauser agreed that the data collection process at Ebensburg was an area of weakness. Tr. 9/15/93 (Hauser) at 63, 145. In particular, he admitted that Ebensburg could collect data on behaviors in a more useful way. Tr. 9/15/93 (Hauser) at 145.

It is generally accepted in the field that throughout the assessment process, the psychiatrist must be flexible in individualizing the data that is to be collected to fit the particular individual, the target behavior, and other behaviors. Tr. 8/3/93 (Fahs) at 73, 76. Dr. Hauser agreed that behavioral data collection should be tailored to the individual. Tr. 9/15/93 (Hauser) at 184. This does not occur at Ebensburg. Instead, the underlying information for a psychiatric assessment comes from a "universal data collection sheet." Tr.

8/3/93 (Fahs) at 76. Any data collection that is "universal" for all people and for all conditions, is "problematic." Id. Dr. Fahs concluded that the blanket employment of the universal data collection sheet for any and all problems, no matter what they are, for any and all individuals, was "entirely inappropriate." Id. See also discussion on Ebensburg's data collection system supra § VII.I.5.

Dr. Hauser admitted that Ebensburg needs to individualize its behavioral assessments and data collection methods to be more responsive to different clients and different behaviors. Tr. 9/15/93 (Hauser) at 65, 145-146. Dr. Lubetsky also agreed that at Ebensburg, there could be more individualized behavioral assessment and monitoring information integrated into the psychiatric process via the functional behavioral analysis. Tr. 9/14/93 (Lubetsky) at 160. When Dr. Lubetsky first visited Ebensburg, not every resident who had been taking psychotropic medications had a completed functional analysis. Tr. 9/14/93 (Lubetsky) at 161.

A psychiatrist needs a wide variety of behavioral and other data in order to complete a proper psychiatric assessment, but none of this information is gathered sufficiently at Ebensburg. The information contained in the universal data collection sheets is the sum total of the information collected for all psychiatric assessments at Ebensburg; this is inadequate. Tr. 8/3/93 (Fahs) at 76.

An individual is typically brought to a psychiatrist because of a particular behavioral difficulty, known as the "target behavior." Tr. 8/3/93 (Fahs) at 64, 71. Common examples of target behaviors in a mentally retarded population like Ebensburg are aggression, self-injurious behavior ("SIB"), or severe disruption. Id. It is generally accepted in the field that

in the assessment phase, the psychiatrist needs to know how often the target behavior is occurring, how long it lasts, how severe the behavior is, when it began, if anything makes the behavior better or worse, if this problem has arisen before, and whether it is episodic. Tr. 8/3/93 (Fahs) at 71-2. Dr. Hauser agreed that this objective data is important during psychiatric assessment.[7]/ Dr. Lubetsky also agreed that in order to prioritize and decide what to treat, the psychiatrist needs to know which behaviors are more severe and which ones are more problematic. Tr. 9/14/93 (Lubetsky) at 163.

Specifically, the psychiatrist needs information about the target behavior's "intensity," "frequency," and "duration." Tr. 8/3/93 (Fahs) at 72. Although Dr. Fahs and all three of the Commonwealth experts who testified about psychiatric practices at Ebensburg uniformly agree that this qualitative information about behaviors is important, it is not collected at Ebensburg.[8]/ See discussion supra § VII.I.5. Dr. Fahs agrees with Dr. Russo and State surveyors that Ebensburg's system of collecting behavior data only on an "interval" basis is inadequate. Tr. 8/3/93 (Fahs) at 76. Dr. Fahs also found Ebensburg's practice of combining together distinct target behaviors for data collection purpose to be entirely

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[7]/ Dr. Hauser indicated that such data can inform subsequent treatment planning. Tr. 9/15/93 (Hauser) at 63. He indicated that "we can make great use of it." Tr. 9/15/93 (Hauser) at 63. He added that with hard or objective data, "you can have an increased level of confidence in whether you're right and you can avoid ... having the subjective view of staff mislead you." Tr. 9/15/93 (Hauser) at 64. Dr. Hauser indicated that such hard data is readily available at an institution because of the presence of staff. Tr. 9/15/93 (Hauser) at 65.

[8]/ Dr. Hauser acknowledged that intensity, frequency, and duration data for target symptoms is important to review and discuss in a psychiatric consult and that they are useful components of a consultation. Tr. 9/15/93 (Hauser) at 147. Dr. Kastner also indicated that intensity, frequency and duration data for certain target behaviors and other behaviors is important in putting some certainty on how to proceed with an individual who is not verbal and non-communicative. Tr. 9/14/93 (Kastner) at 23. Dr. Lubetsky agreed that it may be necessary for Ebensburg to take intensity data for certain target behaviors. Tr. 9/14/93 (Lubetsky) at 154.

inappropriate and inadequate. Tr. 8/3/93 (Fahs) at 76-7. Dr. Fahs found instances, for example, where aggression and self-injurious behavior were identified as one problem and their occurrences were summed together on the universal data collection sheet. Tr. 8/3/93 (Fahs) at 77.

In addition to needing information about the target behavior to conduct a proper assessment, a psychiatrist also needs information about other behavioral difficulties that are associated with the target behavior. Tr. 8/3/93 (Fahs) at 72. For example, the individual may be presented to the psychiatrist with an aggression problem, but the individual may also have problems with self-injurious behavior or overactivity. Id. The psychiatrist will also need information about these other behaviors to complete a proper psychiatric assessment. Tr. 8/3/93 (Fahs) at 72-3. The psychiatrist needs to have a clear understanding of the intensity, the duration, and the frequency of the other behaviors in order to properly diagnose and treat the target behavior. Tr. 8/3/93 (Fahs) at 73. Ebensburg does not adequately collect behavioral information about individuals' "other" behaviors. Tr. 8/3/93 (Fahs) at 76.

The psychiatrist needs still more information about what are called "vegetative signs." Tr. 8/3/93 (Fahs) at 73. Vegetative signs include sleep, appetite, weight, and changes in level of activity. Id. In order for the psychiatrist to make a proper psychiatric assessment, these signs need to be followed carefully. Tr. 8/3/93 (Fahs) at 74. This information is relatively easy and straightforward to obtain; for example, sleep patterns are easily measured by the staff on the third shift at an institution. Id. However, Ebensburg does not adequately collect vegetative signs data. Tr. 8/3/93 (Fahs) at 76.

Outside reviewing agencies have also found problems with the Ebensburg assessment process. For example, State IOC reviewers found that "the assessment process critical to the active treatment process is frequently found to be incomplete and/or incongruent with established goals." U.S. Exh. 67; Tr. 8/3/93 (Fahs) at 79-80. This conclusion is entirely consistent with Dr. Fahs' findings in this regard. Tr. 8/3/93 (Fahs) at 80.[9]/ Dr. Fahs testified that many of the assessment documents at Ebensburg were "superficial." Tr. 8/3/93 (Fahs) at 81. The documents purported to be something useful, but they were not useful at all. Id. He indicated that their placement in the medical chart would make it difficult for any medical professional to find information that allowed for a genuine assessment. Id. Dr. Fahs concluded that these superficial documents impeded the process rather than assisted it. Id. Dr. Fahs stressed that it "pained" him to see these piecemeal, superficial documents cluttering up the record, because what was really needed for the care of the residents was a "real thoughtful response to the provision of care ... not a paper here, a committee meeting there." Tr. 8/3/93 (Fahs) at 81-2.

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[9]/ Dr. Fahs commented that Ebensburg's response to this deficiency was a "superficial" one in that it looked merely to improve documentation without improving the process. Tr. 8/3/93 (Fahs) at 80. He testified that Ebensburg's plan of action after this deficiency was a "cosmetic response." Tr. 8/3/93 (Fahs) at 80. Dr. Hauser acknowledged that "it's certainly a reactive response because if we had documented ahead of time, and made it clear ahead of time, then they wouldn't be able to criticize." Tr. 9/15/93 (Hauser) at 77.

b. The Psychiatric Consult Sessions Where Assessment Information Is Discussed And Where Diagnoses And Treatment Decisions Are Made Are Chaotic, Disorganized, And Undisciplined.

Dr. Fahs concluded that every single psychiatric consult session he observed at Ebensburg was inadequate. Tr. 8/3/93 (Fahs) at 79.[10]/ Given that this is the time set aside for a specialist to assess, diagnose, and make recommendations about appropriate treatment, Dr. Fahs had grave concerns about what he characterized as a "chaotic," "disorganized," and "undisciplined" consultation process. Id at 77-8.[11]/ Based upon their observations of psychiatric consults at Ebensburg, both Dr. Hauser and Dr. Lubetsky agreed that there were problems with the psychiatric consultations at Ebensburg. Dr. Hauser found deficiencies around the "parameters" of the consult, including the limited amount of time for the consult and its level of organization. Tr. 9/15/93 (Hauser) at 61. When he first toured Ebensburg in 1993, Dr. Hauser also found the documentation that flowed from the psychiatric consultations to be an area of weakness that needed to be more "rigorous." Tr. 9/15/93 (Hauser) at 58.[12]/ Dr. Lubetsky agreed with Dr. Hauser that the consults would

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[10]/ Dr. Hauser made his conclusions about the psychiatric process at Ebensburg even though he could not recall the specific details of the data presented in many of the various consults he attended. Tr. 9/15/93 (Hauser) at 146-50. He indicated that he could not recall their specific presentation of hard data in consult. Tr. 9/15/93 (Hauser) at 148. Dr. Hauser testified that he could not recall what form of monitoring data had been presented in the psychiatric consults. Tr. 9/15/93 (Hauser) at 147. Dr. Hauser admitted that after the psychiatric consults, he never went back to validate the accuracy of any of the anecdotal data that he heard. Tr. 9/15/93 (Hauser) at 150-1. In addition, Dr. Lubetsky testified that the psychiatric consultations were "adequate," but he never explained exactly why he felt that way, and instead, immediately launched into testimony about how the psychiatric consults should be improved. Tr. 9/14/93 (Lubetsky) at 113-4.

[11]/ For a discussion of the details of one such consult, see discussion of Andrew H., infra § IX.7.

[12]/ Dr. Hauser indicated that when he writes notes after his consults, he explores in great detail the basis of his conclusions, he outlines the potential risks, he outlines the team process, and he articulates the rationale for his diagnosis. Tr. 9/15/93 (Hauser) at 58.

(continued...)

benefit from better organization. Tr. 9/14/93 (Lubetsky) at 114. In particular, he found problems with communicating adequate written information. For example, he felt the primary physician could better document the thought process of psychiatric decisions and consults. 9/14/93 (Lubetsky) at 114. Dr. Lubetsky further acknowledged that the psychiatrist's summary of the consult did not provide all the details that it could have and Ebensburg's failure to prepare the consult request ahead of time slowed the process down. Tr. 9/14/93 (Lubetsky) at 114-5.

i. Psychiatric Consults Are Devoid Of Adequate Information For Assessment, Diagnosis, And Treatment.

Dr. Fahs found the psychiatric consultations at Ebensburg as "lacking entirely a conveyance of [the appropriate] kind of information to the consulting psychiatrist." Tr. 8/3/93 (Fahs) at 77. [13]/ He "hesitates" to call the discussion during the psychiatric consult as a presentation of "information;" instead, he characterized it as merely "opinions" and "ideas" (comments such as "he seems a little better" or "he's really having a bad time right now.") Id.[14]/ Dr. Fahs testified that in a chaotic setting like the psychiatric consults at Ebensburg, "with no exchange of clinically acceptable information ... it's virtually impossible to make a rational, reasonable decision" about the provision of psychiatric care.

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[12]/(...continued)

[13]/ Thus, Dr. Fahs concluded that "I think that information is inadequate; but ... even what they had was not being shared with the psychiatrist." Tr. 8/3/93 (Fahs) at 78.

[14]/ In his testimony, Dr. Lubetsky also repeatedly characterized the information presented in the Ebensburg psychiatric consults as "opinions." Tr. 9/14/93 (Lubetsky) at 113.

Tr. 8/3/93 (Fahs) at 118-9. In fact, Dr. Goldschmidt, the consult psychiatrist for Ebensburg at the time, admitted to Dr. Fahs that she needed better information to do a proper psychiatric assessment. Tr. 8/3/93 (Fahs) at 82. Dr. Goldschmidt explained that the consult psychiatrist at Ebensburg must depend on the observations of the interdisciplinary team "to fill in the blanks" since she is not on the spot to observe her patients. U.S. Exh. 615 (Goldschmidt Dep.) at 73-4.

Dr. Lubetsky also found that in the Ebensburg psychiatric consultations he observed, much of the information presented was verbal. Tr. 9/14/93 (Lubetsky) at 162.[15]/ He indicated that written data helps substantiate the verbal information, often times makes it clearer, and may be more helpful than verbal information in making a treatment decision. Tr. 9/14/93 (Lubetsky) at 162-4. Verbal presentation of data also does not replace hard data recorded over time.

It is generally accepted in the field that behavioral data needs to be collected and recorded longitudinally over a period of time. Tr. 8/3/93 (Fahs) at 72. This is important because many behavioral problems fluctuate naturally over time. Id. Without longitudinal data of the fluctuating target behavior over time, the psychiatrist might mistakenly attribute improvement in the behavior to the treatment as opposed to the normal fluctuations. Id. This type of longitudinal data is also important because for seriously retarded and disabled individuals like those living at Ebensburg, psychiatric care is necessarily a chronic

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[15]/ Dr. Hauser's memory about the psychiatric consults he attended was not as clear. He could not recall the specific details about data presentation during Ebensburg psychiatric consults and never verified the accuracy of any anecdotal information he heard. Tr. 9/15/93 (Hauser) at 147-151.

undertaking. Id. This type of longitudinal data, however, is not adequately recorded at Ebensburg. Tr. 8/3/93 (Fahs) at 76.

Without written data, no one staff member can effectively convey the wealth and breadth and subtlety of the behaviors that have occurred over time since the individual's last consult. Dr. Lubetsky acknowledged that in relying on verbal reports of behaviors from staff, that the individual staff member present in the Ebensburg psychiatric consults could not have been present to observe and discuss in consult the individual's every behavior over a 24-hour a day schedule. Tr. 9/14/93 (Lubetsky) at 164. Dr. Lubetsky further admitted that staff members reporting anecdotal information may remember only recent events and may not remember behavioral events weeks or months earlier. Tr. 9/14/93 (Lubetsky) at 165. Dr. Hauser agreed, adding that "this is one of the important reasons for the collection of data over time, to try to avoid the risk that a staff member's presentation of data will be biased by their own personal experience." Tr. 9/15/93 (Hauser) at 85-6.[16]/ Dr. Hauser also explained that the collection of hard data allows the psychiatrist to see patterns of behavior over time instead of just reacting to behaviors yesterday. Tr. 9/15/93 (Hauser) at 85.

In sum, the psychiatric consults at Ebensburg are not adequate to enable the psychiatrist to complete a proper assessment that would lead to a proper diagnosis. Tr. 8/3/93 (Fahs) at 78. Dr. Fahs testified that "I cannot possibly see how one could arrive at a careful assessment and diagnostic in the context of not having the kind of information available that I'm referring to, the need for longitudinal data and the need for accurate

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[16]/ Dr. Hauser testified that the opportunity to gather hard data exists in an institution where "you actually have the potential to gather data that can add to the consultation process because you have staff present who you can educate to keep data that can be constructive in a consultation." Tr. 9/15/93 (Hauser) at 87.

reliable information." Id. Without it, Dr. Fahs concluded that "it's impossible to do that." Id.

ii. Psychiatric Consults Take Place Too Infrequently.

All three experts for the Commonwealth testifying about psychiatric care at Ebensburg, as well as Dr. Goldschmidt, herself, agreed that residents would benefit from an increase in the two days per month allotted to psychiatric consultation. Dr. Goldschmidt told Dr. Fahs that the time she was allotted to spend at Ebensburg providing psychiatric consult services pursuant to her contract was "inadequate" and that she felt "pressured." Tr. 8/3/93 (Fahs) at 82.[17]/ Dr. Goldschmidt testified that if she had more time, she would like to be more involved in staff education and she would like to spend more time observing clients individually to aid her in evaluating them. U.S. Exh. 616AA; Tr. 8/3/93 (Fahs) at 82-3.[18]/ Dr. Hauser agreed that the residents at Ebensburg would benefit if the consult psychiatrist could spend more time at the facility. Tr. 9/15/93 (Hauser) at 156, 157. He indicated that if the psychiatrist had more time, the psychiatrist could be more rigorous about, for example, documenting the specific differential diagnoses that are supposed to be

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[17]/ In response to the question "Do you have enough time?" Dr. Goldschmidt responded "I feel like I am rushed, no question about that. I am rushed." U.S. Exh. 616AA; Tr. 8/3/93 (Fahs) at 83. The sentiments Dr. Goldschmidt testified about in her deposition were the same sentiments she expressed to Dr. Fahs on this issue. Tr. 8/3/93 (Fahs) at 83.

[18]/ In her deposition, Dr. Goldschmidt admitted that if she had had more time to consult at Ebensburg, she would have observed her patients in their work and living environments. U.S. Exh. 615 (Goldschmidt Dep.) at 29-30. She indicated that this is important because most Ebensburg residents are non-verbal, and it would have helped in doing psychiatric assessments by giving her a better understanding about what is going on with a particular individual. U.S. Exh. 615 (Goldschmidt Dep.) at 29-30. She also admitted that she would have liked more time to communicate with her patients' interdisciplinary teams. U.S. Exh. 615 (Goldschmidt Dep.) at 31. Dr. Goldschmidt indicated that she would have liked to have had more time to interact with the administration to better understand what options are available for specific residents. U.S. Exh. 615 (Goldschmidt Dep.) at 32.

considered. Tr. 9/15/93 (Hauser) at 71.[19]/ Dr. Lubetsky agreed, as well, that it would be generally helpful to have the psychiatric consultant spend more time at Ebensburg, particularly to provide psychiatric services to individuals with more complicated behaviors. Tr. 9/14/93 (Lubetsky) at 157. Dr. Kastner additionally agreed that generally, increasing the number of psychiatric consult hours per month at a residential facility like Ebensburg would be beneficial and valuable. Tr. 9/14/93 (Kastner) at 9. In particular, he agreed that it would be beneficial to increase the amount of psychiatric consultation time at Ebensburg. Tr. 9/14/93 (Kastner) at 10. Dr. Kastner indicated, for example, that having to do 110 annual medication reviews per year in only 24 days would "stretch" the consult psychiatrist. Tr. 9/14/93 (Kastner) at 9-10. Indeed, Dr. Goldschmidt sometimes only spends five minutes per resident on her drug reviews. Tr. 10/15/93 (O'Brien) at 80, line 24.

The Commonwealth's experts agreed that the Ebensburg consult psychiatrist also did not have enough time to work with and educate the staff. Dr. Lubetsky indicated that it would be helpful for Ebensburg's consulting psychiatrist to provide "teaching" to the staff during the consult. Tr. 9/14/93 (Lubetsky) at 115. This would enable the staff to better understand what the psychiatrist was looking for in terms of providing her with behavioral information. Tr. 9/14/93 (Lubetsky) at 115-6. Dr. Lubetsky concluded that he did not see enough evidence that this type of instruction and guidance to the staff was being provided. Tr. 9/14/93 (Lubetsky) at 116. Dr. Lubetsky indicated that teaching the Ebensburg staff what behaviors to look for would benefit the residents with behavior problems at Ebensburg.

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[19]/ With respect to the performance of the consult psychiatrist at Ebensburg, Dr. Hauser testified that "I actually believe that she wasn't doing the best job she could. I felt that she had it within her to do better." Tr. 9/15/93 (Hauser) at 140.

Tr. 9/14/93 (Lubetsky) at 159. Dr. Hauser testified that it is the role of the consult psychiatrist to educate and train the staff about the value of medication and how to assess psychiatric impairment. Tr. 9/15/93 (Hauser) at 62.

Dr. Goldschmidt did not choose to renew her contract with the Commonwealth of Pennsylvania. As such, since July 1993, Ebensburg has been without the services of a psychiatrist who is under contract to provide its residents with regular psychiatric care. Tr. 10/19/93 (O'Brien) at 81.

3. Ebensburg Is Failing To Provide Its Residents With Adequately Considered Psychiatric Diagnoses In Violation Of Generally Accepted Standards.

It is generally accepted in the field that in formulating a proper diagnosis for an individual who may have a psychiatric disorder, a psychiatrist needs to take the information gathered in the assessment phase and thoughtfully consider what is causing the target behavior to occur. Tr. 8/3/93 (Fahs) at 83-4. The articulation of why a particular disorder is selected over the other possibilities is standard medical care. Tr. 8/3/93 (Fahs) at 85.

The diagnosis is the key to the selection of treatment. Tr. 8/3/93 (Fahs) at 89. Dr. Fahs testified that if the diagnosis is faulty because an improper assessment has been done, then there is a "high probability that an improper treatment will be selected." Id. This is an especially difficult problem when unnecessary drugs are prescribed to an individual. Id.

In formulating a diagnosis, it is generally accepted that a psychiatrist develops a "differential diagnosis" which considers probable diagnoses, possible diagnoses, and still other diagnoses for the particular behavior. Tr. 8/3/93 (Fahs) at 84, 160-1. Dr. Fahs added that "without consideration of the possibilities of the disorder that the person has, the

likelihood of choosing a medication which is effective or specific for the disorder is less than if one does carefully consider the differential diagnosis." Tr. 8/3/93 (Fahs) at 161. Considering all these possibilities ensures that the psychiatrist will have the best chance of providing the individual with the ultimately desired treatment. Tr. 8/3/93 (Fahs) at 84. The consideration process is at the heart of a proper psychiatric diagnostic formulation. Id. The construction of a differential diagnosis and the selection of a working diagnosis is standard medical care and is generally accepted in the field. Tr. 8/3/93 (Fahs) at 85.[20]/

The psychiatric diagnostic process as conducted at Ebensburg is inadequate and does not meet generally accepted standards in the medical community. Id.[21]/ Dr. Fahs concluded that "There was no record, that I reviewed, that reviewed carefully why that particular diagnosis was selected over the other possibilities, with a degree of rigor." Tr. 8/3/93 (Fahs) at 86. Dr. Fahs testified that at Ebensburg, he found "little consideration of differential diagnostic possibilities." Tr. 8/3/93 (Fahs) at 85. Dr. Fahs indicated that in the

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[20]/ Dr. Hauser testified that the formation of an adequate differential diagnosis is important in the psychiatric process of providing psychotropic medications or psychiatric services to residents in a facility for the mentally retarded. Tr. 9/15/93 (Hauser) at 151. Dr. Hauser indicated that doctors and psychiatrists are supposed to give a full consideration to alternative hypotheses in the differential diagnosis. Tr. 9/15/93 (Hauser) at 71. Dr. Lubetsky acknowledged that considering a differential diagnosis is important in providing psychiatric care. Tr. 9/14/93 (Lubetsky) at 146. Dr. Lubetsky agreed that with the developmentally disabled, "it's very difficult to make a diagnosis." Tr. 9/14/93 (Lubetsky) at 119. This is because of the cognitive impairment, the lower functioning, and the non-verbal nature of this population. Tr. 9/14/93 (Lubetsky) at 119, 147. As a result, Dr. Lubetsky testified that the best attempt at a correct diagnosis for this population is to come up with a differential diagnosis. Tr. 9/14/93 (Lubetsky) at 119, 147. Dr. Lubetsky acknowledged that it is important that the psychiatrist consider a variety of diagnostic options. Tr. 9/14/93 (Lubetsky) at 147. Dr. Lubetsky acknowledged that "It is difficult to make a diagnosis in many of these clients; and the more information you get, the better chance you have of formulating a differential diagnosis." Tr. 9/14/93 (Lubetsky) at 159.

[21]/ Dr. Hauser testified that he made no conclusions one way or the other about the adequacy of the diagnoses at Ebensburg. Tr. 9/15/93 (Hauser) at 152.

very few cases he could find a differential consideration of alternative diagnoses, they were not written down in one place where they would be of some use to the medical professionals; instead, the differential consideration was scattered in pieces throughout the record. Tr. 8/3/93 (Fahs) at 85-6. Because it was so scattered, Dr. Fahs concluded that this did not reflect a disciplined approach to psychiatry. Tr. 8/3/93 (Fahs) at 86. In his review of records, Dr. Fahs found that over ninety-five percent were deficient with respect to containing adequate diagnostic formulation. Tr. 8/3/93 (Fahs) at 88.[22]/

Experts for the Commonwealth found problems with Ebensburg's psychiatric diagnoses as well. Dr. Lubetsky agreed that there is room for improvement with respect to Ebensburg's diagnostic process. Tr. 9/14/93 (Lubetsky) at 149. Dr. Lubetsky indicated that he would like to see more differential diagnoses at Ebensburg and a greater effort to look at specific symptoms in fitting criteria to come up with a list of working diagnoses. Id. Dr. Lubetsky indicated that after the psychiatric consult is completed at Ebensburg, he would like to see more of the psychiatrist's thought processes and more of the psychiatrist's decision-making process written down. Id. Dr. Lubetsky indicated, for example, that the documented justification for the administration of psychotropic medications at Ebensburg was inconsistent. Tr. 9/14/93 (Lubetsky) at 150. He added that "the documentation and the psychiatric consultation form did not provide me with enough information to understand the thought process of the diagnosis and the medications in certain charts." Id. Dr. Hauser agreed that there are examples of individual records he reviewed at Ebensburg where their

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[22]/ For a discussion of detailed examples of inadequately considered psychiatric diagnoses at Ebensburg, see infra § IX.7.

psychiatric diagnosis lacked an adequate description of symptoms to support the diagnosis. Tr. 9/15/93 (Hauser) at 152.

Because of the lack of rigor, psychiatric diagnoses at Ebensburg are routinely and regularly changed for some individuals without clarification as to why the change is being made. Tr. 8/3/93 (Fahs) at 86. Dr. Fahs added that he never found a single record at Ebensburg that clearly indicated why the diagnosis was being changed. Id. He indicated that this was an "extraordinarily common problem" at Ebensburg. Id. Dr. Fahs added that it was extraordinarily common to find a lack of discipline, lack of consideration of the diagnostic possibilities, and a lack of indication of the support for why a particular diagnosis was made. Tr. 8/3/93 (Fahs) at 87. Dr. Fahs stressed that "it is important to clarify why that change is being made because then not only does it appear that, in fact, the first diagnosis was given without consideration, it certainly suggests that the next one is given without consideration as well." Tr. 8/3/93 (Fahs) at 86.

It is not generally accepted in the field that one can simply make the diagnosis justify the treatment. Tr. 8/3/93 (Fahs) at 87. Dr. Fahs testified that "if one simply takes the position that the diagnosis justifies the on-going treatment, then changing diagnoses willy-nilly certainly suggests the treatment can be changed willy-nilly." Id. Dr. Fahs indicated that he was sorry to say that he found it common that diagnoses were added after a treatment was already started in order to justify continuing to give the treatment. Id. He testified that this "is standing the whole process on [its] head" because the diagnosis is what should lead to the treatment selection. Id.

Dr. Fahs added that standard clinical practice dictates that "one ought not make a diagnosis retrospectively just because a particular treatment worked." Tr. 8/3/93 (Fahs) at 181. Dr. Fahs stressed that "there are no disorders of which I am aware for which treatment response serves as a diagnostic criteria. The whole purpose of the diagnosis is to be able to select the correct treatment." Tr. 8/3/93 (Fahs) at 180. He added that the purpose is "not to give somebody treatment, see if they get better, and then say the disorder they have is the one this drug is supposed to treat." Id.

Experts for the Commonwealth agreed with this principle. Dr. Kastner testified that "I support Dr. Fahs in his general statement that the diagnosis should guide treatment." Tr. 9/14/93 (Kastner) at 22. Dr. Lubetsky acknowledged that in general, one is taught to "try to make the best diagnosis you can and try not to make your diagnosis based on the response to a medication. Tr. 9/14/93 (Lubetsky) at 120. Dr. Hauser testified that ideally the choice of the medication comes about from the hypothesis that the person has a particular disorder. Tr. 9/15/93 (Hauser) at 40.

In addition to the Justice Department's 1990 letter citing deficiencies in this area, Ebensburg has also been on notice of deficiencies with its psychiatric diagnoses from State surveyors. Tr. 8/3/93 (Fahs) at 90. A 1991 IOC survey team found that documentation for Ebensburg residents with psychiatric diagnoses lacked adequate description of symptoms to support the diagnosis. U.S. Exh. 66; Tr. 8/3/93 (Fahs) at 90. This conclusion is entirely consistent with the conclusions of Dr. Fahs in this regard. Tr. 8/3/93 (Fahs) at 90. Additional symptoms to support a diagnosis do need to be articulated, and they do need to be quantified so that they can be followed over time. Tr. 8/3/93 (Fahs) at 147. That

information needs to be conveyed to the psychiatrist to assist in treatment decisions and diagnostic decisions. Id. One needs to be careful to articulate the symptoms of the individual, rather than just writing down the diagnosis. Tr. 8/3/93 (Fahs) at 90. The 1991 IOC survey team also found that the justification for the administration of psychotropic medication at Ebensburg was inconsistent, and that behavior plans are required, but were not being provided for certain individuals. U.S. Exh. 66; Tr. 8/3/93 (Fahs) at 90. Promised corrective actions by Ebensburg were not carried out. Tr. 8/3/93 (Fahs) at 147. In 1993, the IOC surveyors also cited Ebensburg for prescribing a certain drug for akathisia to James R. even though there was no evidence to support this as the proper diagnosis. U.S. Exh. 67; Tr. 8/3/93 (Fahs) at 96-7.

4. Ebensburg Is Failing To Provide Its Residents With Adequate And Appropriate Psychiatric Treatments In Violation Of Generally Accepted Standards.

a. The Treatment Decision-Making Process At Ebensburg Is Not Adequate.

Ebensburg does not provide its residents with adequate and appropriate treatment of their psychiatric disorders in violation of generally accepted standards in the medical community. Tr. 8/3/93 (Fahs) at 92. There are many deficiencies at Ebensburg at the treatment stage: the weighing of the different treatment options available is inadequately considered at Ebensburg; the rigorous consideration and selection of treatments is weak; whatever documentation is available only gives the "illusion" that a careful weighing of the treatment options is being done; behavioral programs are not considered aggressively for people who have psychiatric disorders; there is a poor coordination of treatment efforts; changing behavioral programs and drug treatments sometimes seem to be unrelated to each

other; and there is an overreliance on the diagnosis justifying the treatment. Tr. 8/3/93 (Fahs) at 92-3.[23]/ Dr. Lubetsky agreed that there is room for improvement with regard to Ebensburg's psychiatric treatment. Tr. 9/14/93 (Lubetsky) at 149.

Dr. Fahs testified that the process of providing psychiatric care to the residents at Ebensburg was "so deficient," that he was not able to comment about particular diagnoses and the correctness of particular treatments. Tr. 8/3/93 (Fahs) at 114. Dr. Fahs added that "I dare say nobody else would be able to comment on that either ... it was just so chaotic that it was hard to second guess." Id.[24]/

It is generally accepted in the field that the psychiatric treatment phase requires a reasoned consideration of what the treatment options are, again flowing from the assessment and diagnosis. Tr. 8/3/93 (Fahs) at 91. Drug treatment must be carried out reasonably and according to generally accepted medical standards such as providing adequate dosage and safe monitoring. Tr. 8/3/93 (Fahs) at 92. Engaging in an inadequate treatment decision-making process affects the Ebensburg residents directly because if the incorrect treatment is selected, people will not respond, except by luck. Tr. 8/3/93 (Fahs) at 93. Dr. Lubetsky agrees that a psychiatrist would have to be "lucky" to provide the correct treatment if the assessment was inaccurate or inappropriate. Tr. 9/14/93 (Lubetsky) at 145-6.

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[23]/ For a detailed discussion of examples of situations at Ebensburg where treatment decisions were inadequate, see infra § IX.7.

[24]/ Dr. Hauser admitted that he did not review each Ebensburg medical record to specifically determine if the treatment was working. Tr. 9/15/93 (Hauser) at 133. Dr. Hauser was not prepared to testify as to which specific records he reviewed to see whether or not their treatment was working. Tr. 9/15/93 (Hauser) at 134.

Dr. Fahs stressed that "if treatment is given which is not indicated, if treatment is withheld which ought to be given, individuals will continue to either suffer from the disability that they have with on-going problems with self-injurious behavior, with on-going problems with agitation, aggression, etcetera, because of undertreatment, or they will suffer the side effects needlessly from the administration of medications which are not beneficial." Tr. 8/3/93 (Fahs) at 93.

b. Inappropriate Treatment Selection At Ebensburg Exposes Individuals To Risks Of Drug Side Effects.

It is generally accepted that a psychiatrist should select medications appropriately, use them properly when they are indicated, and avoid using them when they are not indicated. Tr. 8/3/93 (Fahs) at 65. In addition, a clinician should always use the treatment that carries with it the best benefit to risk ratio for that particular patient. Tr. 8/3/93 (Fahs) at 91. Psychotropic medications[25]/ carry with them a risk because they have associated with them side effects. Tr. 8/3/93 (Fahs) at 65, 91.[26]/ Dr. Fahs testified that psychotropic

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[25]/ A psychotropic medication is any medication that is prescribed with the primary intent of improving an abnormality in thinking, feeling or behavior. Tr. 8/3/93 (Fahs) at 66. Psychotropic medications are not a homogenous class of drugs; they are very different. Tr. 8/3/93 (Fahs) at 66. There are antipsychotic or antidepressant medications, there are stimulants, sedatives, sleeping pills and others. Tr. 8/3/93 (Fahs) at 66. Among all psychotropic medications used for mentally retarded individuals, including those at Ebensburg, antipsychotic medications or neuroleptics are the ones most often used. Tr. 8/3/93 (Fahs) at 66-7. Haldol and Thorazine are examples of neuroleptics. Tr. 8/3/93 (Fahs) at 67. Each class of medication has its own side effects. Tr. 8/3/93 (Fahs) at 66. Dr. Lubetsky indicated that neuroleptics carry with them a variety of side effects such as tardive dyskinesia, extra-pyramidal symptoms ("EPS"), dry mouth, and effects on blood pressure. Tr. 9/14/93 (Lubetsky) at 152.

[26]/ One major class of psychotropic drugs are called "mood stabilizers" such as Lithium, Depakote and Tegretol. Tr. 8/3/93 (Fahs) at 68. Side effects associated with the use of Lithium include hypothyroidism, GI problems, nausea, vomiting, diarrhea, tremors, shaking hands, and very frequent urination. Tr. 8/3/93 (Fahs) at 68. Side effects associated with the use of Tegretol include a decreased white blood cell count, a severe abnormality in the blood cells, severe anemia, a decreased (continued...)

medications are "potentially fraught with difficulties if they're used inappropriately." Tr. 8/3/93 (Fahs) at 66.

An Ebensburg resident who is receiving inappropriate or improper psychotropic medication treatments suffers the risk of incurring the drugs' side effects without deriving any benefit. Tr. 8/3/93 (Fahs) at 69.[27]/ This is real harm. Id.[28]/ Because the individual may suffer side effects, regardless of whether or not the medication is in fact helpful, it is critical not to prescribe psychotropic medications unless there is some benefit to the individual from the use of those medications. Tr. 8/3/93 (Fahs) at 65. In fact, it is generally accepted that one should avoid the use of psychotropic medications when they are not indicated. Id. As a result, clinicians should not rush into using psychotropic drugs. Tr. 8/3/93 (Fahs) at 65-6.[29]/

Given that Ebensburg's psychiatric assessments and diagnoses are so entirely deficient, however, the Ebensburg residents are exposed to the serious side effects of using psychotropic drugs. A serious concern in the field is needless exposure to the risks of

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[26]/(...continued)
platelet count, dizziness, sedation and difficulty walking. Tr. 8/3/93 (Fahs) at 68. Side effects associated with the use of Depakote include liver problems and sedation. Tr. 8/3/93 (Fahs) at 68. Another class of psychotropic medication used at Ebensburg are antidepressant drugs. Tr. 8/3/93 (Fahs) at 68. The side effects associated with the use of antidepressants include sedation, anticholinergic effects, and overstimulation. Tr. 8/3/93 (Fahs) at 68-9.

[27]/ Dr. Lubetsky admitted that an individual may suffer side effects whether the treatment provides benefit or not. Tr. 9/14/93 (Lubetsky) at 146.

[28]/ Another harm is not receiving appropriate treatment for the disorder. Tr. 8/3/93 (Fahs) at 69. Dr. Fahs stressed that "the harm would be at least two-fold, incurring the risk associated with the medications ... and not receiving treatment which may be effective." Tr. 8/3/93 (Fahs) at 69.

[29]/ Dr. Fahs testified that he was trained to be sure before acting with any medical treatment; he quipped that when one is unsure if a medication is indicated, "don't just do something, stand there." Tr. 8/3/93 (Fahs) at 66.

tardive dyskinesia. ("TD"). Tr. 8/3/93 (Fahs) at 67. Tardive dyskinesia is a movement disorder or abnormality that stems from the chronic use of certain psychotropic medications like neuroleptics. Id. Dr. Kastner indicated that tardive dyskinesia is a significant problem in the treatment of people with psychiatric disorders who receive neuroleptic medication. Tr. 9/14/93 (Kastner) at 11. Dr. Kastner testified that tardive dyskinesia is a "serious concern" in the field of developmental psychiatry and in the field of psychiatry in general. Tr. 9/14/93 (Kastner) at 13. Usually tardive dyskinesia shows itself when a patient exhibits tremors of the face and the mouth, the hands, and may exhibit other problems which reflect the change in the chemistry of the brain due to prolonged neuroleptic drug use. Tr. 9/14/93 (Kastner) at 12-3. The onset of TD may be rather insidious, making its appearance only years after the person has been taking the medication. Tr. 8/3/93 (Fahs) at 67. Once TD makes its appearance, however, it is untreatable. Id. Dr. Kastner agreed that there is "really no effective consistently effective treatment for tardive dyskinesia." Tr. 9/14/93 (Kastner) at 12. Dr. Hauser found that there are clients at Ebensburg with involuntary movements that are representing TD. Tr. 9/15/93 (Hauser) at 34. Several of the residents reviewed by Dr. Russo are showing signs of neurological damage and complications, which are side effects of protracted use of psychotropics. Tr. 8/2/93 (Russo) at 55.

It is often difficult to differentiate tardive dyskinesia from other movement disorders. Tr. 9/14/93 (Kastner) at 13. Given that it is difficult, practitioners have developed scales and screening tests to help them determine when tardive dyskinesia was present. Dr. Kastner agreed that tardive dyskinesia should be monitored over time, however, he did not remember if Ebensburg used an AIMS scale or anything else to test for tardive dyskinesia. Tr. 9/14/93

(Kastner) at 13-4. At Ebensburg, there is not a consistent, regular review for psychotropic medication side effects, including AIMS tests for tardive dyskinesia. Tr. 8/3/93 (Fahs) at 100. The AIMS screenings were not regularly done, even though there is an official policy at Ebensburg saying that it is supposed to be done. Id. In fact, Ebensburg nurses do not have any specific assessment tool that they use for looking for side effects of psychotropic medications. U.S. Exh. 638 (Sponsky Dep.) at 71.

Ebensburg residents who are prescribed psychotropic medications in the flawed Ebensburg system are also exposed to the risk of neuroleptic malignant syndrome ("NMS"). Tr. 8/3/93 (Fahs) at 67. NMS is a severe movement disorder creating problems with the autonomic nervous system leading to chaotic blood pressure, breathing problems, high fever, and an alteration in the level of consciousness, occasionally leading to stupor and coma. Id. Neuroleptic malignant syndrome has a mortality rate of ten to twenty percent. Id. Extra-pyramidal syndrome ("EPS") is another common side effect. Many Ebensburg residents like Ann B. are taking Cogentin for the treatment of EPS. Dr. Goldschmidt's November 1992 consult notes that Ann's tongue is protruding. U.S. Exh. 640 (Stratton Dep.) Exh. 2.[30]/

c. Ebensburg Is Failing To Provide Its Residents With Adequate And Appropriate Behavior Programs At The Treatment Stage.

As a result of the risk of side effects, Dr. Fahs stressed that "[n]on-drug treatments are to be preferred." Tr. 8/3/93 (Fahs) at 169. Behavior treatments generally carry with them lower risks than do drug treatments. Tr. 8/3/93 (Fahs) at 91. Thus, if a drug and non-drug treatment are thought to be of equal benefit, it would be logical to choose behavioral

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[30]/ Other common side effects associated with the use of psychotropic medications are sedation, anticholinergic side effects (such as dry mouth, dizziness, constipation and urinary retention), photosensitivity, and many others. Tr. 8/3/93 (Fahs) at 67-8.

treatment over drug treatment. Tr. 8/3/93 (Fahs) at 92. Dr. Hauser agreed that there are times when a psychiatric disorder should be addressed through non-medication means, where the use of medications would be premature. Tr. 9/15/93 (Hauser) at 46. Dr. Hauser termed using medications prematurely without trying alternative treatments as a "red flag" issue. Tr. 9/15/93 (Hauser) at 135.[31]/

Dr. Fahs stressed that "the assessment process which leads to treatment selection only occasionally would suggest that drug treatment should be used ... non-drug treatments should be used whether or not drug treatments are used." Tr. 8/3/93 (Fahs) at 113. Dr. Fahs added that "there's virtually no psychiatric disorder for which the treatment is solely a drug treatment. The treatment of psychiatric disorders requires a coordinated comprehensive approach to treatment, and it is very, very seldom that treatment ought be drugs alone." Tr. 8/3/93 (Fahs) at 90-1.[32]/ Dr. Hauser agreed that it is appropriate to use a coordinated approach of providing drug and non-drug treatments at the same time in synchrony with one another. Id. Dr. Lubetsky testified that when providing a mentally retarded individual drug treatment, it is important to always be providing other forms of treatment along with the medication. Tr. 9/14/93 (Lubetsky) at 148. Dr. Lubetsky indicated that the other treatments may continue to be effective after the medication has been eliminated from the treatment program. Tr. 9/14/93 (Lubetsky) at 148-9.

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[31]/ However, Dr. Hauser was not prepared to testify about the specific names or numbers of records he reviewed where Ebensburg had actually tried alternative treatments before resorting to medication. Tr. 9/15/93 (Hauser) at 136-7. Dr. Hauser admitted that he did not look in each record he reviewed to determine whether each and every individual had an adequate behavior plan to address their behavior. Tr. 9/15/93 (Hauser) at 140-1.

[32]/ Dr. Fahs' own patients that are treated with drugs are also treated with behavioral treatments as well. Tr. 8/3/93 (Fahs) at 113.

However, behavior programs at Ebensburg are not considered aggressively for people who have psychiatric disorders. Tr. 8/3/93 (Fahs) at 93.[33]/ Dr. Goldschmidt admitted that certain psychologists at Ebensburg sometimes rely on psychotropic medications before they try a behavior program. U.S. Exh. 615 (Goldschmidt Dep.) at 59. Given Ebensburg's overdeference to medications for treatment of behavior problems, residents at Ebensburg run an increased risk of medication side effects. U.S. Exh. 615 (Goldschmidt Dep.) at 58-60.[34]/

Ebensburg has been repeatedly cited for its failure to integrate adequate behavior programs with its use of psychotropic medications. The Department of Justice notified defendants, in both 1987 and 1990, of unconstitutional conditions at Ebensburg due to its use of psychotropic medications as a substitute for adequate behavior programs. U.S. Exh. 638 (Sponsky Dep.) Exhs. 49, 50. Other outside surveyors have found similar problems at Ebensburg, as recently as 1993. U.S. Exh. 67 (1993 IOC survey); U.S. Exh. 60 (1992 MA survey); U.S. Exh. 66 (1991 IOC survey); Tr. 8/3/93 (Fahs) at 89-90, 95-99. See further discussion infra § VIII.A.1.

5. Ebensburg Is Failing To Adequately Monitor Its Residents' Progress After Providing Them With Psychiatric Treatment In Violation Of Generally Accepted Standards.

"Monitoring" is the stage where the decision is made as to whether or not the person is receiving benefit from the treatment. Tr. 8/3/93 (Fahs) at 101. Monitoring entails

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[33]/ For a detailed discussion of specific examples of this at Ebensburg, see supra § VIII.A and infra § IX.7.

[34]/ Dr. Goldschmidt believed that if Ebensburg had employed more direct care staff, psychotropic medication use at the facility would be reduced. U.S. Exh. 615 (Goldschmidt Dep.) at 88.

looking for a beneficial response to treatment and monitoring for side effects. Tr. 8/3/93 (Fahs) at 99; Tr. 9/14/93 (Lubetsky) at 151. It is generally accepted that the only way to know if the treatment decision is effective and correct in a particular instance is to monitor the treatment. Tr. 8/3/93 (Fahs) at 69-70.[35]/ Even if a treatment decision is rational and based on a properly undertaken assessment coupled with a thoughtful diagnosis, the treatment may still not work. Tr. 8/3/93 (Fahs) at 70. If that is the case, experts for both the United States and defendants agree that treatment should be stopped and another treatment should be started. Id; Tr. 9/14/93 (Lubetsky) at 153. Monitoring must be undertaken and completed in a disciplined fashion. Tr. 8/3/93 (Fahs) at 100.[36]/ This is generally accepted in the medical community. Id.

If monitoring is not done, individuals may receive medications and not receive any benefit from them; they will continue to suffer from the disorder and will continue to incur the risk of side effects in further taking the drugs. Tr. 8/3/93 (Fahs) at 101; Tr. 9/14/93 (Lubetsky) at 153. As Dr. Fahs testified, for individuals like those at Ebensburg, "That's real harm." Id.

Ebensburg is seriously deficient in appropriately and adequately monitoring its residents who may be receiving psychotropic treatments in violation of generally accepted

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[35]/ Dr. Lubetsky agreed that monitoring is important because it is the only way to know whether the medication is effective or not for that individual. Tr. 9/14/93 (Lubetsky) at 151. Dr. Lubetsky indicated that this is important because if the medication is not helping the individual, then the psychiatrist needs to make a decision about altering the dose or changing the medication. Tr. 9/14/93 (Lubetsky) at 151. Dr. Hauser agreed that monitoring data is an important component of the psychiatric consult process. Tr. 9/15/93 (Hauser) at 179.

[36]/ In fact, the monitoring process should spill over neatly into the assessment phase where information is gathered initially. Tr. 8/3/93 (Fahs) at 99.

standards. Tr. 8/3/93 (Fahs) at 100. Dr. Fahs concluded that in 100% of the Ebensburg medical records he reviewed, treatment monitoring was inadequate. Tr. 8/3/93 (Fahs) at 101.[37]/

Dr. Lubetsky agreed that he would like to see more side effects being monitored at Ebensburg. Tr. 9/14/93 (Lubetsky) at 153-4. Dr. Lubetsky testified that for selected individuals at Ebensburg, there may be a need to take more individualized frequency counts beyond the one or two target behaviors that are being monitored now. Tr. 9/14/93 (Lubetsky) at 154. Dr. Lubetsky added that if reliability checks were performed on the monitoring data at Ebensburg, it would help improve behavior data collection. Id.

Dr. Fahs testified that it was difficult for him to speak specifically to whether or not any Ebensburg individual was receiving any benefit from a particular medication because the monitoring was so inadequate. Tr. 8/3/93 (Fahs) at 119.

6. Ebensburg Residents Are Being Chemically Restrained.

It is clear that many individuals at Ebensburg are being chemically restrained given that they are provided with psychotropic medication without the facility having adequately attempted non-drug alternative treatments like behavior programs. See further discussion supra § VIII.A.2, IX.A.4.c.

In addition, if an individual is given medication without justification or without any evidence that the medication is helpful, that individual can be considered to be "chemically restrained." Tr. 8/3/93 (Fahs) at 94-95. As a result, based on the entirely inadequate

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[37]/ For a discussion of further details of specific cases where Ebensburg has not monitored psychiatric treatments adequately, see infra § IX.7.

psychiatric assessment and monitoring processes at Ebensburg, Dr. Fahs concluded that chemical restraint is "quite common" at Ebensburg. Id. Chemical restraint is common at Ebensburg because, as discussed, residents are provided medication based upon lack of evidence of efficacy, because there are psychotropic drugs provided based on potentially inappropriate indications, and because there are psychotropic drugs provided when the staff simply does not know if a medication is helpful. Tr. 8/3/93 (Fahs) at 95.[38]/

7. Individuals Residing At Ebensburg Have Been Harmed Because Of The Inadequate And Inappropriate Psychotropic Services Provided To Them By The Facility.

Dr. Fahs testified that the problems in the provision of psychiatric services to the Ebensburg residents are so pervasive as to affect 100% of the individuals he reviewed who receive psychiatric care at the facility. Tr. 8/3/93 (Fahs) at 88, 101. To illustrate his points, Dr. Fahs provided a few selected examples of individual psychiatric care that touch on a number of the general conclusions he testified to earlier. Tr. 8/3/93 (Fahs) at 101.

- Andrew H.: Dr. Fahs sat in on a psychiatric consultation for Andrew. Tr. 8/3/93 (Fahs) at 117. Dr. Fahs testified that the consult was "extremely chaotic and disorganized, not focused." Id. Andrew was singing and talking loudly for the entire consult, and yet the staff simply watched him. Id.

Dr. Fahs noted a number of substantive deficiencies at the consult. Id. For example, despite the fact that Andrew's medications had been recently changed, there was absolutely no review of any of the medications that he was taking. Tr. 8/3/93 (Fahs) at 118. At the consult, the staff noted that Andrew "needed" his psychotropic drug, but there was no review of data, no rigorous consideration of non-medication treatments, no real rigorous review of

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[38]/ Dr. Fahs explained that "chemical restraint" is a term that is not used by physicians at all. Tr. 8/3/93 (Fahs) at 94. He added that it "has grown up as a legal term." Tr. 8/3/93 (Fahs) at 94. He indicated that while most physicians might think a "chemical restraint" was the acute administration of a sedating drug in an emergency situation, regulatory guidelines in the area of mental retardation define "chemical restraint" as the unnecessary administration of psychotropic medications. Tr. 8/3/93 (Fahs) at 94-5. This would include medications that are given without any indication or medications that are given without evidence that they are helpful. Tr. 8/3/93 (Fahs) at 95.

anything. Id.[39]/ Dr. Fahs testified that the individuals present at the consult were just "watching," and that no direct care staff were present at the consult. Id. There was no review of any behavioral information. Id. In the midst of the midst of what Dr. Fahs depicted as "chaos," there was a recommendation to add another medication, and a recommendation, by silence, to continue the medication that he was already taking. Id. There was no discussion of any alternative treatments at the consult. Id.[40]/ Andrew suffered harm in having to continue to receive neuroleptic medication without the medical staff knowing if he was receiving any benefit from it. Tr. 8/3/93 (Fahs) at 119. See also discussion about Ebensburg's general failure to protect Andrew H. from harm supra § V.F.1.

- George F.: In providing psychiatric care to George F., Dr. Fahs concluded that Ebensburg did not meet generally accepted professional standards. Tr. 8/3/93 (Fahs) at 106-7. Overall, Dr. Fahs concluded that the psychiatric care provided to George was characterized by poor interdisciplinary coordination: there were medication changes even though his activities and behaviors were not being monitored; there was a clear lack of non-drug behavioral treatment; and the administration of psychotropic medication continued without evidence that it was helpful to him. Tr. 8/3/93 (Fahs) at 105-106.[41]/

George suffered harm by continuing to take a psychotropic drug that is potentially damaging with no evidence that he was deriving any benefit from it. Tr. 8/3/93 (Fahs) at 106. In addition, George had self-injurious behavior (marked by pulling off his toe nails, face slapping and biting his arm), and yet his behavioral program was wholly inadequate. Tr. 8/3/93 (Fahs) at 103.

George was given a chart diagnosis of schizophrenia. Tr. 8/3/93 (Fahs) at 102. Dr. Fahs indicated that he could not find any evidence to support the diagnosis of schizophrenia in George's record. Id. Dr. Hauser testified that after reviewing George F.'s record, he too could not find any evidence to support the diagnosis of schizophrenia. Tr. 9/15/93 (Hauser)

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[39]/ See also § VII.E.3 (discussion of Ebensburg's failure to address Andrew's maladaptive behaviors with non-medication alternatives, such as a behavior program).

[40]/ Dr. Fahs emphasized that decisions about psychotropic medications are important not only because of the notable risks and because of the interference it can cause with the individual's progress, but also for the consequences of when treatment is denied and it should be administered. Tr. 8/3/93 (Fahs) at 118.

[41]/ See also supra § VII.E.3 (discussion of Ebensburg's failure to provide George with a behavior program for biting) and § V.F.3 (discussion of Ebensburg's failure to protect other residents at Ebensburg from George's biting even though directed by the State to do so).

at 170.[42]/ George's diagnosis was changed from schizophrenia to autism for no apparent reason that was discernable from the record. Tr. 8/3/93 (Fahs) at 104-5.

There was indication in the record that he had a problem with constant inappropriate masturbation and yet there was no data presented or available in the record with regard to this behavior. Tr. 8/3/93 (Fahs) at 103. Dr. Fahs stressed that it makes sense to carefully evaluate such an inappropriate sexual behavior in mentally retarded people given that it interferes with their social integration. Id.[43]/ Instead of gathering data, the Ebensburg psychiatrist simply suggested increasing his psychotropic medication to better control his masturbation. Id. His drugs were increased, but there was no accompanying behavioral program put in place. Tr. 8/3/93 (Fahs) at 103-4. Dr. Lubetsky admitted that there was no behavioral program for George's masturbation listed in the "behavior objectives" part of his record. Tr. 9/14/93 (Lubetsky) at 208; U.S. Exh. 956. Dr. Lubetsky testified that he did not recall the specific data format used to monitor George's masturbation, and he did not recall if there was a behavior program in place related to his SIB. Tr. 9/14/93 (Lubetsky) at 197. George's psychotropic medication was increased for unclear reasons. Tr. 8/3/93 (Fahs) at 105. It was also problematic that his psychotropic drugs were increased at the very time his SIB was at its lowest. Tr. 8/3/93 (Fahs) at 104. Dr. Fahs testified that there was a great need for longitudinal data for George because he very likely had a natural fluctuation in his behavioral difficulties. Id. It was hard to tell if George's behaviors improved as a result of any of his treatments because the recorded information was so bad. Tr. 8/3/93 (Fahs) at 105.

Finally, the psychologist indicated that George was "too low functioning" for a behavioral program. Tr. 8/3/93 (Fahs) at 104. Dr. Fahs testified that he was struck by this given that George is no different from the other profoundly mentally retarded individuals at Ebensburg. Id. Dr. Hauser indicated that if the staff at a facility held the position that everybody was too low functioning to benefit from anything, that would obviously be a "problem." Tr. 9/15/93 (Hauser) at 97.

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[42]/ Dr. Fahs commented that the diagnosis of schizophrenia was problematic because a diagnosis of schizophrenia requires an accurate verbal report of an abnormal thinking process; however, he added that there is virtually universal agreement among the psychiatric community who work with people who are mentally retarded that it is exceedingly difficult, if not impossible, to make a diagnosis of schizophrenia in a profoundly mentally retarded person. Tr. 8/3/93 (Fahs) at 102. Dr. Hauser agreed that "the cognitive deficits of a profoundly retarded person are so severe, that you actually can't find out if they meet the diagnosis criteria for schizophrenia." Tr. 9/15/93 (Hauser) at 89. He added, "So, I in a sense, am agreeing with Dr. Fahs about the limitations of the use of the term "schizophrenic" for people with profound retardation." Tr. 9/15/93 (Hauser) at 92. Dr. Lubetsky also agreed that it is difficult to make a diagnosis of schizophrenia since it is difficult to ascertain hallucinations, psychoses, delusions if someone is not verbal. Tr. 9/14/93 (Lubetsky) at 194-5. The fact that a resident has had abnormal behaviors does not in and of itself support the diagnosis of schizophrenia. Tr. 8/3/93 (Fahs) at 102-3.

[43]/ When referring to this specific problem in her deposition, Dr. Goldschmidt did not point to any data or hard information, but instead merely stated that Ebensburg has "a lot of masturbating all over the place." U.S. Exh. 615 (Goldschmidt Dep.) at 97, line 20.

• Gary K.: Overall, the case of Gary K. demonstrates that no assessment was available, there was no disciplined consideration of the differential diagnosis, and he received treatment for his psychiatric disorder only after it had been delayed for a long time. Tr. 8/3/93 (Fahs) at 109. Gary suffered harm in that he was forced to continue to suffer from depression, aggression, and agitation because he was not treated with appropriate antidepressant medication. Tr. 8/3/93 (Fahs) at 107, 109-10. He did not need to continue to suffer from the depression without being adequately treated for as long as he did. Tr. 8/3/93 (Fahs) at 110. Depression is one of the most "treatable" psychiatric disorders. Id.

When Ebensburg finally started treating Gary for his depression, his psychiatric consult notes fail to mention or note his depression. Tr. 8/3/93 (Fahs) at 109. This was striking to Dr. Fahs given that this was the condition he was being treated for, and this was the condition that the inter-disciplinary team had been following. Id. The psychiatrist recommended treatment, and it was begun, with an antidepressant psychotropic medication, but there was no articulation of specific information with regard to that disorder. Tr. 8/3/93 (Fahs) at 108.

Dr. Goldschmidt indicated on a consult visit in October 1992, that she wanted to see Gary the next time she visited Ebensburg. U.S. Exh. 953; Tr. 9/14/93 (Lubetsky) at 199. However, the next time the consult psychiatrist saw Gary in consult was in March 1993 -- over five months later. Tr. 9/14/93 (Lubetsky) at 199-200.[44]/

Gary was given a "diagnosis" of aggressive behavior, but aggressive behavior is not a psychiatric diagnosis. Tr. 8/3/93 (Fahs) at 107. His aggression increased and yet it was difficult for Dr. Fahs to ascertain whether there had been a consideration of non-medication treatments for his increased aggression. Tr. 8/3/93 (Fahs) at 107-8.[45]/

For three months, Gary was provided 150 mg of Desoryl (a psychotropic drug), and yet this was an entirely insufficient dosage. Tr. 8/3/93 (Fahs) at 108.[46]/ Not surprisingly, Gary did not respond and did not get better in terms of his depression. Id. He continued with his agitation and aggression during that time. Id. He was then switched to another psychotropic medication, but there was no gathering or presentation of rigorous disciplined data of his behavior and how George responded to the drugs. Tr. 8/3/93 (Fahs) at 109. Dr. Fahs indicated that the physician and the pharmacist should have intervened earlier. Tr.

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[44]/ For a further discussion of Gary K. and Dr. Goldschmidt's concerns about whether he was being abused see also supra § V.F.1.

[45]/ See also supra § VII.G.1 (discussion of Ebensburg's failure to revise Gary's behavior program for aggression since 1988, in spite of continued aggression including March 1992 incident wherein Gary bit James P.'s scrotum so hard that suturing was required).

[46]/ Reading from the Physicians' Desk Reference, Dr. Fahs indicated that the usual adult dosage of this drug initiates at 150 mg per day. Tr. 8/3/93 (Fahs) at 188. Dr. Fahs added that instead Gary was provided with an initial dose of 50 mg per day which was only increased to 150 mg at a later time. Tr. 8/3/93 (Fahs) at 188. In addition, Gary was kept on this initial dose for over three months. Tr. 8/3/93 (Fahs) at 188.

8/3/93 (Fahs) at 110. It is important for the pharmacist to have input at the interdisciplinary team level into the decision of whether or not to administer drugs. Tr. 8/3/93 (Fahs) at 119. The Ebensburg Chief Pharmacist, Mr. Fris, admitted that he does not have enough contact with Ebensburg's psychiatrist. U.S. Exh. 612 (Fris Dep.) at 104-5. The pharmacist did not attend interdisciplinary team meetings, and the pharmacist had not attended the behavior management committee meetings in months. Tr. 8/3/93 (Fahs) at 120. (Although on the day that Dr. Fahs was present at the facility, Ebensburg made sure that the pharmacist was present at the behavior management committee meeting. Id.)

- Franklin B.: Franklin was provided with an improper psychiatric assessment leading to a delay in treatment while his aggression and severe agitation continued. Tr. 8/3/93 (Fahs) at 110. If Franklin had received an adequate and appropriate assessment and diagnosis, it is less likely that his aggression would have increased. Id. There were other treatment possibilities that seemed reasonable. Tr. 8/3/93 (Fahs) at 113-4. Overall, the psychiatric services provided to Franklin are inadequate because they are being rendered without data and they are not sufficiently coordinated with the psychiatrist, all leading to harm and injury for Franklin from continued agitation and aggression. Tr. 8/3/93 (Fahs) at 117.

At the end of the psychiatric consult provided to Franklin, Dr. Lubetsky indicated that the team had still not completed a differential diagnosis on him. Tr. 9/14/93 (Lubetsky) at 181-2. Dr. Lubetsky admitted that it would have been helpful if the team had explored the precipitant of Franklin's behavior and the consequences of his behavior, but these topics had not been discussed. Tr. 9/14/93 (Lubetsky) at 182. Dr. Lubetsky indicated that it would also have been helpful to have more information about Franklin's target behaviors presented at the consult. Tr. 9/14/93 (Lubetsky) at 182-4. Dr. Lubetsky indicated that hard data and functional analysis of Franklin's behavior would help the psychiatrist appropriately treat the individual's target behavior. Tr. 9/14/93 (Lubetsky) at 185.

The diagnoses provided for Franklin changed over the years for reasons that were not entirely clear because the reasons for the changes were not articulated in the record. Tr. 8/3/93 (Fahs) at 111. At one point his Haldol was increased presumably because of behavioral worsening. Id. However, it was difficult for Dr. Fahs to tell if his behavior actually worsened because there was no intensity behavioral data or information in the record. Id. Dr. Fahs testified that the intensity data was "conspicuous by its absence;" "there was no measure of intensity." Tr. 8/3/93 (Fahs) at 111-2. The only information on which to proceed is anecdotal. Tr. 8/3/93 (Fahs) at 112. At another time, it was problematic for Dr. Fahs that Franklin was subjected to a "major medication change and a major environmental change occurring within two days of each other." Id. Dr. Fahs testified that that is something to be avoided. Id.

The psychiatrist made several recommendations to discontinue or decrease Franklin's psychotropic drugs, but none of her recommendations were implemented. Tr. 8/3/93 (Fahs) at 114-5. Dr. Fahs was perplexed why the changes had not been made since Franklin's behaviors had worsened. Tr. 8/3/93 (Fahs) at 115. Dr. Fahs stressed the need for follow-up of recommendations from the psychiatrist. Id. There was also a recommendation to

decrease one of his psychotropic medications, and yet this was never done and it was not clear why it had not been done. Id.

Franklin was scheduled to be reviewed by the Ebensburg behavior management committee in December 1992, when Dr. Fahs was present at the facility. Tr. 8/3/93 (Fahs) at 115-6. Dr. Fahs testified that he was "anxious to see how deliberations went for consideration of a new drug." Tr. 8/3/93 (Fahs) at 116. However, at the time, Dr. Fahs was told that Franklin could not be reviewed that day because there was no data on him. Id. Dr. Fahs testified "in my mind, what I thought was, well, so now they're going to go back and do the things that I've been mentioning earlier, provide good baseline data or whatever, and it will be reviewed again. That's the purpose of those kinds of reviews." Id. However, when Dr. Fahs was finally able to review Franklin's record after the fact, he discovered that the medication was started five days after that behavior management meeting was scheduled to have taken place. Id. This indicated to Dr. Fahs that the kind of review Franklin had been provided was not useful. Id. Dr. Fahs found it hard to imagine that an adequate amount of information could have been retroactively put together in five days to support the proposed action. Tr. 8/3/93 (Fahs) at 136. As a result, he questioned whether or not that level of review at Ebensburg is helpful. Id.

In fact, Franklin worsened a lot after the medication was started, and it was discontinued about a month later. Tr. 8/3/93 (Fahs) at 116. He continued to be agitated over the next several months. Id.[47]/ Ebensburg has treated Franklin with emergency chemical restraints at least 24 times in the first ten and a half months of 1993. U.S. Exh. 993; Defendants' Brief in Opposition to United States' Motion for Rebuttal Testimony at 35, fn. 13.

- Darren W.: Overall, Dr. Fahs testified that Ebensburg's general psychiatric treatment approach to Darren seemed "very uncoordinated and dilapidated, very disorganized." Tr. 8/3/93 (Fahs) at 129. Dr. Fahs also noted that the overall diagnostic process was disorganized. Tr. 8/3/93 (Fahs) at 121. As a result, Darren suffered harm in that he continued to have difficulty with marked overactivity, suffering bruises and abrasions, because of not having received the appropriate treatment. Tr. 8/3/93 (Fahs) at 130.[48]/

Darren's diagnoses were frequently and abruptly changed at Ebensburg. If a psychiatrist wants to change drugs in a "dishonest" way, Dr. Fahs indicated that he can just change the diagnosis without any scientific basis. Tr. 8/3/93 (Fahs) at 127. Specifically, Darren was provided with a drug and then taken off it just two days later for reasons that were not clear from review of the record. Tr. 8/3/93 (Fahs) at 126. Instead, he was placed

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[47]/ In commenting on the effectiveness of Franklin's treatment plan, Dr. Hauser testified that he was not aware that Franklin had caused injuries to himself and others on at least twelve different occasions between May 1 and August 18, 1993, including breaking a mirror with his hand, pounding his head, and attacking staff. Tr. 9/15/93 (Hauser) at 138-139.

[48]/ Ebensburg claimed that Darren's injuries have been reduced recently, but Dr. Fahs pointed out that there was no evidence put forth by the facility that his injuries decreased because of the reduction in his Haldol. Tr. 8/3/93 (Fahs) at 145.

on another drug, the dosage was later increased and then a few days later, another drug was added. Id. Throughout, Darren had not changed, and yet in a very short span of time, his "condition" was thought to have changed from having akathisia, to asthma, to a panic disorder, and then to obsessive compulsive disorder. Id. The diagnosis was simply changed without any foundation in a diagnostic, thoughtful approach. Id. Dr. Fahs stressed that if one does that, "it misses the point of the diagnosis." Tr. 8/3/93 (Fahs) at 127. At Ebensburg, the appropriate assessment process was not undertaken when the psychiatrist changed diagnoses abruptly in that way. Id. Dr. Fahs indicated that is entirely proper to change diagnoses, but it is not appropriate if the reason for the change is absent. Id.

The psychiatrist then changed Darren's diagnosis again to attention deficit disorder. Tr. 8/3/93 (Fahs) at 128. Dr. Fahs testified that that change in diagnosis "caught me completely out of left field" because Darren was a grown man, but attention deficit disorder is a disorder of childhood. Id. Nonetheless, this behavior was still not being monitored in a disciplined fashion. Id. In addition, there was no supporting evidence of his obsessive compulsive behaviors. Id. Nevertheless, there was a recommendation for the use of an antidepressant medication. Id.

Dr. Fahs could not find an adequate behavioral program in place to enable Darren to better cope with the turmoil associated with a change in living environments to a more chaotic arrangement. Id. As a result, he continued with extreme behavioral difficulties and he suffered a number of abrasions and bruises during his time of overactivity. Id. Darren suffered a fractured toe during this period of overactivity. Id.[49]/

At one point, Darren's medications were abruptly stopped and a marked behavioral worsening followed the discontinuation. Tr. 8/3/93 (Fahs) at 121. He was suddenly taken off a medication that he had been on for years, because it was thought he had asthma. Tr. 8/3/93 (Fahs) at 125. Dr. Fahs indicated that asthma in a 30-year old man was "a strange diagnosis to consider." Id. Dr. Fahs testified that he was "struck by the absence of a pulmonary consultation." Tr. 8/3/93 (Fahs) at 141. Dr. Fahs also indicated that he was struck that there was no "work-up," or a more complete evaluation to see whether or not he actually had developed asthma. Tr. 8/3/93 (Fahs) at 142. Dr. Fahs testified that he merely saw a physician's progress note, but no "work-up." Id. After he was taken off this medication, he experienced a dramatic worsening in his agitation and he began to engage in overactivity, pica, severe rectal digging and smearing of his feces. Tr. 8/3/93 (Fahs) at 125. This required the renewed use of a jumpsuit so that he could not engage in rectal digging. Id.

There were a number of other deficiencies in the psychiatric services provided to Darren scattered throughout his record. For example, at times, Dr. Fahs found that it was not clearly set forth in his record why he was taking the medications he was being provided. Tr. 8/3/93 (Fahs) at 123. Dr. Fahs noted that Darren was being treated for panic, and yet he could find nothing in the record to indicate how his panic was being followed. Tr. 8/3/93 (Fahs) at 124. He also could find nothing in the record to indicate whether or not Darren

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[49]/ See also supra § VI.B.2 (discussion of Ebensburg's failure to provide toileting program for Darren, resulting in restraint in a jumpsuit).

was more or less agitated. Id. The psychiatrist made recommendations to gradually discontinue a psychotropic medication, but the reasons for that change were not entirely clear. Tr. 8/3/93 (Fahs) at 125. Darren's psychotropic drug dosage was increased and decreased across a few months with no clear reason set forth about why there was to be a change and there was no clear monitoring. Tr. 8/3/93 (Fahs) at 128.

- James S.: Dr. Fahs concluded that James S. is being harmed by not receiving treatment that is effective for him. Tr. 8/3/93 (Fahs) at 132. James continued to receive high doses of Haldol for three years without any evidence that it was helpful. Tr. 8/3/93 (Fahs) at 131. Dr. Fahs explained that this exposed James to real harm given that he must incur the significant risk of side effects from Haldol, and yet there was no evidence that it was helpful to treat his ill-defined behaviors. Id. He added that one simply needs to make the absolute best efforts possible to treat this kind of severe SIB and yet, James is not receiving that kind of treatment from Ebensburg. Tr. 8/3/93 (Fahs) at 132. Dr. Fahs testified that there was a real problem with respect to the specificity and adequacy of the psychiatric assessment process given to James. Tr. 8/3/93 (Fahs) at 131. Dr. Fahs noted that James suffered a lot of injuries because of his SIB. Tr. 8/3/93 (Fahs) at 130. However, Dr. Fahs noted that James' SIB had been lumped together for the sake of treatment with other distinct unrelated behaviors such as stealing, aggression, non-compliance and 'pesty-type' behavior. Tr. 8/3/93 (Fahs) at 130-1. Dr. Fahs indicated that "it just didn't make any sense to me at all" that Ebensburg would lump together head banging and stabbing yourself with a fork with non-compliance and pesty behavior. Tr. 8/3/93 (Fahs) at 131.[50]/

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[50]/ See also supra § VII.E.1 (discussion of Ebensburg's failure to provide James with a behavior program for his severe self-injurious behavior).