



MR-PA-006-012

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

VOLUME II

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X.	EBENSBURG FAILS TO PROVIDE ADEQUATE AND APPROPRIATE MEDICAL CARE TO RESIDENTS AT RISK OF LIFE-THREATENING CONDITIONS DUE TO ASPIRATION, GER, AND NUTRITIONAL STATUS . . .	X-1
A.	Medical Management of Aspiration and Gastroesophageal Reflux Is Inadequate	X-1
1.	Aspiration Of Foreign Material Into The Lungs Is A Common Source Of Harm For Individuals With Developmental Disabilities	X-3
a.	Gastroesophageal Reflux Is One Major Cause Of Aspiration In This Population	X-5
b.	Dysphagia Or Feeding Difficulties Is A Second Major Cause Of Aspiration In This Population	X-7
2.	The Assessment And Diagnostic Techniques For Addressing Aspiration Problems Are Well-Known And Generally Accepted	X-8
a.	A Facility Needs To Identify Which Individuals Are At Risk Of Aspirating	X-9
b.	A Facility Needs To Provide Those Individuals At Risk Of Aspirating With A Proper Medical "Work-Up" Of Their Condition	X-9
3.	The Treatments For Aspiration Problems Are Well-Known And Generally Accepted	X-11
4.	Ebensburg Residents At Risk Of Aspirating Have Died As A Result Of The Inadequate And Inappropriate Medical Intervention Furnished By Ebensburg	X-12
5.	Ebensburg Residents At Risk Of Aspirating Have Been Hospitalized As A Result Of The Inadequate And Inappropriate Medical Intervention Furnished By Ebensburg	X-29
6.	Even When Ebensburg Residents At Risk Of Aspirating Are Not Hospitalized They May Be Suffering Harm As A Result Of The Inadequate And Inappropriate Medical Intervention Furnished By Ebensburg	X-36
B.	Ebensburg Does Not Provide Adequate Nutritional Management Services To Residents In Accord With Basic Standards Of Care	X-37
1.	The Outcome Measures Of A Good Nutritional Management System Are Not Evident At Ebensburg	X-37
2.	Nutritional Management Does Not Exist At Ebensburg	X-41
3.	There Are Commonly Agreed Upon Components Of An Adequate Nutritional Management System	X-43
a.	Ebensburg Has Failed To Identify Individuals Whose Swallowing, Oral Motor, And Medical Conditions Place Them Nutritionally At Risk	X-44
b.	Ebensburg Does Not Adequately Assess Residents With Nutritional Management Needs	X-48

i.	Ebensburg's Dysphagia Team Has Failed To Conduct Assessments	X-49
ii.	The Dysphagia Team's Assessments Are Inadequate	X-53
c.	Ebensburg Fails To Provide Adequate And Appropriate Mealtime Interventions For Residents With Nutritional Management Needs	X-54
d.	Ebensburg Fails To Adequately Monitor Residents' Mealtime Intake And Mealtime Interventions	X-58
i.	Mealtime Interventions	X-58
ii.	Mealtime Intake	X-59
4.	Ebensburg Fails To Provide Adequate Staff Training In How To Implement Feeding Plans	X-60
5.	Ebensburg Paraprofessional And Professional Staff Have Not Received Adequate Training In Nutritional Management And Feeding Individuals With Developmental Disabilities	X-62
6.	Ebensburg Has Failed Even In Its Minimal Efforts At Nutritional Management Activities	X-66
a.	Ebensburg's Dysphagia Team Has Been Ineffective And Has Failed In Its Mission	X-66
b.	Ebensburg's Attempts To Develop And Revise Feeding Plans In Late 1992 Were Not Professionally Grounded	X-69
c.	The Dining Observation Form Was Implemented Without Adequate Understanding	X-71
C.	Ebensburg's Treatment Of Jeff K. Is Illustrative Of Medical And Nutritional Management Issues	X-74

**XI. MEALTIMES AT EBENSBURG ARE UNSAFE AND DO NOT MEET
ACCEPTED PROFESSIONAL STANDARDS**

A.	Overview	XI-1
B.	Ebensburg Residents Are Experiencing Obvious Harm From Unsafe Mealtime Practices	XI-2
C.	Ebensburg Residents Are Eating And Being Fed In Unsafe Positions	XI-6
1.	There Are General Standards For Safe Eating Positions	XI-7
2.	Ebensburg Residents Are Fed On Their Backs, Contrary To Accepted Practice	XI-8
3.	Ebensburg Residents Are Being Fed With Their Trunks Improperly Aligned And Their Heads In Extension Contrary To Accepted Professional Practice	XI-12
D.	Ebensburg Residents Are Being Fed Unsafely By Staff	XI-19

1.	Ebensburg Staff Feed Residents At An Excessively Rapid Rate And With Overloaded Spoons Which Are Dangerous Practices	XI-20
2.	Staff Feed Residents By Pushing Their Heads Back Into Hyper-extension Which Is A Dangerous And Unacceptable Practice . .	XI-23
3.	Staff, Themselves, Are Situated In Poor Positions When They Feed Residents Which Contributes To Poor Feeding Practices . .	XI-25
4.	Ebensburg Staff Scrape Food Off Of Residents' Faces While Feeding	XI-25
5.	Ebensburg Staff Do Not Follow Requirements In Residents' Feeding Plans	XI-26
6.	Staff Fail To Intervene Properly When Residents Are Exhibiting Distress During Mealtimes And Have Even Fed Residents While They Are Coughing	XI-30
7.	There Is No Consistency In Staff Feeders Of Residents With Complex Feeding Needs	XI-31
8.	Even Where Ebensburg's Professional And Paraprofessional Staff Feed Residents, They Use Unsafe And Professionally Unsound Practices	XI-32
9.	The Defendants Were Aware Of Problems In The Way In Which Ebensburg Residents Were Being Fed Prior To The United States Filing Its Lawsuit	XI-35
E.	Ebensburg Residents Are Eating Unsafely With No Staff Intervention	XI-36
1.	Ebensburg Administrators And Staff Acknowledge That Residents Exhibit Unsafe Behaviors During Mealtimes And Staff Do No Intervene	XI-40
2.	Ebensburg Residents' Unsafe Behaviors During Mealtimes Have Resulted In Life-Threatening Risks	XI-43
3.	The Defendants Have Been Aware Of Problems At Ebensburg Where Individuals Are Eating At Too Rapid A Pace And Stuffing Their Mouths With Food For The Past Decade	XI-47
F.	The Dining Environment At Ebensburg Is Itself Unsafe	XI-49
G.	The United States' Feeding Videotape Demonstrates Systemic Deficient Practices That Depart From Accepted Professional Standards	XI-50

XII.	EBENSBURG IS HARMING ITS RESIDENTS BY FAILING TO PROVIDE THEM WITH PROACTIVE, PREVENTIVE CONTINUITY OF MEDICAL AND HEALTH CARE IN VIOLATION OF GENERALLY ACCEPTED PROFESSIONAL STANDARDS	XII-1
A.	Medical And Health Care Is Inadequate	XII-1
1.	Ebensburg Is Not Adequately Documenting Long-Term Care for Its Residents	XII-2
2.	Ebensburg Is Not Adequately Documenting Or Coordinating The Input From Outside Consultant Doctors Into The Residents' Long-Term Plan Of Care	XII-9
3.	Ebensburg Is Not Documenting The Communication With Outside Hospitals That Treat Its Residents	XII-11
4.	Ebensburg Is Consistently Failing To Maintain Sufficient Physician Staffing Levels	XII-15
B.	Nursing Services At Ebensburg Are Inadequate	XII-20

1.	Acute And Chronic Nursing Care Do Not Meet Professional Standards	XII-20
2.	There Have Been Delayed Nursing Responses To Injuries	XII-23
3.	Nursing Care Plans Are Inadequate	XII-25
4.	Nurse Recordkeeping Is Inadequate	XII-27
5.	Ebensburg Nurses Need Additional Training	XII-28
6.	The Role Of The Ebensburg Director Of Nursing Is Too Limited	XII-29

XIII. EBENSBURG IS FAILING TO PROVIDE ITS RESIDENTS WITH ADEQUATE NEUROLOGICAL CARE XIII-1

A.	Ebensburg Fails To Provide Residents In Status Epilepticus Adequate Treatment	XIII-1
1.	Status Epilepticus Is A Serious Medical Emergency	XIII-3
2.	Ebensburg Fails To Understand When An Individual Is In Status	XIII-3
3.	The Generally Accepted Standards For The Proper Management And Treatment Of Status Seizures Are Clear	XIII-6
4.	Ebensburg's Treatment Of Status Is Seriously Deficient In Three Respects	XIII-7
a.	Ebensburg Waits Too Long To Treat Its Residents In Status	XIII-8
b.	Ebensburg Treats Its Residents In Status With Intramuscular (IM) Medication In Violation Of Generally Accepted Standards	XIII-11
c.	Ebensburg Physicians Are Inappropriately Treating Residents In Status Via Telephone Rather Than Face To Face	XIII-13
5.	Ebensburg Residents Have Been Harmed Due To The Facility's Poor Management Of Their Status Seizures	XIII-14
B.	Ebensburg Is Harming Its Residents With Epilepsy By Failing To Adequately Intervene In The Management Of Their Seizures	XIII-16
1.	Ebensburg Is Failing To Provide Adequately Address Seizure Injuries	XIII-16
2.	Ebensburg Is Failing To Provide Adequate EEG Diagnostic Testing For Its Residents With Epilepsy	XIII-19
3.	Ebensburg Is Unduly Engaging In The Practice of Anticonvulsant Polypharmacy	XIII-24
4.	Ebensburg Is Failing To Properly Manage The Side Effects Of Anticonvulsant Medication Administered To Its Residents	XIII-29
5.	Ebensburg Is Failing To Fully Involve An Expert Neurologist In the Neurological Care Of Its Epileptic Residents	XIII-33
a.	The Neurologist's Advice Is Ignored	XIII-33

b.	The Neurologist Does Not Have Control Over The Individuals That Need Expert Input	XIII-35
c.	The Number Of Consult Neurology Hours Is Inadequate	XIII-36
d.	Time Constraints Preclude The Neurologist From Seeing All The Individuals Who Are Candidates For Neurological Care	XIII-37
6.	Ebensburg Is Not Adequately Documenting Medical And Neurological Care For Its Residents In Violation Of Generally Accepted Standards	XIII-38

XIV. EBENSBURG FAILS TO PROVIDE RESIDENTS WITH ADEQUATE PHYSICAL THERAPY AND PHYSICAL MANAGEMENT SERVICES WHICH HAS RESULTED IN HARM

A.	The Defendants Have Been On Notice Of Deficiencies In Services For Ebensburg Residents With Physical Disabilities Since At Least 1987	XIV-1
B.	Background On Ebensburg Residents With Physical Disabilities	XIV-3
C.	Intervention Is Necessary To Prevent Deformity Patterns	XIV-4
D.	Physical Therapy Staffing At Ebensburg Is Inadequate	XIV-7
E.	The Limited Physical Therapy Related Services At Ebensburg Are Inadequate	XIV-11
F.	Ebensburg's Services To People With Physical Disabilities Do Not Comport With Accepted Standards And Principles	XIV-16
1.	Ebensburg Fails To Conduct Adequate Physical Therapy Assessments In Keeping With Accepted Professional Standards In The Field	XIV-17
a.	Ebensburg Physical Therapy Assessments Are Inadequate In Content And Analysis Of Residents' Needs	XIV-18
b.	The Physical Therapy Assessments At Ebensburg Are Not Conducted With The Frequency Dictated By Commonly Accepted Professional Standards	XIV-20
2.	Ebensburg Does Not Develop Adequate Physical Management Plans For Residents With Physical Disabilities	XIV-21
a.	Physical Therapists At Ebensburg Do Not Develop Physical Management Plans	XIV-21
b.	Interdisciplinary Teams Do Not Develop Adequate Physical Management Plans	XIV-22
c.	Physical Therapists Are Not Involved In The Interdisciplinary Process	XIV-23

3.	Ebensburg Does Not Provide Adequate Physical Management Services	XIV-25
a.	Physical Management Is Necessary To Prevent Significant Health Risks	XIV-25
b.	Ebensburg Residents Do Not Receive Therapeutic Positioning	XIV-31
i.	Therapeutic Positioning Is Necessary For Residents With Physical Disabilities To Prevent Health Risks	XIV-31
ii.	What Little Positioning Is Done At Ebensburg Is Not Therapeutic	XIV-34
iii.	Sidelying Is Inadequate At Ebensburg	XIV-38
iv.	Prone On Forearms Is Not Used At Ebensburg	XIV-40
v.	Quadrapped On Forearms Is Not Used At Ebensburg	XIV-41
c.	Ebensburg Residents With Physical Disabilities Do Not Receive Adequate Gross Motor Programs	XIV-41
d.	Ebensburg Residents Have Suffered Significant Health Problems And Lost Physical Capabilities Due To A Lack Of Adequate Physical Management Services	XIV-42
e.	Ebensburg Professional And Paraprofessional Staff Believe That Residents Would Benefit From Physical Management	XIV-44
4.	The Wheelchairs At Ebensburg Are Inadequate	XIV-48
a.	Wheelchairs Are Inappropriate And Residents Are Not Positioned Properly In Them	XIV-48
b.	Ebensburg Does Not Develop, Modify, And Monitor The Condition Of Wheelchairs Appropriately	XIV-52
5.	Ebensburg Staff Do Not Handle, Lift, And Transfer Ebensburg Residents Safely And In Accordance With Accepted Standards	XIV-56
a.	Ebensburg Residents Have Suffered Harm As A Result Of Improper Handling, Lifting, And Transferring By Staff	XIV-60
6.	Staff Training In Physical Management Is Inadequate At Ebensburg	XIV-63

XV.	DIRECT CARE STAFFING AT EBENSBURG IS INADEQUATE	XV-1
A.	Ebensburg Is Not Meeting Its Direct Care Staff Quotas	XV-1
B.	Injuries And Abuse Occur When There Are Not Enough Direct Care Staff	XV-3
C.	There Are Not Enough Staff To Implement Behavior Programs At Ebensburg	XV-4
D.	The Commonwealth Refuses To Provide More Staff To Ebensburg	XV-5
E.	Ebensburg Administrators Have Repeatedly Requested Additional Staff	XV-8
F.	Staff Breaks Further Reduce The Number Of Staff Actually Present During Shifts	XV-13
XVI.	CONDITIONS DURING SURVEYS REFLECT EBENSBURG'S BEST EFFORTS	XVI-1
XVII.	EBENSBURG IS TOO LARGE TO ADEQUATELY SERVE THE PEOPLE WHO LIVE THERE	XVII-1
XVIII.	INDIVIDUALS REMAIN AT EBENSBURG IN SPITE OF DEFENDANTS' UNANIMOUS BELIEF THAT THEY WOULD BE BETTER SERVED IN THE COMMUNITY	XVIII-1
A.	Defendants Recognize The Need For Community Placement	XVIII-1
B.	Lack of Funds Is Preventing Individuals Who Could Live In The Community From Moving Into The Community	XVIII-4
C.	Individuals Who Remain At Ebensburg Despite Determinations That They Would Be Better Served In The Community Are Being Harmed	XVIII-6
D.	Ebensburg's Community Placement Plans Depart From Accepted Professional Standards	XVIII-10
XIX.	THE DEFENDANTS HAVE BEEN AWARE OF THE DEFICIENCIES AT ISSUE IN THIS LAWSUIT FOR A LONG PERIOD OF TIME	XIX-1

X. EBENSBURG FAILS TO PROVIDE ADEQUATE AND APPROPRIATE MEDICAL CARE TO RESIDENTS AT RISK OF LIFE-THREATENING CONDITIONS DUE TO ASPIRATION, GER, AND NUTRITIONAL STATUS.

A. Medical Management Of Aspiration And Gastroesophageal Reflux Is Inadequate.

The most pressing medical concern at Ebensburg is the prevalence of aspiration pneumonia among residents at the facility. Tr. 7/27/93 (Sulkes) at 86. Dr. Sulkes characterized this problem as a major cause of harm, discomfort, hospitalization and morbidity for Ebensburg residents. Tr. 7/27/93 (Sulkes) at 86. Dr. Sulkes testified that as a result, facility-wide, "there's too much sickness and dying going on" at Ebensburg. Tr. 7/28/93 (Sulkes) at 48, lines 14-5.^{1/}

In the interests of providing adequate and appropriate medical care, medical professionals in an institution caring for a developmentally disabled population have a responsibility to provide adequate and appropriate medical intervention in the care of those individuals who are at risk of aspirating. Tr. 7/27/93 (Sulkes) at 108. This responsibility is generally accepted within the medical community specializing in the care of people with developmental disabilities. Tr. 7/27/93 (Sulkes) at 108.^{2/} In fact, endeavoring to prevent people from aspirating and from developing pneumonia is something basic that a doctor first

^{1/} Dr. Sulkes testified that his professional opinion in this area does not just represent the conflict of one doctor's professional judgment versus another's professional judgment. Tr. 7/28/93 (Sulkes) at 81. He acknowledged that the medical staff at Ebensburg may be "professionals" and that these "professionals" may be exercising "judgment," but they are not exercising "professional judgment" because he stressed that they are not acting in concert with established standards around the country about the quality of care for people with developmental disabilities. Tr. 7/28/93 (Sulkes) at 81-2.

^{2/} Dr. Rosenthal agreed with this sentiment, testifying that it is important to intervene in the treatment of gastroesophageal reflux ("GER") before the serious and often painful and debilitating complications develop. Tr. 12/13/93 (Rosenthal) at 165.

learns early on in medical school. Tr. 7/27/93 (Sulkes) at 109. It is an essential aspect of care. Tr. 7/27/93 (Sulkes) at 109.

Taking "preventive" measures is an essential component in providing adequate and appropriate intervention to those individuals at risk of aspirating. Tr. 7/27/93 (Sulkes) at 109.^{3/} Appropriate diagnostic measures are the first form of prevention. Tr. 7/27/93 (Sulkes) at 109. To the degree that medical professionals cannot prevent the developmental disabilities themselves, the essence of care is to prevent the complications of the developmental disability. Tr. 7/27/93 (Sulkes) at 109. One can prevent these complications by simply paying attention to the known chronic problems that arise with people with developmental disabilities. Tr. 7/27/93 (Sulkes) at 109.

Ebensburg meets neither its own policies nor the generally accepted standards in the field.^{4/} Its efforts in preventing aspiration are insufficient and inadequate. Tr. 7/27/93 (Sulkes) at 113. Ebensburg has not fulfilled its responsibility to provide adequate and appropriate medical intervention to those residents at risk of aspiration. Tr. 7/27/93 (Sulkes) at 113. This is true both for residents with feeding-dysphagia and gastroesophageal problems. Tr. 7/27/93 (Sulkes) at 113. Dr. Sulkes has reached this same conclusion in each and every one of his five tours of the facility dating back to 1989. Tr. 7/27/93 (Sulkes) at

^{3/} For further discussion of this topic generally, outside the aspiration context, see infra § XII.

^{4/} On paper at least, Ebensburg recognizes the need to provide its residents with "preventative" medical and health care. For example, in the contract performance standards for each of the four Ebensburg staff physicians, (standards which the doctors have all read, signed, and agreed to undertake), it states in pertinent part that "A preventative health services program is [to be] developed and implemented for all clients to include: Means for prompt detection and referral of health problems." Tr. 7/27/93 (Sulkes) at 110, lines 20-23; U.S. Exhs. 141A, 141B, 141C, 141D. This contract performance standard indicates that watching for medical and health problems is fundamental to the standard of health care for Ebensburg physicians. Tr. 7/27/93 (Sulkes) at 110-1.

113-4. He indicated that over that period of time, nothing improved with respect to the facility addressing the needs of it's residents at risk of aspirating. Tr. 7/27/93 (Sulkes) at 114.^{5/} Following Dr. Sulkes' first tour of Ebensburg, the Department of Justice specifically notified defendants as part of its CRIPA investigation that Ebensburg residents were facing serious risks of aspiration and malnutrition. U.S. Exh. 638 (Sponsky Dep.) Exh. 50.

1. Aspiration Of Foreign Material Into The Lungs Is A Common Source Of Harm For Individuals With Developmental Disabilities.

Aspiration is the inhalation into the lungs of something, (usually food or digestive juices), that should not normally be there. Tr. 7/27/93 (Sulkes) at 86. Aspiration usually occurs in one of two ways. The first way is when material in the pharynx is swallowed down the wrong tube. Tr. 7/27/93 (Sulkes) at 87. This swallowing dysfunction could be the result of mechanical problems with eating and swallowing or it could be because the person ate too quickly. Tr. 7/27/93 (Sulkes) at 88. Difficulty in swallowing is typically called dysphagia. The second major cause of aspiration, especially in people with physical developmental disabilities, is gastroesophageal reflux ("GER"). Tr. 7/27/93 (Sulkes) at 87.

Individuals with developmental disabilities living in an institution are more susceptible to aspirating than the general population at large. Tr. 7/27/93 (Sulkes) at 94.^{6/}

^{5/} Dr. Sulkes indicated that any treatments or assessments that had been undertaken at Ebensburg in 1993, after Dr. Sulkes' last tour, would not cure in any way Dr. Sulkes' conclusion that Ebensburg had failed to take preventative action earlier on to intervene medically in the care and treatment of someone with an aspiration problem. Tr. 7/28/93 (Sulkes) at 83. He added that it was important for the medical staff to have addressed and anticipated these problems early enough so that they would not become unremedial for some individuals later on. Tr. 7/28/93 (Sulkes) at 83.

^{6/} Dr. Shertz acknowledged that the Ebensburg population tends to have a higher incidence of respiratory infections than does the general population. U.S. Exh. 632 (Shertz Dep.) at 89.

This is because people with developmental disabilities have a host of motor problems, movement problems, and mobility problems that render them unable to cough up aspirated material as effectively as someone in the general population. Tr. 7/27/93 (Sulkes) at 94-5. While everyone may aspirate to some extent, those with physical disabilities cannot handle the aspiration. Tr. 7/28/93 (Sulkes) at 67-8. In addition, individuals with developmental disabilities are more susceptible to GER than individuals in the general population. Tr. 7/27/93 (Sulkes) at 94-5.

Individuals with developmental disabilities can suffer harm from aspiration whether it is caused by dysphagia or GER. Tr. 7/27/93 (Sulkes) at 91-2. Aspiration pneumonia is a serious threat to the health of people with developmental disabilities. Tr. 9/13/93 (Kastner) at 231. For example, when there is any form of foreign material in the lungs, an individual will cough often and uncomfortably. Tr. 7/27/93 (Sulkes) at 92. Further, the chronic irritation of having foreign material in the lungs results in excess mucus production. Tr. 7/27/93 (Sulkes) at 92. In addition, the distal breathing tubes, the trachea and the bronchi, are lined with muscle that contracts when irritated by aspirated material. Tr. 7/27/93 (Sulkes) at 92. This produces wheezing. Tr. 7/27/93 (Sulkes) at 92. Assuming that the foreign aspirated material seeps far enough down the lungs, it will not be able to be coughed out. Tr. 7/27/93 (Sulkes) at 92; U.S. Exhs. 795, 795D. This is especially true for people with developmental disabilities like those individuals residing at Ebensburg who have trouble or cannot generate an effective cough. Tr. 7/27/93 (Sulkes) at 92. With the foreign material sitting in the lungs, the harm is likely to progress to the level of a bacterial infection like pneumonia from being a mere chemical irritation. Tr. 7/27/93 (Sulkes) at 92-3. On top of

all this, the foreign material blocks the airway so that air exchange cannot take place. Tr. 7/27/93 (Sulkes) at 93; U.S. Exh. 666. The aspiration problems outlined above are exacerbated when a person with developmental disabilities is positioned lying on his back. If the person has aspirated material, there is a tendency for gravity to carry the foreign material into the lower lobes. Tr. 7/27/93 (Sulkes) at 94; U.S. Exh. 795.^{7/}

a. Gastroesophageal Reflux Is One Major Cause Of Aspiration In This Population.

Gastroesophageal reflux or "reflux" occurs when digestive materials and liquids leave the stomach and travel back upstream against the direction in which they are supposed to go. Tr. 7/27/93 (Sulkes) at 89. Reflux can become especially dangerous when the stomach contents slosh back upstream up the esophagus to the pharynx, and then spill over the top and down into the lungs. Tr. 7/27/93 (Sulkes) at 88; U.S. Exhs. 666, 795, 795A, 795B, 795C, 795D. The gastric contents in the esophagus, bronchi and lungs usually cause chemical irritation possibly leading to pneumonia. U.S. Exh. 632 (Shertz Dep.) at 168.

The developmentally disabled mentally retarded population living in an institution like Ebensburg is more susceptible to gastroesophageal reflux than is the general population at large. Tr. 7/27/93 (Sulkes) at 90. This is true for many different reasons:

First, many individuals with developmental disabilities have a gastroesophageal junction or gastroesophageal sphincter that is not strong enough to contract down and keep

^{7/} The person's position and anatomy will largely dictate where in the lungs the aspirated material will go. Tr. 7/27/93 (Sulkes) at 94; U.S. Exh. 795D. The left lung is divided into two lobes (upper and lower), and the right lung is divided into three lobes (upper, middle and lower). Tr. 7/27/93 (Sulkes) at 93; U.S. Exh. 795. The trachea leading to the lungs divides into two main bronchi. Tr. 7/27/93 (Sulkes) at 93. An irritation of the bronchi is called bronchitis. Tr. 7/27/93 (Sulkes) at 93. The right bronchi is a little bit steeper than the left bronchi and as a result, there is a tendency for material to be aspirated into the right lung. Tr. 7/27/93 (Sulkes) at 93; U.S. Exh. 795.

stomach contents from sloshing back upstream. Tr. 7/27/93 (Sulkes) at 88; U.S. Exh. 795A, 795B, 795C; U.S. Exh. 632 (Shertz Dep.) at 168. As a result, this weak sphincter predisposes these people to reflux. Tr. 7/27/93 (Sulkes) at 88-9.

Second, some individuals have a problem with their central nervous system such as cerebral palsy or other brain or neurologic dysfunction that produces abnormalities in muscle tone leading to GER. Tr. 7/27/93 (Sulkes) at 90-1; U.S. Exh. 632 (Shertz Dep.) at 170.

Third, some individuals with developmental disabilities have spinal curves that sometimes put pressure on their abdomen and belly which make it likely for stomach acid and stomach contents to slosh back upstream. Tr. 7/27/93 (Sulkes) at 90.

In addition, the staff at an institution like Ebensburg can contribute to the individual's predisposition to reflux by improperly positioning the individual on his or her back or in what is called a "supine" position. Tr. 7/27/93 (Sulkes) at 90; U.S. Exh. 632 (Shertz Dep.) at 170. GER is a very severe problem for someone who spends a lot of time in a reclined position. Tr. 7/27/93 (Sulkes) at 90. When an individual predisposed to reflux is sitting upright, gravity keeps the liquid in the right place in the stomach. Tr. 7/27/93 (Sulkes) at 89; U.S. Exh. 795B. However, when individuals are reclined on their backs, they are placed in an improper position that is a set up for reflux. Tr. 7/27/93 (Sulkes) at 89; U.S. Exh. 795C. If the gastroesophageal sphincter is weak, the reclined or supine position produces a free flow of stomach fluid back up the esophagus to the back of the throat. Tr. 7/27/93 (Sulkes) at 89. If the material remains there long enough, the person eventually will take a breath and will suck or aspirate the refluxed material right down into his or her lungs.

Tr. 7/27/93 (Sulkes) at 89. Dr. Rosenthal agreed that proper positioning is important during and after meals if an individual has GER. Tr. 12/13/93 (Rosenthal) at 166.

The material that is refluxed (up the esophagus and sometimes into the lungs) is comprised largely of highly acidic stomach acid. Tr. 7/27/93 (Sulkes) at 89. As the stomach acid sloshes back up into the esophagus, it causes irritation and can cause bleeding. Tr. 7/27/93 (Sulkes) at 89-90. In some cases, GER can cause massive, life-threatening bleeding. Tr. 7/27/93 (Sulkes) at 90. At the very least, it is painful for the individual. Tr. 7/27/93 (Sulkes) at 90. Dr. Rosenthal agreed that GER can cause complications that are serious, painful, life threatening, and debilitating. Tr. 12/13/93 (Rosenthal) at 164. These complications include failure to thrive, pneumonia, esophagitis, protein loss, esophageal stricture, gastrointestinal ("GI") bleeding, and chronic aspiration pneumonia which can result in chronic lung disease. Tr. 12/13/93 (Rosenthal) at 164.

One major contributor to mucus production is the stomach acid coming back up into the resident's esophagus, going into the throat and airway. Tr. 7/27/93 (Sulkes) at 137. The body then makes mucus in response. Tr. 7/27/93 (Sulkes) at 137. If the stomach acid and contents are aspirated all the way down into the lungs, it can cause a significant chemical irritation to the lungs and the breathing passages. Tr. 7/27/93 (Sulkes) at 90. In short, stomach acid is not supposed to make its way into the lungs. Tr. 7/27/93 (Sulkes) at 89.

b. Dysphagia Or Feeding Difficulties Is A Second Major Cause Of Aspiration In This Population.

Certain individuals with severe developmental disabilities have physical problems and need particularized assistance from staff at an institution in order to eat and drink. Tr. 7/27/93 (Sulkes) at 96-7. Many individuals cannot feed themselves or need help in feeding

themselves. At Keystone, for example, many of the individuals have problems eating and they are often difficult to feed because of their severe disabilities. Tr. 7/27/93 (Sulkes) at 83.^{8/} In addition, many of these and other individuals have particularized swallowing problems or dysphagia. As a result, these residents suffer from poor nutrition. Tr. 7/27/93 (Sulkes) at 83. Dr. Shertz acknowledged that the Ebensburg population is at greater risk due to feeding disorders than is the general population. U.S. Exh. 632 (Shertz Dep.) at 89. There is agreement among all of the medical experts who testified on this topic that feeding individuals whose underlying physical or health status is already compromised in an unsafe position or unsafe manner can cause aspiration. Tr. 7/27/93 (Sulkes) at 95-96; Tr. 12/13/93 (Rubin) at 100-101; Tr. 9/14/93 (Kastner) at 7-8; Tr. 12/13/93 (Rosenthal) at 166. There is also agreement among the experts that positioning after meals is critical in preventing aspiration due to GER. Tr. 7/27/93 (Sulkes) at 97; Tr. 12/13/93 (Rosenthal) at 166. For a more comprehensive discussion on positioning and feeding techniques see infra § XI.

2. The Assessment And Diagnostic Techniques For Addressing Aspiration Problems Are Well-Known And Generally Accepted.

There is no dispute about the proper and generally accepted ways to care for the common health problems of people with developmental disabilities. There are textbooks written about it. Tr. 7/27/93 (Sulkes) at 109. There are whole chapters in these textbooks on feeding and feeding problems, swallowing problems, on dysphagia, and on GER. Tr. 7/27/93 (Sulkes) at 109. None of this is a secret to the medical professionals working in the

^{8/} These residents in Keystone are typically non-ambulatory. Tr. 7/27/93 (Sulkes) at 82. Many of the individuals in Keystone are so immobile that they cannot roll over by themselves and they have to be turned by staff. Tr. 7/27/93 (Sulkes) at 82. Many individuals in Keystone also have contracted limbs, badly curved spines, and contracted chests. Tr. 7/27/93 (Sulkes) at 83.

field and it is exactly the kind of care and treatment Dr. Sulkes testified that he was trained to undertake in his fellowship ten years ago. Tr. 7/27/93 (Sulkes) at 110.

a. A Facility Needs To Identify Which Individuals Are At Risk Of Aspirating.

Ebensburg has not even taken the first steps in this regard. For example, Dr. Kastner indicated that at Ebensburg, there is not even a registry or institution-wide comprehensive list of individuals who have suffered aspiration pneumonia. Tr. 9/13/93 (Kastner) at 231, 239. Dr. Shertz admitted that Ebensburg has not identified everyone who aspirates. U.S. Exh. 632 (Shertz Dep.) at 158. Ms. Sponsky thinks it is important that every individual with reflux at Ebensburg be identified. U.S. Exh. 637 (Sponsky Dep.) at 61. She does not know, however, whether each person with reflux has, in fact, been identified. U.S. Exh. 632 (Sponsky Dep.) at 158. For a more complete discussion of Ebensburg's failure to identify residents at risk of aspiration see infra § X.B.3.

b. A Facility Needs To Provide Those Individuals At Risk Of Aspirating With A Proper Medical "Work-Up" Of Their Condition.

Careful and thoughtful assessment and diagnosis of a medical problem takes place during what is called a medical "work-up." Tr. 7/28/93 (Sulkes) at 56. Dr. Rubin summed up the general principles that a physician should follow in conducting a medical "work-up:"

First of all, an awareness that the condition exists. Secondly, a recognition of the symptoms of the condition such that appropriate diagnostic and preventative measures can be undertaken. Thirdly, the awareness of the kinds of tests that may confirm the presence of the condition, using appropriate medication to treat the condition. Fourthly, continued monitoring of the efficacy of the medication, and the symptoms and signs of the condition to prevent complications.

Tr. 12/13/93 (Rubin) at 81. Dr. Kastner agreed that more and better monitoring of residents with aspiration pneumonia is always valuable at a facility like Ebensburg. Tr. 9/13/93 (Kastner) at 239.

However, the Ebensburg staff has not provided its residents with adequate work-ups of their aspiration and reflux problems. Tr. 7/27/93 (Sulkes) at 107. In several cases, individuals had documented reflux and nevertheless were continuing to suffer bouts of aspiration pneumonia. Tr. 7/27/93 (Sulkes) at 107. Appropriate care would demand further evaluation in a medical work-up. Tr. 7/27/93 (Sulkes) at 107. If the person has an identified problem and continues to be sick, the physicians need to take the next step and better address these complications so that they do not re-occur. Tr. 7/27/93 (Sulkes) at 107-8. If the physicians do not take such steps, they are contributing to the problem. Tr. 7/27/93 (Sulkes) at 108. In fact, it becomes an inexorable problem, with insult after insult inflicted upon the suffering residents. Tr. 7/27/93 (Sulkes) at 108.

Consistent with Dr. Sulkes' testimony, Dr. Rosenthal testified that if an individual who is mentally retarded has a lot of mucus production and is coughing and choking for a period of time, a physician should evaluate whether reflux is contributing to or causing these symptoms. Tr. 12/13/93 (Rosenthal) at 166. Other situations where the possibility of GER should be explored are recurring episodes of aspiration pneumonia, vomiting, GI blood loss, chronic anemia, chronic pneumonias, failure to gain weight, hyperproteinemia, choking and cyanosis with feeding, persistent nighttime cough, nighttime vomiting, emesis on the pillow, and esophageal stricture. Tr. 12/13/93 (Rosenthal) at 166-167.

Early detection and identification of gastroesophageal reflux is important in preventing serious complications of chronic lung disease as a result of aspiration pneumonia from GER. Tr. 12/13/93 (Rubin) at 81-82. By treating the symptoms at an early stage, it is possible to prevent the progression of much of the condition, prevent aspiration syndrome, and avoid much of the pain and discomfort that accompanies GER. Tr. 12/13/93 (Rubin) at 82.

With respect to diagnosing reflux, for example, there are many well-known ways a physician can discover whether or not an individual who he suspects has GER actually has it. Tr. 7/27/93 (Sulkes) at 91. Dr. Kastner acknowledged that there are screening procedures that can be used to identify gastroesophageal reflux. Tr. 9/13/93 (Kastner) at 239. The easiest way, if the person can talk, is to ask the person if they have any pain or if they taste acid in their mouths. Tr. 7/27/93 (Sulkes) at 91. The next easiest way is to observe the person to see if the person's mouth fills with fluid when they are not eating. This is an indication that the fluid presumably came from the stomach. Tr. 7/27/93 (Sulkes) at 91. There are also a variety of laboratory tests that can be done to identify GER. Tr. 7/27/93 (Sulkes) at 91. Testing of stool, mucus and vomit for blood is a good way to reveal hidden bleeding caused by reflux. Tr. 7/27/93 (Sulkes) at 115-6, 123-4.

3. The Treatments For Aspiration Problems Are Well-Known And Generally Accepted.

Generally accepted treatments for reflux include proper positioning, adaptations in the consistency and viscosity of food, medical treatments to reduce the acid output of the stomach (acid neutralizers and medicines that actually decrease the volume of acid produced), medications that are designed to have the effect of increasing the muscle tone of the lower esophageal sphincter allowing the liquid to enter into the intestine more appropriately and to

prevent refluxing back up to the esophagus. Tr. 7/28/93 (Sulkes) at 82-3. Fundoplication surgery is a commonly used treatment for GER in which the surgeon creates a small cuff of stomach around the bottom of the esophagus to aid a weak gastroesophageal sphincter resist reflux. Tr. 7/28/93 (Sulkes) at 69. While the fundoplication procedure is an option, Dr. Sulkes stressed that the nonsurgical treatments should be vigorously pursued first in treating someone's reflux. Tr. 7/28/93 (Sulkes) at 83. Dr. Rosenthal agreed that surgical options should be considered after medical treatment approaches. Tr. 12/13/93 (Rosenthal) at 155. Nonetheless, Dr. Rosenthal testified that if the symptoms of gastroesophageal reflux are serious, it is important to take more aggressive action than just observing. Tr. 12/13/93 (Rosenthal) at 163-4.

Dr. Rubin did not agree with Dr. Kastner's statement that there is no standard of care in the area of gastroesophageal reflux. Tr. 12/13/93 (Rubin) at 80-81. In fact, "there are quite clear standards of care when it comes to evaluating, diagnosing and managing people with gastroesophageal reflux." The standards are the same principles (discussed above) of diagnosis and treatment of many acute and chronic medical conditions. Tr. 12/13/93 (Rubin) at 81.

4. Ebensburg Residents At Risk Of Aspirating Have Died As A Result Of The Inadequate And Inappropriate Medical Intervention Furnished By Ebensburg.

Details of the medical and health care provided to those residents who have died from aspiration pneumonia serve as the most obvious and poignant evidence that the facility has been deficient in this area.

To flesh out and provide additional support for the general conclusions made above, Dr. Sulkes testified about the details of the care provided to a few of the Ebensburg residents at risk of aspirating who died due to inadequate and inappropriate medical intervention and management by Ebensburg. Tr. 7/27/93 (Sulkes) at 114. The following individuals are not the only examples of those Ebensburg residents who have died due to inadequate and inappropriate medical intervention for their aspiration. Tr. 7/27/93 (Sulkes) at 133.

a. Margaret D.

Ebensburg had a duty to provide Margaret with adequate and appropriate medical intervention for her health problems, and yet the facility did not meet its responsibilities. Had Margaret been receiving adequate and appropriate medical intervention from Ebensburg, her medical problems would have been preventable. Tr. 7/27/93 (Sulkes) at 119-20.

Margaret D. died in January 1992 after she had suffered from a progressive deterioration of her lung function over the course of many years living at Ebensburg. Tr. 7/27/93 (Sulkes) at 114. Margaret's health steadily and progressively deteriorated up until the time she died in 1992. She had been hospitalized in 1989 for left lower lobe pneumonia and in 1991 for pneumonia. Tr. 7/27/93 (Sulkes) at 114; U.S. Exh. 144. These difficulties were very likely related to feeding problems or reflux or both. Tr. 7/27/93 (Sulkes) at 118.

Overall, the nursing notes in her medical chart indicate that in the last years of her life, Margaret was having clearly evident problems with copious mucus production, lots of coughing and difficulty eating, feeding and swallowing. Tr. 7/27/93 (Sulkes) at 118-9. Dr. Rosenthal testified that if an individual who is mentally retarded has a lot of mucus

production and is coughing and choking for a period of time, a physician should evaluate whether GER is contributing to or causing these symptoms. Tr. 12/13/93 (Rosenthal) at 166.

In the last few years of her life, the Ebensburg physicians evidently did not even consider her documented and chronic reflux problem in addressing her medical needs. Tr. 2/27/93 (Sulkes) at 119. In arriving at diagnoses and in providing her with treatment for her pneumonias and mucus problems, Ebensburg missed the obvious markers that Margaret had reflux:

First, for thirteen years it should have been obvious that she had reflux because she had suffered a hiatal hernia in 1979. Tr. 7/27/93 (Sulkes) at 114. A hiatal hernia is one potential marker and partial evidence of reflux. Tr. 7/28/93 (Sulkes) at 55.^{36/} Once the physician discovers a hiatal hernia, he or she should take the next step to figure out what other diagnostic tests will reveal further information about whether reflux is actually present in the person. Tr. 7/28/93 (Sulkes) at 55. In short, it is a marker that further reflux work up is needed. Tr. 7/28/93 (Sulkes) at 56.

Second, Margaret had been treated for anemia. Tr. 7/27/93 (Sulkes) at 115. Anemia can be one of the effects of reflux in that the esophagus becomes eroded by the strongly acidic stomach juices which produce bleeding possibly causing anemia. Tr. 7/27/93 (Sulkes) at 115.

Third, even though she was being treated for anemia, no one at the facility ever checked Margaret's stool to see if she had blood in it. Tr. 7/27/93 (Sulkes) at 115-6. One

^{36/} A hiatal hernia is a radiologic finding where it appears that part of the stomach is positioned above the diaphragm; this is often found in people with reflux. Tr. 7/28/93 (Sulkes) at 55.

checks the stool of someone with reflux for occult blood, i.e., blood that's not immediately obvious. Tr. 7/27/93 (Sulkes) at 116. Bleeding in the esophagus is not immediately obvious and can often be revealed only through checking a stool sample. Tr. 7/27/93 (Sulkes) at 116.

Finally, the mucus production itself should have been an indication that Margaret had reflux. Tr. 7/27/93 (Sulkes) at 120. One major contributor to mucus production is the stomach acid coming back up into the resident's esophagus, going into the throat and airway. Tr. 7/27/93 (Sulkes) at 137. The body then makes mucus in response. Tr. 7/27/93 (Sulkes) at 137.

The facility did not meet its responsibilities towards Margaret on many other levels: a more complete diagnostic evaluation was required to reveal exactly why she was having the large amount of mucus production. Tr. 7/27/93 (Sulkes) at 119. A sufficiently aggressive diagnostic work-up early on might have led to medical interventions that might have prevented all this. Tr. 7/27/93 (Sulkes) at 120. Day after day, even though the staff dutifully documented that she was having problems, they needed to, but did not, stop and ask "why." Tr. 7/27/93 (Sulkes) at 119. Dr. Rosenthal testified that if the symptoms of gastroesophageal reflux are serious, it is important to take more aggressive action than just observing. Tr. 12/13/93 (Rosenthal) at 163-4. Margaret's respiratory care needed to be closely monitored and yet it was not. Tr. 7/27/93 (Sulkes) at 120. Margaret should have been seen by a gastroenterology consultant but never was. Tr. 7/28/93 (Sulkes) at 33. Dr.

Rosenthal testified that where complications of GER are present, a gastroenterologist should be involved in the care of the resident. Tr. 12/13/93 (Rosenthal) at 164.^{37/}

In the weeks before she died, the harm Margaret suffered was real. It is clear from reviewing the notes in her medical chart, that Margaret was generating "loads of mucus" prior to her death. Tr. 7/27/93 (Sulkes) at 117, line 24; U.S. Exhs. 331AA, 787.^{38/}

Even though Margaret had lost twenty pounds and she continued to produce a lot of mucus for the last few months of her life, Ebensburg did not complete a medical "work-up" for reflux on her and it did not add anything new in her diagnostic medical evaluation. Tr. 7/27/93 (Sulkes) at 116, 119; U.S. Exhs. 331AA, 787. Instead of addressing the root cause of the problem, Ebensburg decided merely to suction her to remove the mucus because she could not cough it up anymore. Tr. 7/27/93 (Sulkes) at 119. Further, she was ordered to be placed in postural drainage (where she was tilted over a pillow or bolster to drain mucus from her lungs). Tr. 7/27/93 (Sulkes) at 119. In fact, at the moment she died, Margaret had been placed on a wedge for postural drainage. Tr. 7/27/93 (Sulkes) at 120. When the staff finally rolled her off the wedge, she was blue and pulseless. Tr. 7/27/93 (Sulkes) at 120. She was supposed to have been placed in postural drainage for only thirty minutes, but the staff did not roll her off the wedge until a full forty-five minutes had elapsed. Tr.

^{37/} Pennsylvania claims that after Dr. Sulkes' visit in the fall of 1992, they began using a gastroenterologist for second opinions. Tr. 7/28/93 (Sulkes) at 33-4. Ebensburg should employ the services of a gastroenterologist more often. Tr. 7/28/93 (Sulkes) at 33.

^{38/} Only after Dr. Sulkes' visit in the fall of 1992, did Ebensburg begin using a gastroenterologist for second opinions. Tr. 7/28/93 (Sulkes) at 33-4. In 1992, Ebensburg obtained the services of a gastroenterologist for its residents 13 times, but 11 of these consults occurred after September 1, 1992. Tr. 10/13/93 (Bellomo) at 183. Ebensburg had provided its residents with gastroenterologist consults only 1 time in 1991 and only 2 times in 1990. Tr. 10/13/93 (Bellomo) at 184.

7/27/93 (Sulkes) at 120. The lack of appropriate attention while she was in postural drainage at the end of her life made the medical intervention and management she received at Ebensburg inadequate and inappropriate. Tr. 7/27/93 (Sulkes) at 120.^{21/}

The facility's lack of adequate and appropriate intervention also led to her September 1991 hospitalization for pneumonia. Tr. 7/27/93 (Sulkes) at 118-9. It is clear from reviewing the notes in her medical chart, that Margaret was also generating "loads of mucus" prior to her hospitalization. Tr. 7/27/93 (Sulkes) at 117, line 24; U.S. Exhs. 331AA, 787.^{22/} In the month prior to this hospitalization, the Ebensburg physician duly noted that Margaret was getting mucousy and was choking after eating, but the physician ignored her. Tr. 7/27/93 (Sulkes) at 115. Accepted professional standards dictate testing vomitus for occult blood if there is a history of GI bleeding and taking appropriate steps to treat the condition. Tr. 12/13/93 (Rubin) at 85. Dr. Rosenthal agreed that it is important to test vomitus (or mucus) for occult blood if there is a history of GI bleeds. Tr. 12/13/93 (Rosenthal) at 165. The Ebensburg physician's only reaction however, was that this may have been a chronic runny nose and the physician did not conduct any further evaluation as

^{21/} Dr. Kastner indicated that he did look at the death record of Margaret D., but he certainly did not testify about and could not recall much about the details of the medical care she received at Ebensburg. For example, he could not recall whether or not she died after having received percussion therapy in a head down position. Tr. 9/13/93 (Kastner) at 235.

^{22/} For example, Margaret was noted in the record to be "coughing and expectorating a large amount of mucus," September 18, 1991; "large amount of mucus and coughing ... unable to feed," September 24, 1991; "expectorating a large amount of yellow green mucus ... later continues to cough with much mucus which is presently white to clear ... refused supper, gagging," September 28, 1991; "expectorating copious amounts of green phlegm ... ate only a few bites of lunch ... continues to cough ... ate only a few bites for supper as would start coughing when food was put in mouth ... listless," September 30, 1991; "bringing up large amounts of mucus ... ate only a few bites of breakfast ... became cyanotic while coughing ... ate very little lunch," October 1, 1991. U.S. Exhs. 331AA, 787.

to whether or not this mucus and choking may have been due to reflux. Tr. 7/27/93 (Sulkes) at 115. Upon her return from the hospital, there was still no mention by an Ebensburg physician that she should be worked-up for reflux. Tr. 7/27/93 (Sulkes) at 115. The sixty day note written by the Ebensburg physician after Margaret's return from the hospital summed up the past sixty days with simply this: "pneumonia, plan, continue same." Tr. 7/27/93 (Sulkes) at 116, line 14.

When the facility notes what is happening to the resident medically without developing any sort of long term chronic plan of care, (as Ebensburg did with Margaret), they are responding reactively to the resident's deteriorating condition rather than acting proactively to prevent any future recurrence. Tr. 7/27/93 (Sulkes) at 135.

Prior to a hospitalization in 1989, there was so much mucus piling up in her airway that she ended up in the hospital. Tr. 7/27/93 (Sulkes) at 118. The hospital discharge diagnosis was aspiration pneumonia. Tr. 7/27/93 (Sulkes) at 118.^{23/} Throughout all her medical problems, Ebensburg never provided Margaret with a Dysphagia Team evaluation before she died. U.S. 641 (Wagner Dep.) Exh. 3.

^{23/} The month before this hospitalization, Margaret was noted in the record to be "expectorating a large amount of clear to frothy mucus especially after being fed or given liquids," July 1, 1989; "continues to expectorate large amounts of clear whitish mucus ... she is becoming very difficult to feed because of excessive mucus causing her to choke," July 13, 1989; "continues to cough and gag while being fed," July 14, 1989. U.S. Exhs. 331AA, 787; Tr. 7/27/93 (Sulkes) at 118. A few days later she remained difficult to feed. Tr. 7/27/93 (Sulkes) at 118. This pattern continued until she ended up in the hospital. Tr. 7/27/93 (Sulkes) at 118.

b. Stephen S.

Stephen S. died on May 1991 due to a combination of problems: pneumonia, gastrointestinal bleeding and overwhelming infection or sepsis. Tr. 7/27/93 (Sulkes) at 121.^{24/} In the years 1989 through to his death in 1991, Stephen was hospitalized repeatedly for aspiration, pneumonia and bleeding problems. Tr. 7/27/93 (Sulkes) at 121, 123.^{25/}

Just prior to a December 1990 hospitalization, for example, the notes in Stephen's medical chart indicate that on November 13, 1990, he was observed with a mouthful of emesis consisting of mucus and clear liquid. Tr. 7/27/93 (Sulkes) at 122; U.S. Exh. 466AA, 787. This was clearly refluxed stomach contents because the later notes indicate that the emesis was coffee ground colored, i.e., there was blood in the emesis. Tr. 7/27/93 (Sulkes) at 122; U.S. Exhs. 466AA, 787.^{26/}

These later notes in Stephen's chart indicate the daily trauma that Stephen was suffering through: "emesis of large amount of mucus with brown strands ... continues to gag ... vomited again clear liquid with brown strands ... vomit tested positive for blood,"

^{24/} In reaching his conclusions about Ebensburg and its care of those individuals at risk of aspiration, Dr. Kastner did not review Stephen's record or any details of his medical care. Def. Exh. HH.

^{25/} In 1989 alone, he was hospitalized for pneumonia in January, hospitalized for aspiration pneumonia in March, May and June, for aspiration bronchitis in June, and for gastrointestinal bleeding in November. U.S. Exhs. 144, 788. Further, in December 1990, he was hospitalized for right lower lobe pneumonia, and in May 1991, Stephen was hospitalized with pneumonia. U.S. Exhs. 144, 788.

^{26/} Again, the refluxed stomach acid is irritating to the esophagus and makes the esophagus bleed revealing itself in vomit or mucus. Tr. 7/27/93 (Sulkes) at 124. When a person's GER is brought under control, the bleeding will stop because the acid is no longer irritating the esophagus. Tr. 7/27/93 (Sulkes) at 124.

November 15, 1990; "clear and coffee ground colored mucus emesis," November 23, 1990; "bubbling emesis of mucus, coffee ground colored," November 24, 1990; clear moderate amount of mucus, coffee ground colored," December 3, 1990; "emesis of yellow-green liquid with dark flecks throughout it ... emesis tested positive for blood," December 7, 1990. U.S. Exhs. 466AA, 787. Finally, on December 8, 1990, his respirations became labored and he actually became blue. Tr. 7/27/93 (Sulkes) at 122. He was sent to Mercy Hospital for pneumonia. Tr. 7/27/93 (Sulkes) at 122.

Just because Stephen had not been sent to the hospital earlier does not mean that he did not have a serious medical and health problem all along. Tr. 7/27/93 (Sulkes) at 122. Stephen had a serious problem for at least a month -- a problem serious enough to have hospitalized a person in the general public. Tr. 7/27/93 (Sulkes) at 122. The efforts Ebensburg employed on his behalf before the hospitalization were cursory. Tr. 7/27/93 (Sulkes) at 122.

Ebensburg had a duty to provide Stephen with adequate and appropriate medical intervention for his health problems, and yet they did not meet their responsibilities. Dr. Rosenthal testified that if an individual who is mentally retarded has a lot of mucus production and is coughing and choking for a period of time, a physician should evaluate whether reflux is contributing to or causing these symptoms. Tr. 12/13/93 (Rosenthal) at 166. She also testified that the possibility of GER should be explored when an individual has a history of recurring episodes of aspiration pneumonia, vomiting, GI blood loss, chronic anemia, and chronic pneumonias (among others). Tr. 12/13/93 (Rosenthal) at 166-167.

Coffee ground colored mucus and vomit should be tested for blood whenever it occurs. Tr. 7/27/93 (Sulkes) at 123. The tests to determine whether or not an individual has GER are fairly inexpensive. Tr. 7/27/93 (Sulkes) at 124. Accepted professional standards dictate testing vomitus for occult blood if there is a history of GI bleeding and taking appropriate steps to treat the condition. Tr. 12/13/93 (Rubin) at 85. Dr. Rosenthal agreed that it is important to test vomitus (or mucus) for occult blood if there is a history of GI bleeds. Tr. 12/13/93 (Rosenthal) at 165. Moreover, it is important to notify the physician if a nurse finds that vomitus tests positive for occult blood. Tr. 12/13/93 (Rosenthal) at 165-6. When a facility does not test emesis for blood, the condition will likely go untreated and the individual can potentially become extremely anemic or can suffer from a potentially life threatening bleed. Tr. 7/27/93 (Sulkes) at 123-4. However, Ebensburg would test Stephen's emesis for blood only sporadically; nonetheless, every time they did check it, it turned up positive for blood. Tr. 7/27/93 (Sulkes) at 123.

Stephen had known reflux. In fact, Ebensburg knew that Stephen had gastroesophageal reflux as of 1989. Tr. 7/27/93 (Sulkes) at 121. However, in November 1990, in Stephen's chart, there were no plans on how to address his reflux or his recurrent bouts of aspiration pneumonia. Tr. 7/27/93 (Sulkes) at 121-2. The sixty day summary notes in the medical chart are a place for staff and physicians to be discussing on-going long term medical plans and any variations to the long term plan. Tr. 7/27/93 (Sulkes) at 121.

Stephen needed aggressive management of gastroesophageal reflux very early on but he did not get it until it was too late to benefit him in any way. Tr. 7/27/93 (Sulkes) at 121. The physician in charge of Stephen's care needed to think early and fully about what course

of action to take. Tr. 7/28/93 (Sulkes) at 75. It was clear that without earlier and more aggressive medical intervention, Stephen's recurrent aspirations and aspiration pneumonias were going to eventually cause his death. Tr. 7/28/93 (Sulkes) at 76. The fact that Ebensburg did not adequately address Stephen's aspiration soon enough meant that he was less likely to be a successful candidate for more aggressive medical interventions like fundoplication surgery than he would have been before all his hospitalizations for pneumonia. Tr. 7/28/93 (Sulkes) at 73. The longer a person is allowed to deteriorate before surgery is considered, the greater the risk of undertaking the surgical procedure. Tr. 7/28/93 (Sulkes) at 73. It was another story of "too little, too late sort of intervention." Tr. 7/28/93 (Sulkes) at 73, lines 11-12. As a result, while he was alive, Stephen was made very uncomfortable because the acidic stomach contents continually came up into his esophagus and into his lungs. Tr. 7/28/93 (Sulkes) at 76.

In the last few weeks of his life, he was gagging, and vomiting brown bloody liquid. Tr. 7/27/93 (Sulkes) at 123. The notes in Stephen's chart indicate that he had "vomited dark brown liquid and mucus," April 30, 1991; "large emesis of brown liquid ... continues to gag," May 11, 1991; "large emesis of dark colored liquid and mucus strands ... gagging, bubbling mucus ... very pale," May 15, 1991; "gagging, gulping, vomiting, color ashen and pale ... sent to Mercy Hospital for pneumonia," May 16, 1991. U.S. Exhs. 466AA, 787.

Stephen was one of the individuals at Ebensburg who had entered a "pipeline" that was going to carry him inexorably to his death. Tr. 7/27/93 (Sulkes) at 121. All the way along, interventions might have been available, but no one thought about them until it was too late for them to do any good. Tr. 7/27/93 (Sulkes) at 121. There were more aggressive

interventions that Stephen could have received that he never got. Tr. 7/27/93 (Sulkes) at 123. All this suffering could have been averted two years earlier. Tr. 7/27/93 (Sulkes) at 123. Ebensburg never provided Stephen with a Dysphagia Team consult before he died. U.S. Exh. 641 (Wagner Dep.) Exh. 3.^{27/}

c. Keith T.

Keith T. died on March 30, 1993 of aspiration pneumonia. U.S. Exh. 788.^{28/} Keith first suffered from respiratory problems back in 1986 when he had an aspiration associated with a respiratory arrest and he stopped breathing. Tr. 7/27/93 (Sulkes) at 126. Between February 1989 and October 1990, he was hospitalized seven times attributed to aspiration pneumonia. Tr. 7/27/93 (Sulkes) at 126. In 1989, he was hospitalized in February, July, October and November for aspiration pneumonia. U.S. Exhs. 144, 788. In 1990, Keith was hospitalized in April, June, and October for aspiration pneumonia. U.S. Exhs. 144, 788. He was repeatedly hospitalized for three years, becoming sicker and sicker, until he finally died. Tr. 7/27/93 (Sulkes) at 128.

Dr. Sulkes testified that his death was preventable. Tr. 7/27/93 (Sulkes) at 128. He also concluded that some of his hospitalizations were preventable. Tr. 7/27/93 (Sulkes) at

^{27/} There were only eight barium studies performed on Ebensburg residents in 1990, five in 1991, and thirty-five in 1992. Tr. 10/18/93 (Sheppard) at 118. As of January 7, 1993, only five to ten video fluoroscopy studies had been done at Ebensburg. U.S. Exh. 641 (Wagner Dep.) at 162. For the Dysphagia Team's purposes, a video fluoroscopy is more effective than a barium swallow. U.S. Exh. 641 (Wagner Dep.) at 170. As of January 1993, Ebensburg was just in the process of setting up a system with the hospital a system of expanding diagnostic testing and receiving copies of video fluoroscopies. U.S. Exh. 641 (Wagner Dep.) at 169-170.

^{28/} Kastner testified that he did not look at the death record of Keith T. Tr. 9/13/93 (Kastner) at 235. In reaching his conclusions about Ebensburg and its care of those individuals at risk of aspiration, Dr. Kastner did not review Keith's record or any details of his medical care. Def. Exh. HH.

128. The hospitalizations and discomfort Keith suffered in the last years of his life were attributable to the inadequate and inappropriate medical intervention of the Ebensburg staff. Tr. 7/27/93 (Sulkes) at 131. This was directly attributable to the poor chronic care Keith had received over the years from Ebensburg. Tr. 7/27/93 (Sulkes) at 128. Keith had a multiple year history of problems with aspiration and yet no one at the facility paid any attention to this problem until the last six months of his life. Tr. 7/27/93 (Sulkes) at 125-6. His respiratory problems "just continued to pile up until -- until they killed him." Tr. 7/27/93 (Sulkes) at 126, lines 5-6.

When the facility notes what is happening to the resident medically without developing any sort of long term chronic plan of care, (as Ebensburg did with Keith), they are responding reactively to the resident's deteriorating condition rather than acting proactively to prevent any future recurrence. Tr. 7/27/93 (Sulkes) at 135.

Reviewing Keith T.'s chart made Dr. Sulkes "angry." Tr. 7/27/93 (Sulkes) at 131, line 4. He was angry because Keith was another example of someone at Ebensburg who had entered the "pipeline" and was moved inexorably to his death due to aspiration, and yet it seemed as if the Ebensburg medical staff "just really hadn't been paying attention, either to him or -- or to what I'd been saying." Tr. 7/27/93 (Sulkes) at 126, 131, lines 8-9. Dr. Sulkes added that he had been "really upset that this man had this unquestionably uncomfortable deterioration of pneumonia over and over and over ... with respiratory distress involved with that; a difficulty feeding, the discomfort involved ... [a]nd then he ended up dying; it's tragic." Tr. 7/27/93 (Sulkes) at 131, lines 10-15.

Ebensburg had a duty to provide Keith with adequate and appropriate medical intervention for his health problems, and yet they did not meet their responsibilities. The Ebensburg medical staff committed numerous errors of omission and commission. For example, even though Keith had been hospitalized repeatedly between February 1989 and October 1990, no one at the facility ever looked to see whether he had any feeding problems and no one ever looked to see whether he had reflux. Tr. 7/27/93 (Sulkes) at 126. There was no feeding program identified for Keith during that time. Tr. 7/27/93 (Sulkes) at 126. He also did not see a gastroenterologist or an ear nose and throat expert. Tr. 7/27/93 (Sulkes) at 126. Dr. Rosenthal testified that where complications of GER are present, a gastroenterologist should be involved in the person's care. Tr. 12/13/93 (Rosenthal) at 164.

The Ebensburg medical staff also missed a clear marker that Keith in fact had reflux. In the last years of his life, the medical staff chose to believe that Keith was not refluxing, but rather was voluntarily regurgitating or ruminating. Tr. 7/27/93 (Sulkes) at 126-7.^{29/} A voluntary act of regurgitation is called "rumination." Tr. 7/27/93 (Sulkes) at 126. However, in April 1991, medical records indicated clearly that Keith had regurgitated or refluxed stomach contents during his sleep. Tr. 7/27/93 (Sulkes) at 126. If one regurgitates during sleep, it is not a voluntary act. Tr. 7/27/93 (Sulkes) at 126. However, instead of pursuing the reflux angle further, the Ebensburg doctors chose to label his regurgitations as voluntary ruminations even though refluxing material while asleep is necessarily an

^{29/} Ms. Wagner testified in her deposition on January 7, 1993 that she suspected that Keith T. had silent aspiration syndrome. U.S. Exh. 641 (Wagner Dep.) at 76. Keith also regurgitates stomach contents on a regular basis and Ms. Wagner suspected that he could be aspirating his stomach contents. U.S. Exh. 641 (Wagner Dep.) at 78. Ms. Wagner thought that Keith was voluntarily regurgitating. U.S. Exh. 641 (Wagner Dep.) at 78.

involuntary act. Tr. 7/27/93 (Sulkes) at 127. Dr. Rosenthal agreed that if the wrong problem is being treated then good medical care is not being provided. Tr. 12/13/93 (Rosenthal) at 167.

Until February 1992, the physician's problem list in Keith's annual medical report never mentioned reflux or swallowing problems. Tr. 7/27/93 (Sulkes) at 127. The head of the Ebensburg dysphagia team confirmed that Keith had a chronic history of choking. U.S. Exh. 641 (Wagner Dep.) at 36. Thus, even though Keith had been admitted multiple times with aspiration pneumonia, and even though he had involuntarily refluxed material in his sleep, diagnosis of and treatment for reflux had not been listed as part of his long term plan of care. Tr. 7/27/93 (Sulkes) at 127. In fact, it took three years for a physician to document in the long term plan that aspiration was a problem for Keith at all. Tr. 7/27/93 (Sulkes) at 127. Dr. Rosenthal testified that if the symptoms of gastroesophageal reflux are serious, it is important to take more aggressive action than just observing. Tr. 12/13/93 (Rosenthal) at 163-4.

Finally, in the last six months of his life, a work-up was begun for Keith, but at this point, it was undertaken too late to help his deteriorating lungs. Tr. 7/27/93 (Sulkes) at 127. He was hospitalized in early March 1993 for aspiration pneumonia and he died later that month. U.S. Exhs. 144, 788.^{30/}

^{30/} Contrary to the implications of opposing counsel, Keith T. did not die as a result of fundoplication surgery. Tr. 7/28/93 (Sulkes) at 77.

d. Sam B.

Sam. B. died of aspiration pneumonia in April 1993. Tr. 7/27/93 (Sulkes) at 131.^{31/} Sam had been giving clear unmistakable warnings about his serious condition for over ten years. Tr. 7/27/93 (Sulkes) at 131. His first aspiration pneumonia occurred in 1978. Tr. 7/27/93 (Sulkes) at 132. He was diagnosed with reflux esophagitis in 1980 and he suffered bouts of pneumonia in 1980, 1983, 1985, 1986 and 1987. Tr. 7/27/93 (Sulkes) at 132. However, until things got desperate with him, and it was too late to help him, nobody at Ebensburg took any action for Sam. Tr. 7/27/93 (Sulkes) at 132.

In March 1993, he began to have difficulty swallowing. Tr. 7/27/93 (Sulkes) at 132. Through a barium swallow test, it was revealed that he was aspirating. Tr. 7/27/93 (Sulkes) at 132. He was later hospitalized with aspiration pneumonia, and yet, the Ebensburg doctor concluded that his condition was due to a virus in the building. Tr. 7/27/93 (Sulkes) at 132. Given his documented history of aspiration pneumonia, swallowing problems and his documented history of reflux, the aspiration problem was more likely going to have arisen from a feeding or swallowing problem or from reflux, and not from a virus. Tr. 7/27/93 (Sulkes) at 132. Dr. Sulkes testified that it was "[v]ery troubling" that the Ebensburg doctor ignored the feeding, swallowing and reflux angles as being the apparent or possible cause of Sam's medical problem. Tr. 7/27/93 (Sulkes) at 133, line 6. Dr. Rosenthal agreed that if the wrong problem is being treated then good medical care is not being provided. Tr. 12/13/93 (Rosenthal) at 167. There was not even a notation in the record that indicated that

^{31/} In reaching his conclusions about Ebensburg and its care of those individuals at risk of aspiration, Dr. Kastner did not review Sam's record or any details of his medical care. Def. Exh. HH.

the doctor considered aspiration pneumonia and ruled it out in favor of the virus theory. Tr. 7/27/93 (Sulkes) at 133.

Furthermore, Dr. Sulkes had personally observed Sam being fed at Ebensburg about five months before he died. Tr. 7/27/93 (Sulkes) at 133. At that time, Dr. Sulkes observed that Sam had been provided with no head control, there was no head control suggested in his program, and yet Sam had been coughing while being fed. Tr. 7/27/93 (Sulkes) at 133.

In addition, in the ten days prior to his death, Sam was in respiratory distress, but no one at Ebensburg requested a respiratory work-up with fundamental observation or physical examination. Tr. 7/27/93 (Sulkes) at 133. When someone is in respiratory distress, their breathing becomes faster as they try to get oxygen, but there is no notation of that and there was no request for it. Tr. 7/27/93 (Sulkes) at 133. Sam had not been provided with a dysphagia team consult as of January 1993. U.S. Exh. 641 (Wagner Dep.) Exh. 3.

- James O. died in 1989 and had had 23 hospital admissions for lung problems, and yet Ebensburg never provided him with a swallowing work up, never gave him a gastrointestinal work up, and never provided him a lung work up. Tr. 7/27/93 (Sulkes) at 139. Even though there were a lot of hospital admission notes in his medical record, there was no long term medical plan of care for James. Tr. 7/27/93 (Sulkes) at 139. For the last three years of his life, every sixty day medical note in his record said: "continue present therapy and care." Tr. 7/27/93 (Sulkes) at 139.^{32/} James did not receive a Dysphagia Team consult from Ebensburg. U.S. 641 (Wagner Dep.) Exh. 3.

- Bobby Y. died of aspiration pneumonia in December 1988. Tr. 7/27/93 (Sulkes) at 139.^{33/} Bobby had had dysphagia identified for eleven years and yet the only two recommendations in his medical record that addressed his dysphagia indicated that his tongue thrust should be decreased and he should have a pureed diet. Tr. 7/27/93 (Sulkes) at 139.

^{32/} In reaching his conclusions about Ebensburg and its care of those individuals at risk of aspiration, Dr. Kastner did not review James' record or any details of his medical care. Def. Exh. HH.

^{33/} In reaching his conclusions about Ebensburg and its care of those individuals at risk of aspiration, Dr. Kastner did not review Bobby's record or any details of his medical care. Def. Exh. HH.

Bobby did not receive a Dysphagia Team consult from Ebensburg. U.S. 641 (Wagner Dep.) Exh. 3.

- Harold H. died in 1988 of aspiration pneumonia. Tr. 7/27/93 (Sulkes) at 139.^{34/} During his life at Ebensburg, he had been fed in a cart and he had a spinal curve. Tr. 7/27/93 (Sulkes) at 139. Harold did not receive a Dysphagia Team consult from Ebensburg. U.S. 641 (Wagner Dep.) Exh. 3.

5. Ebensburg Residents At Risk Of Aspirating Have Been Hospitalized As A Result Of The Inadequate And Inappropriate Medical Intervention Furnished By Ebensburg.

Details of the medical and health care provided to those Ebensburg residents who have been hospitalized due to aspiration pneumonia serves as further compelling evidence that the facility has been deficient in this area.

Aspiration and aspiration related illnesses are currently prevalent at Ebensburg. Tr. 7/27/93 (Sulkes) at 141. Inadequate and inappropriate intervention and medical management of the residents' aspiration problems potentially still affects a large number of residents at Ebensburg. Tr. 7/27/93 (Sulkes) at 141.

Dr. Sulkes testified about the details of the individualized care provided to many of the living Ebensburg residents at risk of aspirating who have been harmed due to inadequate and inappropriate medical intervention and management by Ebensburg. Tr. 7/27/93 (Sulkes) at 114. The following individuals are not the only examples of those Ebensburg residents who have been harmed due to inadequate and inappropriate medical intervention for their aspiration. Tr. 7/27/93 (Sulkes) at 140.

^{34/} In reaching his conclusions about Ebensburg and its care of those individuals at risk of aspiration, Dr. Kastner did not review Harold's record or any details of his medical care. Def. Exh. HH.

Ronald P. has had numerous hospital admissions for aspiration and pneumonia-related problems in 1990, 1991 and 1992. Tr. 7/27/93 (Sulkes) at 134.^{35/} By September 1992, Ronald had had nine admissions that were potentially attributed to aspiration or its complications. Tr. 7/27/93 (Sulkes) at 134. After each deterioration, the Ebensburg medical staff responded to Ronald's acute event, but they did not develop or execute a long term medical plan of care to prevent this from happening in the future. Tr. 7/27/93 (Sulkes) at 134. Ebensburg has a duty to provide Ronald with adequate and appropriate medical intervention for his health problems, and yet they did not meet their responsibilities. When the facility notes what is happening to Ronald medically without developing any sort of long term chronic plan of care, they are responding reactively to his deteriorating condition rather than acting proactively to prevent any future recurrence. Tr. 7/27/93 (Sulkes) at 135.^{36/} Dr. Sulkes testified that the signals being sent out by residents like Ronald who are repeatedly hospitalized for recurrent pneumonia or the like, are obvious signals that the medical staff at Ebensburg should be picking up. Tr. 7/27/93 (Sulkes) at 135.

^{35/} In January 1990, Ronald was hospitalized for aspiration right lower lobe pneumonia, and in December 1990, he was hospitalized for possible aspiration and for aspiration pneumonia. U.S. Exh. 144, 788. In June 1991, he was hospitalized for pneumonitis, and in October 1991 he was hospitalized for aspiration pneumonia. U.S. Exh. 144, 788. In 1992, Ronald was hospitalized in January for right lower lobe pneumonia, in February for gastrostomy/ dysphagia, in September for hypoxemia and later in the month for acute respiratory insufficiency. U.S. Exh. 144, 788.

^{36/} Dr. Kastner admitted that he did not personally observe or examine Ronald. Tr. 9/14/93 (Kastner) at 5. Dr. Kastner acknowledged that his review of Ronald's medical record was "solely for the purpose of identifying pulmonary episodes, episodes of infection, bronchospasm or other pulmonary entities. Tr. 9/14/93 (Kastner) at 5. In fact, Dr. Kastner did not indicate in court that he had actually reviewed Ronald's medical record, asserting only that he reviewed the annual medical summaries. Tr. 9/14/93 (Kastner) at 5. Thus, he did not indicate that he reviewed the physician's annual assessment, or the physician's progress notes, or the nursing notes, or the hospitalization discharge and admissions sheets, or any outside consult sheets or anything else in the medical record. Tr. 9/14/93 (Kastner) at 5.

On cross-examination, opposing counsel implied that Ronald's tube feeding regimen has been very successful. However, Dr. Sulkes personally observed Ronald being tube fed in November 1992. Tr. 7/27/93 (Sulkes) at 135. He noticed that Ronald was receiving his tube feeding while he was lying on his back. Tr. 7/27/93 (Sulkes) at 135. Dr. Sulkes testified that feeding anyone in this position was "quite dangerous." Tr. 7/27/93 (Sulkes) at 135(23).^{37/} Lying someone with reflux on their back during feeding is a very bad position because it increases the likelihood that the stomach contents will flow right back upstream through the esophagus leading to the bronchi and the lungs. Tr. 7/27/93 (Sulkes) at 135. Dr. Rosenthal agreed that positioning is important during and after meals if an individual has GER. Tr. 12/13/93 (Rosenthal) at 166. During this tube feeding, Dr. Sulkes also observed that Ronald was snoring and his head was in extension which was compromising his airway. Tr. 7/27/93 (Sulkes) at 135. The head of Ebensburg's dysphagia team confirmed that Ronald had a chronic history of choking. U.S. Exh. 641 (Wagner Dep.) at 36. The head of Ebensburg's Dysphagia Team also confirmed that Ronald had been placed on a gastrostomy tube as a result of his repeated aspirations. U.S. Exh. 641 (Wagner Dep.) at 56.

Patricia W. has had six admissions for pneumonia and one for bronchitis while living at Ebensburg. Tr. 7/27/93 (Sulkes) at 136.^{38/} Dr. Sulkes testified that when he personally

^{37/} Dr. Kastner admitted to never having observed Ronald during a feeding on his visit to Ebensburg. Tr. 9/14/93 (Kastner) at 5. In addition, Dr. Kastner was not able to recall whether or not Ronald had any difficulty swallowing. Tr. 9/14/93 (Kastner) at 5-6.

^{38/} In 1989, Patti was hospitalized for left lower lobe pneumonia and for aspiration pneumonitis in a one month period. U.S. Exhs. 144, 788. In November 1990, she was hospitalized for aspiration bronchitis pneumonia. U.S. Exhs. 144, 788. In 1992, she was hospitalized in January for pneumonia, in February for aspiration pneumonia, in March for aspiration pneumonia, and in June for acute bronchitis. U.S. Exhs. 144, 788.

saw her and reviewed her record in September 1992, he "became very upset." Tr. 7/27/93 (Sulkes) at 136, line 4. In past visits, Dr. Sulkes had known that Patricia had been producing a lot of mucus over the years because she had been having recurrent aspiration. Tr. 7/27/93 (Sulkes) at 137. When Dr. Sulkes last saw her, this was still true. Dr. Sulkes testified that current feeding practices employed at Ebensburg for Patricia are "killing her." Tr. 7/27/93 (Sulkes) at 136, line 17.^{39/} Sulkes added that under current practices at Ebensburg, Patti is going to suffer from "more aspiration pneumonia, more lung problems, and she will die." Tr. 7/27/93 (Sulkes) at 136.

In forming this opinion, Dr. Sulkes relied upon his past and current observations, and the assertions of Patricia's primary care physician that she has very tenuous lungs, bad motor disability, a weak chest that is not very strong, and the comment that any little stimulus could tip her over the edge. Tr. 7/27/93 (Sulkes) at 136.^{40/} Dr. Rosenthal testified that it is important to intervene in the treatment of GER before the serious and often painful and debilitating complications develop. Tr. 12/13/93 (Rosenthal) at 165. However, even though the Ebensburg physician recognized these problems, no one had yet taken Patricia to see a lung expert or pulmonologist. Tr. 7/27/93 (Sulkes) at 137.

^{39/} Dr. Kastner admitted that he never personally saw Patti W. while he toured Ebensburg. Tr. 9/14/93 (Kastner) at 2. He admitted that he never personally observed Patti during a meal; he never observed how the staff was feeding her, or observed if she was having any swallowing difficulty, or if she was positioned correctly. Tr. 9/14/93 (Kastner) at 2-3.

^{40/} Dr. Kastner claimed to have reviewed her chart, and yet he could not say whether or not she had gastroesophageal reflux. Tr. 9/14/93 (Kastner) at 3. He also could not answer a question as to whether or not Ebensburg claimed Patti had a lung problem or a GER problem. Tr. 9/14/93 (Kastner) at 3. Dr. Kastner admitted that "all I can say is I reviewed her records for the purposes of identifying any pulmonary episodes ... that was the entire focus of my review of her record. I'm not prepared to comment on anything beyond that." Tr. 9/14/93 (Kastner) at 3.

Only after Dr. Sulkes made the suggestion that they do so, did Ebensburg schedule Patti for an appointment with a lung specialist. Tr. 7/27/93 (Sulkes) at 137.^{41/} The lung specialist indicated in his report that Patti's condition had deteriorated to such an extent that now there was nothing that could be done for her. Tr. 7/27/93 (Sulkes) at 137. The fact that the pulmonologist said that there is now nothing more that can be done for her, does not indicate that there could not have been more done for her two or three years earlier to prevent this. Tr. 7/28/93 (Sulkes) at 39. Dr. Sulkes testified that he was glad the pulmonologist finally was able to examine Patti, but he wished that he could have examined her two or three years earlier, and not just after he made the suggestion after one of his tours in September 1992. Tr. 7/28/93 (Sulkes) at 39.

Ebensburg had a duty to provide Patti with adequate and appropriate medical intervention for her health problems, and yet they did not meet their responsibilities. Dr. Rosenthal testified that if an individual who is mentally retarded has a lot of mucus production, has suffered recurring episodes of aspiration pneumonia, vomiting, chronic pneumonias or is coughing and choking for a period of time, a physician should evaluate whether reflux is contributing to or causing these symptoms. Tr. 12/13/93 (Rosenthal) at

^{41/} Dr. Kastner acknowledged that Patti W. was one of only three individuals at Ebensburg who received an outside pulmonary consult in 1992; she received her one and only pulmonary consult that year on September 17, 1992. Tr. 9/14/93 (Kastner) at 3-4; U.S. Exh. 915. Dr. Kastner was not aware that Dr. Sulkes, the U.S. physician consultant, had just toured Ebensburg from September 1-3, 1992 about two weeks prior to Patti's outside pulmonary consult. Tr. 9/14/93 (Kastner) at 4-5.

166.^{42/} Until March 23, 1993, Ebensburg had never provided Patti with a Dysphagia Team consult. U.S. 641 (Wagner Dep.) Exh. 3; Tr. 10/18/93 (Sheppard) at 119.

Ethel M. has had multiple hospital admissions for aspiration related problems. Tr. 7/27/93 (Sulkes) at 137.^{43/} Dr. Sulkes concluded that Ethel is "deteriorating" and he had grave concerns about her future. Tr. 7/27/93 (Sulkes) at 137, lines 17-8.^{44/} The sixty day notes in Ethel's medical records reveal no long term plan of medical care. Tr. 7/27/93 (Sulkes) at 138. Despite her repeated hospitalizations, the recommendations in Ethel's medical chart indicate "continue same." Tr. 7/27/93 (Sulkes) at 138, line 6. Dr. Rosenthal testified that if the symptoms of gastroesophageal reflux are serious, it is important to take more aggressive action than just observing. Tr. 12/13/93 (Rosenthal) at 163-4. Ethel was not provided with anti-reflux surgery until 1992 -- many years after she first started

^{42/} During cross-examination, opposing counsel tried to imply that there was some significance to whether Patti had obstructive or restrictive lung disease. Tr. 7/28/93 (Sulkes) at 34-5. However, Dr. Sulkes testified that whether Patti W. has restrictive or obstructive lung disease does not matter in her case because the fact remains that she is continuing to suffer recurrent bouts of aspiration. Tr. 7/28/93 (Sulkes) at 35. She had already had multiple admissions to the hospital for aspiration pneumonia. Tr. 7/28/93 (Sulkes) at 39. Her records also reveal other aspiration markers such as the fact that she has delayed swallow and reduced oral mobility. Tr. 7/27/93 (Sulkes) at 136; Tr. 7/28/93 (Sulkes) at 36. She is already well down the "pipeline." Tr. 7/28/93 (Sulkes) at 39. If she has a restrictive component to her lung disease, that only makes matters worse in that she will be less able to bounce back from an aspiration pneumonia. Tr. 7/28/93 (Sulkes) at 36. If her lung cannot expand normally due to a restrictive component, then the facility has to be even more vigilant in ensuring that other insults to her lungs do not occur. Tr. 7/28/93 (Sulkes) at 36.

^{43/} She suffered one admission in 1989 for aspiration bronchitis, two in 1990 for aspiration pneumonia with gastrointestinal bleeding and for respiratory distress, and six in 1992 (right middle lobe pneumonia, aspiration pneumonia, aspiration pneumonia, probable aspiration pneumonia, probable aspiration, asphyxiation/ mucus plug). Tr. 7/27/93 (Sulkes) at 137; U.S. Exhs. 144, 788.

^{44/} In reaching his conclusions about the medical care offered to its residents at risk of aspiration, Dr. Kastner acknowledged that he did not look at the medical records of Ethel M. Tr. 9/14/93 (Kastner) at 7. Dr. Kastner was not aware that in 1992 alone, (the year he concentrated on in his review), Ethel was hospitalized repeatedly for pulmonary events including numerous aspiration pneumonias. Tr. 9/14/93 (Kastner) at 7; U.S. Exh. 144.

experiencing complications from gastroesophageal reflux. Tr. 7/27/93 (Sulkes) at 137.

Ebensburg has made no attempt to determine whether Ethel continues to reflux. Tr. 7/27/93 (Sulkes) at 137. In spite of her many hospitalizations for aspiration related problems, the Ebensburg Dysphagia Team did not make an evaluation and recommendation for Ethel until February 1993, well after Dr. Sulkes' last tour. Tr. 7/28/93 (Sulkes) at 58-9. Ethel was not evaluated by the Dysphagia Team until February 4, 1993. U.S. Exh. 641 (Wagner Dep.) Exh. 3; Tr. 10/18/93 (Sheppard) at 119. This was the case in spite of the fact that the head of the Dysphagia Team confirmed that Ethel had a chronic history of choking. U.S. Exh. 641 (Wagner Dep.) at 36. The head of the team also confirmed that Ethel had been placed on a gastrostomy tube as a result of her repeated aspirations. U.S. Exh. 641 (Wagner Dep.) at 56.

- Frank H. has been hospitalized numerous times: twice in 1989 for right lower lobe pneumonia and aspiration pneumonia, in 1991 for aspiration pneumonia, and in 1992 for acute bronchitis. Tr. 7/27/93 (Sulkes) at 138, U.S. Exhs. 144, 788. In spite of the fact that Frank continues to have aspiration episodes and it is clear that they are not isolated events, Dr. Sulkes concluded that still, no one at Ebensburg has taken the time and effort to figure out why Frank continues to suffer from aspiration pneumonia. Tr. 7/27/93 (Sulkes) at 138. The annual medical evaluation notes in Frank's chart at Ebensburg indicate that the medical plan for him is "to observe," not to diagnose or intervene, but "to observe." Tr. 7/27/93 (Sulkes) at 138, lines 21-22. Dr. Rosenthal testified that if the symptoms of gastroesophageal reflux are serious, it is important to take more aggressive action than just observing. Tr. 12/13/93 (Rosenthal) at 163-4. Frank was not provided with a Dysphagia Team consult from Ebensburg until July 6, 1993. U.S. Exh. 641 (Wagner Dep.) Exh. 3; Tr. 10/18/93 (Sheppard) at 119.

- William P. has known reflux. Tr. 7/27/93 (Sulkes) at 139. He also suffered a thirty pound weight loss over sixteen months. Tr. 7/27/93 (Sulkes) at 140. One of the complications of reflux is weight loss. For example, if every time your stomach contents slosh back upstream they come out your mouth, you do not retain the nutrients from the food. Tr. 7/27/93 (Sulkes) at 139-40. Even though William suffered this dramatic weight loss, no one at the facility noted that this may be due to complications from reflux or that reflux was contributing in any way to that. Tr. 7/27/93 (Sulkes) at 140. Dr. Rosenthal testified that if an individual who is mentally retarded even has a problem gaining weight, a

physician should evaluate whether reflux is contributing to or causing these symptoms. Tr. 12/13/93 (Rosenthal) at 166.

- Anthony R. has had hospital admissions for pneumonia in 1986, 1987 and 1991, but these hospitalizations were not even mentioned in his annual medical evaluation. Tr. 7/27/93 (Sulkes) at 140. His primary care physician did not even note this in his medical records. Tr. 7/28/93 (Sulkes) at 77. Anthony was also hospitalized in 1989 for asthmatic bronchitis, and in 1991 for aspiration pneumonia. U.S. Exh. 144. However, at the time of Dr. Sulkes' last visit, Ebensburg had not provided him with a barium swallow work up, or an x-ray study. Tr. 7/27/93 (Sulkes) at 140. In addition, there was no work-up either looking for reflux or for dysphagia in his evaluation. Tr. 7/28/93 (Sulkes) at 77. As of January 1993, Ebensburg had not provided Anthony with a Dysphagia Team consultation. U.S. Exh. 641 (Wagner Dep.) Exh. 3.

6. Even When Ebensburg Residents At Risk Of Aspirating Are Not Hospitalized They May Be Suffering Harm As A Result Of The Inadequate And Inappropriate Medical Intervention Furnished By Ebensburg.

Dr. Sulkes also testified that even beyond the deaths and hospitalizations, the harm from aspiration is taking place "all the time" at Ebensburg. Tr. 7/27/93 (Sulkes) at 107, line 12. Residents are suffering harm on a day-to-day basis at the facility even if they are not hospitalized. Tr. 7/27/93 (Sulkes) at 106. Ebensburg residents are hospitalized only when pneumonia occurs after a massive amount of foreign material seeps down their lungs. Tr. 7/27/93 (Sulkes) at 106. Only when someone gets sick enough will they be sent to the hospital. Tr. 7/27/93 (Sulkes) at 107. The hospitalizations for pneumonia are therefore just the "visual blips" more clearly revealing the often constant level of trouble in this area at the facility. Tr. 7/27/93 (Sulkes) at 107.

There are people living at Ebensburg who chronically have increased secretions, who have chronic wheezing, and who have tenuous lung functions all the time because they are always aspirating. Tr. 7/27/93 (Sulkes) at 106-7. Sometimes they aspirate huge amounts and sometimes they aspirate smaller ones, but it is always an irritant and is always a set up

for potentially bigger problems. Tr. 7/27/93 (Sulkes) at 107. For many residents, just because they have not been hospitalized does not mean that they have not been harmed. Tr. 7/27/93 (Sulkes) at 107.

One individual who Dr. Sulkes believed to be suffering harm, but who had not been hospitalized is Tim P. Tr. 7/27/93 (Sulkes) at 139.^{45/} Dr. Sulkes personally observed Tim and concluded that just because he had not been hospitalized yet did not mean he did not have any problems. Tr. 7/27/93 (Sulkes) at 139. Tim has had brown tinged vomitus and he is anemic, and yet no one at Ebensburg has checked his stool. Tr. 7/27/93 (Sulkes) at 139. No one has worked him up to determine where this bleeding is coming from. Tr. 7/27/93 (Sulkes) at 139. Further, Ebensburg had not provided him with a swallowing study or a barium swallow study. Tr. 7/27/93 (Sulkes) at 139. Ebensburg had not provided Tim with a Dysphagia Team consult as of January 1993. U.S. Exh. 641 (Wagner Dep.) Wagner Dep. Exh. 3. Indeed, as of the time of Dr. Sheppard's tour in July 1993, Tim's condition had deteriorated to the point that he was being fed by a gastrostomy tube. Tr. 10/18/93 (Sheppard) at 96; Tr. 7/29/93 (McGowan) at 115.

B. Ebensburg Does Not Provide Adequate Nutritional Management Services To Residents In Accord With Basic Standards Of Care.

1. The Outcome Measures Of A Good Nutritional Management System Are Not Evident At Ebensburg.

A primary goal of nutritional management is to maintain and achieve good nutritional health, including adequate body weight. Tr. 7/29/93 (McGowan) at 157; Tr. 10/12/93 (Sheppard) at 14. A common way of measuring good nutritional health is by calculating the

^{45/} After his last visit to Ebensburg, Tim was, in fact, hospitalized for pneumonia on March 4, 1993.

mass body index ("BMI"). Tr. 10/12/93 (Sheppard) at 100-101. Dr. Sheppard has found that there is a significant relationship between an individual's BMI and abnormal stool, gastroesophageal reflux, vomiting, and respiratory illness. Tr. 10/18/93 (Sheppard) at 64. The majority of Keystone residents have BMI's that are below the normal range. U.S. Exhs. 967, 970. Forty-nine Keystone residents, or 61% of all people who live at Keystone, are below the lowest limit of the normal BMI range. U.S. Exh. 967.^{46/} Of the 25 Keystone residents shown on the United States' feeding videotape, 20 are below their recommended BMI. Tr. 7/29/93 (McGowan) at 111-136; U.S. Exh. 970.^{47/} Some Keystone residents have BMI's that are significantly below the accepted range. Seventeen Keystone residents have BMI's of 15.5 or lower, which is more than 25% below the lowest number of the acceptable BMI range of 21-27.^{48/} Dr. Sheppard agrees that these are individuals who are significantly at risk due to their low body weight and compromised nutritional status. Tr. 10/18/93 (Sheppard) at 67-68. As far back as 1990, the United States notified the Commonwealth of its concerns that Ebensburg's inadequate nutritional management practices posed a risk of malnutrition. U.S. Exh. 638 (Sponsky Dep.) Exh. 50 at 3.

^{46/} Three Keystone residents, or 4%, are below the lowest limit of the normal BMI range but the Dysphagia Team considers them to be within normal limits. Only 35% of Keystone residents are within or above normal BMI limits. U.S. Exh. 967.

^{47/} These residents are Barry D., Ronald E., Joseph T., Frank H., Timothy P., Harold B., William A., Duane P., Beth S., Ellen H., James M., Joseph R., Tim G., John H., Tony R., Raymond W., Rhett T., David K., Lee V., and Jerry Mc. Two additional Keystone residents were not included among the Dysphagia Team evaluations measuring BMI. These are Ronald P., who is fed with a gastrostomy tube, and Sam B., who died after the videotape was taken of aspiration pneumonia. Tr. 7/29/93 (McGowan) at 116; 122. (Note that Sam B. is incorrectly transcribed as Sam V. in the transcript at 122, line 7.)

^{48/} Ten of these seventeen residents are shown on the United States' feeding videotape. These are: Barry D., Ellen H., Frank H., David K., Duane P., Timothy P., Anthony R., Joseph R., Joseph T., and Raymond W. U.S. Exh. 970.

Other commonly accepted goals of nutritional management are to maintain good respiratory health (absence of pneumonia, aspiration), to ensure ease of eating without distress (coughing and choking), and to develop good eating skills. Tr. 7/29/93 (McGowan) at 157; Tr. 10/12/93 (Sheppard) at 14-15. As discussed supra § X.A, Ebensburg residents are suffering from poor respiratory health and gastroesophageal reflux. In fact, Dr. Sulkes identifies these life-threatening conditions as the "most pressing" medical concern at Ebensburg. As discussed infra § XI, Ebensburg residents experience much distress during mealtimes and are not being taught to develop good eating skills.

Dr. Sheppard's opinions about the adequacy of mealtime practices at Ebensburg were limited to whether residents were experiencing active distress at mealtime and the nature of the feeding techniques. Tr. 10/18/93 (Sheppard) at 60. She did not look at the outcome of these techniques, i.e., whether there were improvements in the individual's underlying health. Tr. 10/18/93 (Sheppard) at 60. Although she testified that she looked at some weight records, she only reviewed them for two residents at Keystone, where individuals have the greatest health related needs. Tr. 10/18/93 (Sheppard) at 111-112; U.S. Exh. 1041; Tr. 7/27/93 (Sulkes) at 83. The first Keystone resident whose record she reviewed to look at nutritional issues was Keith T. U.S. Exh. 1041. Keith died in March 1993 -- one month after Dr. Sheppard's first tour. U.S. Exh. 788. Keith had multiple hospitalizations for aspiration pneumonia and related respiratory problems. Tr. 7/27/93 (Sulkes) at 126; U.S. Exh. 144, 788. Dr. Sulkes testified that his death was preventable and attributable to Ebensburg's poor chronic care of his nutritional management related problems. Tr. 7/27/93 (Sulkes) at 125-126, 128. The only other Keystone resident whose record Dr. Sheppard

reviewed to look at nutritional management related issues was Anthony (Tony) R. U.S. Exh. 1041. Anthony has also had multiple hospitalizations for aspiration and respiratory problems. U.S. Exh. 144. However, at the time of Dr. Sulkes' last visit in November 1992, Ebensburg Center had not provided him with a barium swallow work up or an x-ray study. Tr. 7/27/93 (Sulkes) at 140. In addition, Ebensburg had not conducted a work-up either for reflux or for dysphagia. Tr. 7/28/93 (Sulkes) at 77. Anthony still did not have a Dysphagia Team evaluation by January 1993, even though the head of the Team admitted that she had observed Anthony frequently coughing and possibly choking during meals. U.S. Exh. 641 (Wagner Dep.) at 60, 61. He was not even screened by the Dysphagia Team until June 22, 1993. U.S. Exh. 970. His BMI at the time was 13.40, which is more than 25% below the lowest limit of Ebensburg's acceptable BMI range. *Id.* This puts him among the individuals whom Dr. Sheppard consider to be significantly at risk due to their low body weight and compromised nutritional status. Tr. 10/18/93 (Sheppard) at 67-68. In between the time of Dr. Sheppard's February 1993 tour of Ebensburg and her return in July 1993, Anthony was placed on a feeding tube. Tr. 10/18/93 (Sheppard) at 132. Dr. Sheppard's comments on Tony at the point in the videotape where Ms. McGowan describes him as refluxing following his meal were that "here is just a face with mucus dribbling from his lip; "nothing to do with nutritional management." Tr. 10/12/93 (Sheppard) at 78. Dr. Sheppard does not feel qualified to evaluate the medical risks of aspiration and is not an expert in gastroesophageal reflux. Tr. 10/18/93 (Sheppard) at 71-72.

2. Nutritional Management Does Not Exist At Ebensburg.

No one at Ebensburg is responsible for overseeing and integrating the nutritional management of residents and there is no system in place to facilitate adequate nutritional management. Tr. 7/29/93 (McGowan) at 158-159. Ebensburg's Dysphagia Team does not adequately address residents' nutritional management needs at the facility. Tr. 7/29/93 (McGowan) at 165. The Team focuses only on swallowing, which is but one narrow aspect of nutritional management. *Id.* at 165. The Dysphagia Team has not dealt with individuals with gastroesophageal reflux. U.S. Exh. 613 (Frye Dep.) at 85; U.S. Exh. 641 (Wagner Dep.) at 157. The Team's concerns do not extend below the neckline; they are only involved with the throat and swallowing. U.S. Exh. 613 (Frye Dep.) at 193, 194. Nutritional management, however, is much broader than simply attention to dysphagia and what occurs during mealtimes. Tr. 7/29/93 (McGowan) at 157-158. It encompasses general health care issues by looking at all of the factors which affect a person's ability to take in and utilize nutrients twenty-four hours a day. *Id.* at 157. In addition to how an individual eats, it includes such factors as positioning, medication, and overall health status, including adequacy of weight and gastrointestinal and respiratory functions. *Id.* Given the complex nature of the nutritional management needs of Ebensburg residents (many of whom have compromised respiratory functions, are significantly underweight, have physical disabilities, and have related medical complications), an integrated interdisciplinary approach is essential to maintain their health and prevent deterioration. Tr. 7/29/93 (McGowan) 159, 161-163; Tr. 7/30/93 (McGowan) at 26. Dr. Sheppard agrees that interdisciplinary coordination between disciplines, including speech therapy, occupational therapy, physical therapy,

dietary, and nursing, is important. Tr. 10/12/93 (Sheppard) at 125; Tr. 10/18/93 (Sheppard) at 37. Dr. Hinkle also places an interdisciplinary approach on his list of steps that an institution should take to ensure safe and proper feeding. Tr. 12/16/93 (Hinkle) at 35; U.S. Exh. 1120.

Such an interdisciplinary approach does not exist at Ebensburg to address the nutritional management needs of residents. Tr. 7/29/93 (McGowan) at 159. Ebensburg's physical therapists are not involved in any way with feeding issues. Mr. Arnall does not know any members of the Dysphagia Team and does not have any contact with them. Tr. 10/13/93 (Arnall) at 95. Neither he nor any of the other contract physical therapists at Ebensburg are involved with positioning during mealtimes. Tr. 10/13/93 (Arnall) at 95. As Mr. Arnall explains that it is not part of their "contractual obligation." Tr. 10/13/93 (Arnall) at 95. Ms. Frye, the LOTA on Ebensburg's Dysphagia Team, concurs that she does not have any professional interaction with either the physical therapists or physical therapy aides at Ebensburg. U.S. Exh. 613 (Frye Dep.) at 145. She thinks that Ebensburg residents would benefit if there was interaction and coordination between the occupational therapy department and the physical therapy department. U.S. Exh. 613 (Frye Dep.) at 145-146, 147. To Ms. Frye's knowledge, no one has every suggested that occupational and physical therapists coordinate therapeutic programs at Ebensburg, but she thinks it would be a good idea if they did coordinate. U.S. Exh. 613 (Frye Dep.) at 146.

There is also a failure to coordinate between nursing, occupational therapy, and the Dysphagia Team. For example, Ms. Sponsky developed an aspiration screening form without any input from the Dysphagia Team or Ebensburg's occupational therapist. Tr.

7/30/93 (McGowan) at 35. In fact, even though the screening tool had been in existence for several months, neither Kathy Wagner, the head of the Dysphagia Team, or Lois Graham, Ebensburg's Director of Occupational Therapy, even knew that it existed until they were shown copies of it at their depositions. Tr. 7/30/93 (McGowan) at 36; U.S. Exh. 618 (Graham Dep.) at 63; U.S. Exh. 641 (Wagner Dep.) at 74. Despite a directive from Mr. Bellomo to Ms. Sponsky on January 13, 1993 asking her to determine whether information from the aspiration screening form is available to the occupational therapist, as of one month later, Ms. Sponsky had not discussed this issue with the occupational therapist or anyone else in Ebensburg's occupational therapy department. U.S. Exh. 638 (Sponsky Dep.) at 49-50. In fact, Ms. Sponsky has never discussed any joint nursing and occupational therapy issues with the Ebensburg's Director of Occupational Therapy. U.S. Exh. 638 (Sponsky Dep.) at 51. Ms. Sponsky also does not have any involvement with the Dysphagia Team. U.S. Exh. 637 (Sponsky Dep.) at 70. Ebensburg nurses do not develop nutritional management plans and the Director of Nursing does not have any sense of the number of Ebensburg residents who have nutritional management needs -- even whether the number is large or small. U.S. Exh. 638 (Sponsky Dep.) at 27. In sum, the concept of nutritional management is a foreign one to Ebensburg. Tr. 7/29/93 (McGowan) at 159.

3. There Are Commonly Agreed Upon Components Of An Adequate Nutritional Management System.

An adequate nutritional management system requires the following basic and essential elements:

1. identification of residents at risk;

2. comprehensive interdisciplinary assessments that evaluate not only how the resident eats but also intervening factors, such as underlying medical issues, the impact of medications, respiratory patterns, and behavioral problems;

3. development of an individualized intervention plan;

4. staff training in implementation of interventions; and

5. monitoring the efficacy of interventions and revising them when needed.

Tr. 7/29/93 (McGowan) at 159-164.

There is no dispute that these components constitute commonly accepted standards.

Dr. Sheppard agrees that each of these five aspects of nutritional management are key and have been generally accepted in the field for over a decade. Tr. 10/12/93 (Sheppard) at 124-135. In fact, she has written articles endorsing these principles that date back to 1981. *Id.* at 124. Dr. Hinkle further agrees that each of these elements is essential and constitute "steps that an institution can take to ensure safe and proper feeding." Tr. 12/16/93 (Hinkle) 34-35; U.S. Exh. 1120. These standards have been formally adopted by a number of states, including by federal court order in institutional reform litigation in Florida. Tr. 7/30/93 (McGowan) at 3; 36. None of these basic components of adequate nutritional management is in place at Ebensburg. *Id.* at 160, 161, 164.

a. Ebensburg Has Failed To Identify Individuals Whose Swallowing, Oral Motor, And Medical Conditions Place Them Nutritionally At Risk.

It is critical to identify individuals with feeding and swallowing disorders. In a paper that Dr. Sheppard presented in 1988 during the annual conferences of the American Association on Mental Retardation and the American Academy for Cerebral Palsy and

Developmental Medicine, she stated that:

Feeding and swallowing disorders are issues that command daily attention in institutions for the mentally retarded. Mealtime management is the most frequently reviewed and constant concern. Timely and effective management of these problems depends on identifying the individuals with dysphagia and defining the severity of their disability.

Tr. 10/12/93 (Sheppard) at 126. Because the entire population at Ebensburg is at risk for dysphagia it is particularly important that everyone is screened to determine who has a swallowing or oral motor disorder. Tr. 10/12/93 (Sheppard) at 127. As of the time that the defendants concluded their case-in-chief in October 1993, Ebensburg still had not screened all residents, despite the fact that Dr. Sheppard had advised facility administrators that this was a "weakness" some eight months earlier during her February 1993 tour. Tr. 10/12/93 (Sheppard) at 102, 130; Tr. 10/19/93 (Sheppard) at 130. In fact, Ebensburg did not begin screening residents for dysphagia until April 1993. Tr. 10/12/93 (Sheppard) at 129-130. As of July 1993, only Laurel House residents had been screened and Keystone residents were in the process of being screened with follow up assessments for dysphagia. Tr. 10/12/93 (Sheppard) at 130. As of October 18, 1993, less than half of all Ebensburg residents had been screened. Tr. 10/18/93 (Sheppard) at 130; Tr. 10/13/93 (Bellomo) at 211.

Ebensburg has also never screened residents to identify those who have oral motor problems despite the fact that Ms. Graham, the Director of Occupational Therapy, thinks that such a screening is important. U.S. Exh. 616 (Graham Dep.) at 126-127. She agrees that if someone has a significant oral motor problem and has not been identified, it presents health risks that are life-threatening. U.S. Exh. 617 (Graham Dep.) at 127-128. Ms. Graham believes that there are Ebensburg residents with oral motor problems who have not been

identified. U.S. Exh. 617 (Graham Dep.) at 126. Ebensburg has further never screened its residents to identify potential chokers. Tr. 10/12/93 (Sheppard) at 161-162. In addition, Ebensburg has also never conducted a comprehensive screening to identify all residents who need adaptive feeding equipment. U.S. Exh. 616 (Graham Dep.) at 112.

Ebensburg has failed to even identify residents who aspirate and are at risk of aspiration, despite the fact that the Facility Director, the Nursing Director, and the Medical Director all agree that aspiration can be life-threatening. U.S. Exh. 602 (Bellomo Dep.) at 174; U.S. Exh. 637 at 74; U.S. Exh. 632 (Shertz Dep.) at 158. Although she agrees that it is important for Ebensburg to identify every resident who aspirates and is at risk of aspiration, Ms. Sponsky does not know whether all Ebensburg residents who aspirate or are at risk of aspiration have been identified. U.S. Exh. 637 (Sponsky Dep.) at 47-48. As of late August 1992, Ebensburg had not conducted any screening to identify residents who aspirate and are at risk of aspiration. Tr. 7/30/93 (McGowan) at 33-34. Following Ms. McGowan's August 1992 tour, Ebensburg developed a screening tool for aspiration. Tr. 7/30/93 (McGowan) at 34; U.S. Exh. 855. Ebensburg did not start using the aspiration screening tool until shortly before Ms. McGowan returned for her follow up tour on November 12, 1992. U.S. Exh. 637 (Sponsky Dep.) at 43. Ms. Sponsky developed the tool at Mr. Bellomo's direction. U.S. Exh. 637 (Sponsky Dep.) at 40. She did not know why Mr. Bellomo wanted her to develop it. U.S. Exh. 637 (Sponsky Dep.) at 41. Mr. Bellomo did not identify any outcomes or advise Ms. Sponsky of any steps that should be taken with regard to the aspiration screening. U.S. Exh. 637 (Sponsky Dep.) at 53. Despite the fact that Mr. Bellomo claims that he places a time limit on every assignment he makes, Tr.

10/13/93 (Bellomo) at 206, he did not place any time frames on completing the aspiration screening. U.S. Exh. 637 (Sponsky Dep.) at 53.

In Ms. McGowan's opinion, the screening tool is inadequate in its scope and content to identify all residents who are at risk of aspiration because it does not evaluate key factors that place a person at risk of aspiration. Tr. 7/30/93 (McGowan) at 34. For example, it does not require meal time observations and it does not evaluate such critical information as a resident's medications, weight history, and bowel function. Tr. 7/30/93 (McGowan) at 34. Although Ms. Sponsky believes that it is important to identify individuals with silent aspiration syndrome at Ebensburg, she does not know whether the screening form she developed is intended to identify people with this syndrome. U.S. Exh. 637 (Sponsky Dep.) at 55. Ms. Sponsky does not know whether all Ebensburg residents with reflux have been identified and admits that the screening form will not help to identify individuals who are presenting symptoms of gastroesophageal reflux but have not yet had medical tests to confirm the existence of reflux. Id. at 60.

Ebensburg nurses have not received any training in how to complete the screening tool. U.S. Exh. 637 (Sponsky Dep.) at 44. They are supposed to develop health care plans based upon the results of the aspiration screening. Id. at 51. Ms. Sponsky does not know if any such plans have been developed. Id. The Nursing Standards Committee was supposed to develop a health care plan protocol for nurses to use if aspiration is detected by through the screening. Id. at 52. As of February 16, 1993, some three months after the form had already been implemented, the Committee still had not yet developed a protocol and there was no scheduled date for developing it. U.S. Exh. 638 (Sponsky Dep.) at 159.

The aspiration screening tool is only slated to be used as part of a resident's annual review. U.S. Exh. 637 (Sponsky Dep.) at 42. Ebensburg therefore plans on taking one year to complete the screening process. Tr. 10/13/93 (Bellomo) at 212. Ms. Sponsky, however, directed Keystone to complete the screening on an expedited basis. U.S. Exh. 637 (Sponsky Dep.) at 50. During her deposition on January 14, 1993, Ms. Sponsky stated that she was "sure" aspiration screening had been completed at Keystone. U.S. Exh. 637 (Sponsky Dep.) at 50. Despite this heightened attention to the aspiration screening, when Ms. Sponsky was asked to bring the completed forms to the completion of her deposition on February 16, 1993, the Keystone screenings still had not been completed and Ms. Sponsky did not know when they were even scheduled to be completed. U.S. Exh. 683 (Sponsky Dep.) at 158-159. In fact, as of February 1993, some three months after the screening had begun, only thirty of the ninety-four Keystone residents had been screened. Tr. 7/30/93 (McGowan) at 35. As of the time of her tours, Dr. Sheppard still did not see the results of any aspiration screenings in Keystone charts. Tr. 10/12/93 (Sheppard) at 175.

b. Ebensburg Does Not Adequately Assess Residents
With Nutritional Management Needs.

Even when Ebensburg is aware of a specific nutritional management need that it must assess, it has failed to do so. For example, Christine G.'s interdisciplinary team met on January 8, 1993 to conduct her annual review. U.S. Exh. 363. Her team noted that its primary concern has been Christine's health: "She has endured a number of health problems and continues to struggle with very fragile health at this writing." U.S. Exh. 363. In fact, her annual review, which was originally scheduled for November 1992 had to be postponed because Christine had been hospitalized for two months for pneumonia. Id. At the time of

Christine's annual review, she "remained attached to a feeding tube." Id. at 1-2. A dietician was not present at Christine's annual review. Id. at 1. In the dietician's absence, all that her team had to work with was a three month old nutritional assessment which the team noted was out of date because "there have been definite changes in her condition as her health has declined and thus some parts of this assessment are not longer valid." Id. at 3. As far back as 1990, the United States notified the Commonwealth that Ebensburg's nutritional assessments were inadequate. U.S. Exh. 638 (Sponsky Dep.) Exh. 50 at 3.

i. Ebensburg's Dysphagia Team Has Failed To Conduct Assessments.

Both Dr. Sulkes and Ms. McGowan agree that the Dysphagia Team at Ebensburg has failed to assess residents who are at serious risk of aspirating due to feeding and swallowing problems. Tr. 7/27/93 (Sulkes at 142. Tr. 7/29/93 (McGowan) at 166-167. As far back as February 1992, Ebensburg was aware of the critical need for its Dysphagia Team to assess each Keystone resident. Tr. 7/29/93 (McGowan) at 166-167. It was not until sixteen months later, during the summer months of 1993, that the Dysphagia Team began to even preliminarily screen Keystone residents. Tr. 10/12/93 (Sheppard) at 130. As of two weeks before the trial began in this case, even those Keystone residents whom the Dysphagia Team determined needed a comprehensive assessment based upon the screening results still had not all been assessed. Tr. 10/12/93 (Sheppard) at 130.

On the very day that this lawsuit was filed, February 10, 1992, Ebensburg held a mortality and morbidity committee meeting to review the death of Margaret D., who died on January 29, 1992. U.S. Exh. 41(e). Margaret D. had reflux esophagitis, a history of

aspiration pneumonia, and prior to her death could not eat because of mucus secretions.

Id.^{49/} Despite these problems, she had never been evaluated by Ebensburg's Dysphagia Team. U.S. Exh. 641 (Wagner Dep.) Exh. 3. A discussion of the role of the Dysphagia Team took place during the mortality and morbidity committee meeting. U.S. Exh. 41(e) at 6. Both Mr. Bellomo and Ms. Sponsky felt that the Dysphagia Team should be more actively involved in assessing individuals in Keystone:

Mr. Bellomo recommended that whenever an aspiration history is there he would like to see the dysphagia team at least rule out swallowing disorder. Mrs. Sponsky stated she agreed with that, but then every individual who resides in Keystone House should have that done because the potential is there for everyone of them.

Tr. 7/29/93 (McGowan) at 166-167; U.S. Exh. 41(e) at 6. Despite these specific acknowledgements by the facility director and director of nursing of the need to assess every Keystone resident, by the end of December 1992, the Dysphagia Team had evaluated only a total of seven out of the 94 Keystone residents. Tr. 7/29/93 (McGowan) at 166. Of the seven Keystone residents who had been assessed, four had been evaluated prior to Mr. Bellomo's and Ms. Sponsky's concerns, so only an additional three people were evaluated by the Dysphagia Team during this eleven month time period. U.S. Exh. 641 (Wagner Dep.), Wagner Dep. Exh. 3.^{50/} Even where Mr. Bellomo has concerns about a specific

^{49/} See also the discussion of Ebensburg's inadequate medical management of Margaret D. in § X.A.

^{50/} In light of the fact that Ebensburg residents are at risk of pneumonia due to age and aspiration, Mr. Bellomo also identified the need to examine and potentially enhance the role of the respiratory therapist available to Ebensburg through its on-going contract with Mercy Hospital. U.S. Exh. 41(e) at 5. Despite identifying this need during the Mortality and Morbidity committee review of Margaret's death in February 1992, Mr. Bellomo testified at trial that he did not take this action until October 1992, some eight months later, and only after the United States proposed it in a draft consent decree. Tr. 10/14/93 (Bellomo) at 157.

individual, there is no sense of urgency about involving the Dysphagia Team. For example, on January 11, 1993, Mr. Bellomo wrote a memo to Mr. Bonfanti, Keystone's Unit Manager requesting a review of Ron E.'s "specific needs in eating." U.S. Exh. 343(aaa). In particular, he queries whether a referral to the Dysphagia Team should be made. Despite Mr. Bellomo's involvement, the Dysphagia Team did not assess Ron until eight months later (September 19, 1993). Tr. 10/19/93 (O'Brien) at 95. ^{51/} Moreover, as of January 7, 1993, the head of the Dysphagia Team could readily identify at least ten individuals in Keystone who were frequently coughing and possibly experiencing recurrent choking during meals. U.S. Exh. 641 (Wagner Dep.) at 60, 61.^{52/} Of these ten residents, however, the Dysphagia Team had evaluated only one as of January 1993 and that person was not evaluated until December 22, 1992. U.S. Exh. 641 (Wagner Dep.) at 61, 62; U.S. Exh. 641 (Wagner Dep.) Exh. 3. Although the Dysphagia Team is supposed to assess all Ebensburg residents who have a choking episode warranting a medical procedure,^{53/} it has failed to do this as well (including failing to assess Gary K. and Vincent P., who required the Heimlich maneuver). Tr. 10/12/93 (Sheppard) at 143-146; U.S. Exh. 273.

As of January 7, 1993, the Dysphagia Team also did not routinely evaluate each individual who returned to Ebensburg after having been hospitalized for aspiration

^{51/} Ron was also screened by the Dysphagia Team, but not until June 22, 1993, as part of the overall Dysphagia Team screening in Keystone House. U.S. Exh. 970 (Ron E.'s swallowing screening). Although during the screening his positioning was found to be problematic, he did not receive a comprehensive evaluation by the Dysphagia Team until three months later. Tr. 10/19/93 (O'Brien) at 95; U.S. Exh. 970

^{52/} These individuals are: Ron E., Frank H., Duane P. Anthony R., Raymond W., Jeanne D., Karen S., Lois S., Jimmy M., and Tim P. U.S. Exh. 641 (Wagner Dep.) at 60, 61.

^{53/} U.S. Exh. 641 (Wagner Dep.) at 46.

pneumonia. U.S. Exh. 641 (Wagner Dep.) at 72. The Team was not even notified each time a resident was hospitalized for aspiration pneumonia. U.S. Exh. 641 (Wagner Dep.) at 73. Ms. Wagner feels that it is important for the Dysphagia Team to evaluate all individuals who have been hospitalized for aspiration pneumonia because "that's who we are here to serve, to try to prevent further aspiration, to do what we can to ensure safety in the future." U.S. Exh. 641 (Wagner Dep.) at 72, line 25 through 73 lines 1-2. Dr. Sheppard agrees that it is a "significant deficiency" if there is no process for the Dysphagia Team to evaluate all residents who have been hospitalized for aspiration pneumonia. Tr. 10/12/93 (Sheppard) at 189, lines 16-20. No one at Ebensburg, however, had ever thought about developing a mechanism to ensure that the Dysphagia Team evaluated each Ebensburg resident hospitalized for aspiration, even after the morbidity and mortality committee meeting in February 1992. U.S. Exh. 641 (Wagner Dep.) at 73. It was not until after Ms. Wagner was specifically asked at her deposition one year later, on January 7, 1993, whether the Dysphagia Team evaluated each Ebensburg resident hospitalized for aspiration, that a mechanism to notify the Dysphagia Team of such hospitalizations was even initiated. Plaintiff's Exhibit 10004.

Although Ms. Wagner "hoped" that the Team had evaluated every Ebensburg resident who aspirates, she did not know at the time of her deposition on January 7, 1993 whether the Team had actually evaluated each resident. U.S. Exh. 641 (Wagner Dep.) at 66-67. In fact, as of January 7, 1993, the Dysphagia Team had only evaluated two of the thirteen Ebensburg residents who had been hospitalized since the Team's creation in June 1990. U.S.

Exh. 949. By the time the Dysphagia Team finally evaluated these residents, there were significant delays. For example:

- Ethel M. was hospitalized for aspiration pneumonia three times for a total of four weeks in March, May, and November 1992 and was not evaluated by the Dysphagia Team following any of her hospitalizations. U.S. Exh. 949. She was finally evaluated by the Dysphagia Team in February 1993, three months after her last hospitalization. Tr. 10/18/93 (Sheppard) at 119.

- Patti W. was hospitalized in both February and March 1992 for twenty-nine days for aspiration pneumonia and was not evaluated by the Dysphagia Team following either of her hospitalizations. U.S. Exh. 949. In fact, she was not evaluated by the Dysphagia Team until one year later, March 23, 1993. Tr. 10/18/93 (Sheppard) at 119.

- Frank H. was hospitalized for a week with aspiration pneumonia during January 1991 and was not evaluated by the Dysphagia Team until July 6, 1993 -- two and a half years later. U.S. Exh. 949; Tr. 10/18/93 (Sheppard) at 119.

ii. The Dysphagia Team's Assessments Are Inadequate.

The few dysphagia assessments that have actually been conducted at Ebensburg are inadequate. Tr. 7/29/93 (McGowan) at 165-166. They are very narrow and brief in terms of content, scope, and the amount of time that is spent conducting the evaluation. *Id.* at 166. As of January 7, 1993, the Dysphagia Team did not use a specific assessment form for its evaluation. U.S. Exh. 641 (Wagner Dep.) at 97. It also did not have a list of areas to review to ensure that it is gathering all the pertinent information as it reviews a chart as part of its dysphagia assessment. U.S. Exh. 641 (Wagner Dep.) at 86. Ms. Fulton, who is a dietician, is responsible for reviewing nutritional issues in a resident's chart when the Team conducts its dysphagia evaluations. U.S. Exh. 641 (Wagner Dep.) at 82. During Ms. Fulton's absence from the Team for six months from April through the fall of 1992, Ms. Wagner and Ms. Frye would screen the charts to determine if another dietician should look at the chart. U.S. Exh. 641 (Wagner Dep.) at 83. Ms. Wagner, however, is not "quite

sure" what Ms. Fulton looks at in the chart. U.S. Exh. 641 (Wagner Dep.) at 82. The dietary area is a "nebulous" one to Ms. Wagner. U.S. Exh. 641 (Wagner Dep.) at 82. Ms. Wagner "is not that knowledgeable" about interpreting the information that Ms. Fulton reviews. U.S. Exh. 641 (Wagner Dep.) at 83. In addition, as part of the dysphagia evaluation, the Team only speaks to staff about the individual being evaluated for three to five minutes. U.S. Exh. 641 (Wagner Dep.) at 96. Dr. Sheppard unequivocally agreed that as of the conclusion of her last tour of Ebensburg, as late as July 1993, the dysphagia evaluations needed to be expanded so that contributing causes were better defined as part of the assessment. Tr. 10/12/93 (Sheppard) at 199.

No one on the Dysphagia Team is responsible for reviewing medications when evaluating a resident for potential dysphagia. U.S. Exh. 641 (Wagner Dep.) at 106. The Team never directly consults with Ebensburg's pharmacist. U.S. Exh. 641 (Wagner Dep.) at 107. At most, the Team only refers to the pharmacist's annual report in the resident's chart. U.S. Exh. 641 (Wagner Dep.) at 107. Although Ms. Wagner is aware that seizure medications and anti-psychotics can cause dysphagia and use of these medications is one of the most common reasons that dysphagia occurs in Ebensburg residents, she is unaware of the specific types of seizure medications and anti-psychotics that are more likely to cause dysphagia. U.S. Exh. 641 (Wagner Dep.) at 14.

c. Ebensburg Fails To Provide Adequate And Appropriate Mealtime Interventions For Residents With Nutritional Management Needs.

An adequate, interdisciplinary assessment of an individual's nutritional management needs is the foundation for developing appropriate interventions. Tr. 7/27/93 (Sulkes) at 97;

Tr. 7/29/93 (McGowan) at 161-164. Dr. Sheppard agrees that an adequate assessment is critical in order to appropriately exercise professional judgment about the types of mealtime interventions that should be used, particularly where an individual has significant physical limitations and is eating poorly. Tr. 10/12/93 (Sheppard) at 201. As discussed above, these assessments are lacking at Ebensburg.

Appropriate mealtime procedures and techniques are necessary to mitigate the potentially life-threatening complications of dysphagia, such as aspiration and low body weight. Tr. 10/12/93 (Sheppard) at 199-200. Each individual who has to be fed in Keystone did not have a feeding plan specifying these mealtime procedures and techniques until late 1992, following Ms. McGowan's first tour of Ebensburg. Tr. 7/29/93 (McGowan) at 148; U.S. Exh. 604 (Bonfanti Dep.) at 52. Prior to 1992, feeding plans were not routinely developed for Keystone residents. U.S. Exh. 629 (Schofield Dep.) at 23.^{54/}

Only five people in Keystone have any type of specialized occupational therapy feeding program. U.S. Exh. 616 (Graham Dep.) at 111. Two of the five residents have a program to maintain self-feeding skills and three have oral motor and positioning feeding programs. U.S. Exh. 616 (Graham Dep.) at 111, 112. The three residents who have occupational therapy programs for feeding are Tim P., Ellen H., and James M. U.S. Exh.

^{54/} For example, in November 1990, Dr. Sulkes observed that Donna S. was having problems with feeding and yet, there was no feeding program available for her. Tr. 7/27/93 (Sulkes) at 103. Two months later, in January 1991, she suffered from lower lobe pneumonia. Tr. 7/27/93 (Sulkes) at 103; U.S. Exh. 144. In January 1992, an occupational therapy note in her chart merely indicated that she had to be fed, has chewing difficulties, and poor oral motor skills. Tr. 7/27/93 (Sulkes) at 103-4. That was all – there were no recommendations about how to feed her other than that she needs to be fed. Tr. 7/27/93 (Sulkes) at 104. In November 1990, Dr. Sulkes observed Linda K. clearly having difficulty swallowing. Tr. 7/27/93 (Sulkes) at 101. There was no feeding supplemental procedure in the dining room or anywhere in her chart. Tr. 7/27/93 (Sulkes) at 101.

617 (Graham Dep.) at 117-118. Ms. Graham did not write the feeding plans for any of these three individuals. U.S. Exh. 617 (Graham Dep.) at 118. Instead, a LOTA wrote them. U.S. Exh. 617 (Graham Dep.) at 118. These three Keystone residents are all shown on the United States' feeding tape being fed by LOTA's and experiencing significant distress. See discussion infra § XI.

The feeding plans in existence at Ebensburg are inadequate. Tr. 7/29/93 (McGowan) at 229. Dr. Sheppard agrees that in order to be adequate, a feeding plan must address proper positioning as well as feeding techniques. Tr. 10/12/93 (Sheppard) at 201. The feeding plans at Keystone do not contain proper positioning techniques. Tr. 7/29/93 (McGowan) at 149. In a number of plans, pictures that are supposed to demonstrate appropriate positioning in fact demonstrate extremely poor positions for feeding. Tr. 7/29/93 (McGowan) at 149-150. Moreover, the feeding plans do not adequately address the specific feeding technique that should be used. Tr. 7/30/93 (McGowan) at 31-32. They are very general and very rarely specify any technique other than "present spoon center front," which fails to provide the feeder with any guidance about specific feeding techniques, such as the amount of pressure and how to pull the spoon out of the mouth. Tr. 7/30/93 (McGowan) at 31-32. Ebensburg staff do not use professionally accepted techniques to compensate for oral motor problems. For example, staff do not use head, neck, and jaw control techniques to prevent tongue thrusts. Tr. 7/29/93 (McGowan) at 120-121. Dr. Hinkle agrees that there are techniques that can and should be used to control a tongue thrust. Tr. 12/16/93 (Hinkle) at 28. In fact, improper technique of placement of the spoon can actually cause a tongue thrust. Tr. 12/16/93 (Hinkle) at 28. Ebensburg staff also do not angle the spoon when

withdrawing it from the mouth to assist with lip closure when a resident has difficulty closing the mouth to swallow. Tr. 7/29/93 (McGowan) at 122-123, 124. Both Ms. McGowan and Dr. Sheppard agree that the spouted cups used for feeding residents liquids at Ebensburg are unacceptable. Tr. 7/29/93 at 96; Tr. 10/12/93 (Sheppard) at 205. In fact, Dr. Sheppard thinks that Ebensburg's practice of using spouted cups is a departure from accepted professional standards in the field. Tr. 10/12/93 (Sheppard) at 205. Spouted cups are inadequate to teach the skill of cup drinking and pose difficulties in controlling the rate of liquids. Tr. 10/12/93 (Sheppard) at 205. Despite Ms. McGowan's and Dr. Sheppard's criticisms of these cups, they were still being used at Ebensburg as late as July 1993. Tr. 10/12/93 (Sheppard) at 206. As of February 1993, Dr. Sheppard also found Ebensburg residents who needed, but were not receiving, a different diet texture to accommodate their limited chewing skills. Tr. 10/12/93 (Sheppard) at 26.

The only specific resident whose record Dr. Sheppard reviewed and discussed in her direct testimony, was John B. ^{55/} Tr. 10/12/93 (Sheppard) at 93. Despite the fact that John has experienced significant weight loss since 1990, is eighteen pounds underweight, and is unable to feed himself, his entire feeding plan that was in effect at the time of Dr. Sheppard's February tour consisted of the following:

1. Take the individual to the dining area.
2. Put bib in place to protect clothing.
3. Check for proper diet and beverage.
4. To encourage the individual to feed himself.
5. Staff will feed if he refuses.
6. Remove bib.

^{55/} Dr. Sheppard did attempt to testify about the date on which she speculated Frank H.'s feeding plan was developed but the Court sustained an objection to this testimony. Tr. 10/12/93 (Sheppard) at 99.

7. Wipe the individual's face and hands after meals.
8. Return the individual to the living area.
9. Change clothing as needed.

Tr. 10/18/93 (Sheppard) at 11, 13; U.S. Exh. 1036. Dr. Sheppard agreed that John's most recent physician's assessment contained no current information about his weight loss and deterioration in his ability to feed himself. Tr. 10/18/93 (Sheppard) at 15; U.S. Exh. 1036. For a detailed discussion of Ebensburg's failure to treat adequately the medical aspects of residents with nutritional management needs, see supra § X.A.

d. Ebensburg Fails To Adequately Monitor Residents' Mealtime Intake And Mealtime Interventions.

i. Mealtime Interventions

When the Dysphagia Team makes recommendations, it does not regularly follow through to ensure that its recommendations are being implemented. U.S. Exh. 641 (Wagner Dep.) at 113. Ms. Frye, a member of the Team, explains that the Dysphagia Team has not been given the responsibility and does not have the time to ensure that its recommendations are implemented. U.S. Exh. 613 (Frye Dep.) at 70, 72. She feels, however, that Ebensburg residents would benefit from the Dysphagia Team being able to follow through to ensure that recommendations are carried. U.S. Exh. 613 (Frye Dep.) at 72.^{56/} Ms. Graham is also not responsible for ensuring that any recommendations she makes involving diet texture,

^{56/} Dr. Sulkes found a number of instances where the Dysphagia Team's failure to ensure its recommendations were implemented. For example, Washington D. was seen by the dysphagia team in June 1992. Tr. 7/27/93 (Sulkes) at 142. At that time, they recommended that Washington be given a barium swallow x-ray. Tr. 7/27/93 (Sulkes) at 142. However, when Dr. Sulkes reviewed his record three months later, the barium study had not yet been performed and there was no documentation in the record giving a reason why it had not yet been performed. Tr. 7/27/93 (Sulkes) at 143. In addition, the dysphagia team did nothing to ensure that their recommendations for David V. were being implemented. Tr. 7/27/93 (Sulkes) at 143.

adaptive equipment, and oral motor techniques are carried out. U.S. Exh. 618 (Graham Dep.) at 12. Ms. Wagner, the head of the Dysphagia Team, is not involved in any structured program of monitoring staff consistency in implementing feeding plans and taking corrective action when necessary and knows of no such system at Ebensburg. U.S. Exh. 641 (Wagner Dep.) at 202-203. As of January 1993, Ms. Wagner did not have any responsibilities during mealtimes in Keystone, although she believes that it would be advantageous to routinely observe meals. U.S. Exh. 641 (Wagner Dep.) at 203, 214.

ii. Mealtime Intake

It is important to have a mechanism to monitor how well Ebensburg residents eat at each mealtime. Tr. 10/12/93 (Sheppard) at 133. Ebensburg did not have any system in place to record the amount of food that individuals at Ebensburg ate in buildings other than Keystone until October 28, 1993. U.S. Exh. 637 (Sponsky Dep.) at 19. As far back as 1990, the United States notified the Commonwealth of its concerns that Ebensburg was failing to document the nutritional intake of residents. U.S. Exh. 639 (Sponsky Dep.) Exh. 50 at 3. Although it is important to record liquid intake as part of mealtime monitoring, when Ebensburg finally implemented a facility-wide system to record how well residents were eating, it did not include liquids. The Director of Nursing, who wrote the policy stated: "We don't consider liquids as part of a meal. It [the policy] doesn't address liquids. U.S. Exh. 637 (Sponsky Dep.) at 11, 13. Mr. Bellomo directed Ms. Sponsky on November 5, and again on November 19, 1992, to develop a system to summarize information collected during mealtimes recording how much residents ate. U.S. Exh. 636 (Sponsky Dep.) Exh. 16. Four months later, as of February 16, 1993, Ms. Sponsky had not developed any such

system and did not know when it would be developed. U.S. Exh. 637 (Sponsky Dep.) at 21-22; U.S. Exh. 638 (Sponsky Dep.) at 14. Ms. Malloy, nurse supervisor at Ebensburg, confirms that there are no monthly summaries prepared on how well each resident has eaten. U.S. Exh. 622 (Malloy Dep.) at 98. Until Ms. McGowan asked about it during her first tour of Ebensburg in August 1992, Ebensburg also had no written policy outlining what staff should do if a resident refuses food. U.S. Exh. 637 (Sponsky Dep.) at 11.

4. Ebensburg Fails To Provide Adequate Staff Training In How To Implement Feeding Plans.

Staff training is key in ensuring adequate nutritional management and implementation of feeding plans. Tr. 7/29/93 (McGowan) at 160-161. Dr. Sheppard agrees that direct care staff need frequent and specific training about how to feed the residents for whom they are responsible. Tr. 10/18/93 (Sheppard) at 16. In addition to generalized training, direct care staff need specific training in how to care for the unique needs of the specific individuals for whom they are responsible. Tr. 7/29/93 (McGowan) at 161-162, 238. Just as feeding plans must be individualized to address the needs of each resident, so too, each staff person responsible for implementing the feeding plan must receive training specifically on that plan. Tr. 7/29/93 (McGowan) at 161, 238. This is known as "competency based training" which entails teaching staff basic principles, demonstrating the principles on the individuals on whom they will be used, requiring staff to demonstrate their proficiency in performing the activity, and monitoring staff performance to ensure they continue to perform the activity correctly. Tr. 7/29/93 (McGowan) at 238. Both Dr. Hinkle and Dr. Sheppard agree that demonstrating competency should be a part of feeding training. Tr. 10/18/93 (Sheppard) at 28; Tr. 12/16/93 (Hinkle) at 35, 42-43. In fact, Dr. Hinkle agrees that competency-based

training is critical and includes it among the steps that an institution should take to ensure safe feeding. Tr. 12/16/93 (Hinkle) at 35; U.S. Exh. 1120. Ebensburg did not even begin to provide competency based training in how to feed residents until August 19, 1993, after the United States rested its case-in-chief. Tr. 10/15/93 (Bellomo); U.S. Exh. 1000. As of the time of her July 1993 tour, Dr. Sheppard agreed that Ebensburg needs to improve its staff training by establishing a schedule for retraining staff. Tr. 10/18/93 (Sheppard) at 25. There is also a need for more professional staff, such as occupational and speech pathologists, to monitor mealtimes at Ebensburg. Tr. 7/29/93 (McGowan) at 230-231.

The professional and paraprofessional staff at Ebensburg are not involved in training staff in how to feed residents and implement feeding plans. As of January 1993, the Dysphagia Team at Ebensburg had not provided any formal training sessions to Ebensburg staff within the past year. Tr. 10/18/93 (Sheppard) at 19; U.S. Exh. 613 (Frye Dep.) at 44. The Dysphagia Team was also not involved in training staff in how to implement feeding plans even after the Team reviewed, revised, and developed new plans during the fall of 1992. U.S. Exh. 613 (Frye Dep.) at 177-178; U.S. Exh. 638A (Stiles Dep.) at 72. Ms. Malloy, who has written feeding plans, has never provided any demonstrations to staff about to how to feed them individuals. U.S. Exh. 622 (Malloy Dep.) at 89. Sue Fagan, LOTA in Keystone, is not involved in training direct care staff in how to implement feeding plans. U.S. Exh. 610 (Fagan Dep.) at 84. Instead, staff training in feeding plans consists of staff reading the procedure. U.S. Exh. 610 (Fagan Dep.) at 84; U.S. Exh. 622 (Malloy Dep.) at 89.

When Mr. Tackett started working in Keystone in the late fall of 1991, he was responsible for feeding residents on his very first day without having had any training in how to feed them. Tr. 8/3/93 (Tackett) at 7-8. He was not aware of nor did he have any contact with the Dysphagia Team while he was at Keystone. Tr. 8/3/93 (Tackett) at 13.

When staff not regularly assigned to Keystone House are pulled in from another building to cover staff shortages, they feed individuals without any oral instructions or demonstrations. Domino Deposition at 77, lines 12-25. The only effort that is made to familiarize pulled staff with the unique feeding needs of individuals at Keystone is through the mealtime supplemental procedures book. U.S. Exh. 604 (Bonfanti Dep.) at 19. This consists of looking at the picture and procedure and signing the staff person's name to the staff instruction record. U.S. Exh. 604 (Bonfanti Dep.) at 19; U.S. Exh. 609 (Domino Dep.) at 76-77.

5. Ebensburg Paraprofessional And Professional Staff
Have Not Received Adequate Training In Nutritional
Management And Feeding Individuals With
Developmental Disabilities.

Kathy Wagner, the head of the Dysphagia Team since its inception, did not take any courses during her academic training in dysphagia. U.S. Exh. 641 (Wagner Dep.) at 223. The only training that the Dysphagia Team received at the point that it was formed was a two day seminar on dysphagia. U.S. Exh. 641 (Wagner Dep.) at 219. The seminar, however, did not apply specifically to individuals with mental retardation. U.S. Exh. 641 (Wagner Dep.) at 220. She did not receive any further training in dysphagia until two years later when she attended two seminars at Allegheny General Hospital. The first seminar at Allegheny General Hospital was in the fall of 1992. U.S. Exh. 641 (Wagner Dep.) at 29,

30, 31. Mary Frye also attended the training. U.S. Exh. 641 (Wagner Dep.) at 29. The training covered dysphagia and its relationship to respiration. U.S. Exh. 641 (Wagner Dep.) at 29. The other two members of the Dysphagia Team, Karen Fulton and Marcia Stiles, did not attend the training. U.S. Exh. 641 (Wagner Dep.) at 29. The training did not deal in any way with individuals who are mentally retarded. U.S. Exh. 641 (Wagner Dep.) at 30. Ms. Wagner subsequently attended another seminar at Allegheny General Hospital in late 1992 on the same topic. U.S. Exh. 641 (Wagner Dep.) at 221. She still feels, however, that she needs additional training on swallowing and its relationship to dysphagia. U.S. Exh. 641 (Wagner Dep.) at 34.

Mary Frye has been the LOTA on the Dysphagia Team since it was formed in June 1990. U.S. Exh. 613 (Frye Dep.) at 12, 13, 14. The only specialized training that Ms. Frye has received with respect to feeding or swallowing issues were two seminars on dysphagia, one in 1990 when the Team was formed and the other in the fall of 1992 by Allegheny General Hospital, which she attended with Ms. Wagner. U.S. Exh. 613 (Frye Dep.) at 23, 26. Ms. Frye did not learn anything new in the 1992 seminar.

Marcia Stiles, a registered nurse who was appointed to the Dysphagia Team in September 1992, has expressed the need to attend the outservice training in dysphagia that both Ms. Wagner and Ms. Frye attended in 1990. U.S. Exh. 638A (Stiles Dep.) at 9, 56-57, 89. She has not been permitted to attend the training because it has not been offered at a location close to Ebensburg. U.S. Exh. 638A (Stiles Dep.) at 89.

Ms. Wagner admits that there are areas where additional knowledge would be beneficial to the Dysphagia Team. U.S. Exh. 641 (Wagner Dep.) at 34. In addition to more

information about dysphagia and its relationship to respiration, she would like to use video fluoroscopic studies more and would like additional information about ultrasound imaging as a diagnostic tool. U.S. Exh. 641 (Wagner Dep.) at 34. There is no budget for the Dysphagia Team for training opportunities even though Ms. Wagner believes that there should be such a budget. U.S. Exh. 641 (Wagner Dep.) at 31. The Dysphagia Team at Ebensburg does not have a library nor has it ever conducted a literature search on dysphagia and other swallowing and feeding problems. U.S. Exh. 641 (Wagner Dep.) at 224. She would like to have a library and begin to extrapolate trends but there is no time to do that. U.S. Exh. 641 (Wagner Dep.) at 225.

Lana Geriak is a LOTA who is responsible for feeding residents and supervising other staff feeding residents. U.S. Exh. 615 (Geriak Dep.) at 78, 95. She has not had any inservices on feeding techniques within the past two years. U.S. Exh. 615 (Geriak Dep.) at 79. She has had no educational background or training courses with respect to feeding individuals with mental retardation, nor has she attended any seminars or outservice training. U.S. Exh. 615 (Geriak Dep.) at 80, 84. She is not satisfied with her knowledge of how to feed people at Ebensburg and would like to learn more. U.S. Exh. 615 (Geriak Dep.) at 81.

Lisa Schofield, a LOTA who worked at Keystone between 1989 and May 1992 and was involved with developing feeding plans for Keystone residents, also wishes that she knew more about how to safely and effectively feed individuals who are mentally retarded. U.S. Exh. 629 (Schofield Dep.) at 38. The only outservice training that Ms. Schofield has had with respect to feeding individuals who are mentally retarded was a four hour course at another State facility. U.S. Exh. 629 (Schofield Dep.) at 35-37. The only other expertise

she has to evaluate feeding problems is based on her experience at Ebensburg. U.S. Exh. 629 (Schofield Dep.) at 37.

Claire Domino has been a Residential Services Supervisor at Keystone since 1986 and also serves as a Qualified Mental Retardation Professional for Keystone clients. U.S. Exh. 609 (Domino Dep.) at 8, 9, 13. She is responsible for supervising staff as they feed residents. U.S. Exh. 609 (Domino Dep.) at 14-15. She is also pictured on the United States' videotape feeding Joseph R. who extends his head back during the feeding process. Tr. 7/29/93 (McGowan) at 126-127; U.S. Exh. 258. Ms. Domino has never had any outservice training. U.S. Exh. 609 (Domino Dep.) at 49. She wants both more in-house and outside training. U.S. Exh. 609 (Domino Dep.) at 64. In particular, she believes that "someone from the outside" is needed to present training. U.S. Exh. 609 (Domino Dep.) at 64. To her knowledge, no one from the outside has ever provided training to Ebensburg on feeding issues. U.S. Exh. 609 (Domino Dep.) at 65. She does not feel completely satisfied or comfortable with her level of knowledge of feeding techniques. U.S. Exh. 609 (Domino Dep.) at 56.

Sue Fagan is a LOTA in Keystone who is shown on the United States' videotape feeding Tim P. additional food and fluid while his mouth is full of food that he is unable to swallow. Tr. 7/29/93 (McGowan) at 115; U.S. Exh. 258. The only training Ms. Fagan received in how to feed individuals with developmental disabilities and physical disabilities was in 1980 from an occupational therapist at Keystone. U.S. Exh. 610 (Fagan Dep.) at 25-26, 34. Ms. Fagan has not had any courses outside of Ebensburg on how to feed individuals with physical disabilities. U.S. Exh. 610 (Fagan Dep.) at 34.

Although Dr. Sheppard offered her opinion that there were "professional judgments" in Ebensburg's decisions about how to train staff in feeding programs, she did not know who made these judgments or the content of any training. Tr. 10/18/93 (Sheppard) at 20, 21. Dr. Sheppard did not question direct care staff concerning their knowledge about feeding and did not sit in on any staff training sessions. Tr. 10/18/93 (Sheppard) at 16.

6. Ebensburg Has Failed Even In Its Minimal Efforts At Nutritional Management Activities.

a. Ebensburg's Dysphagia Team Has Been Ineffective And Has Failed In Its Mission.

Ebensburg's Dysphagia Team was formed in June 1990. U.S. Exh. 641 (Wagner Dep.) at 12. There are four members on the Team: Kathleen Wagner, a speech therapist has headed the team since its inception. U.S. Exh. 641 (Wagner Dep.) at 25. ^{57/} The other members are Mary Frye, LOTA, Karen Fulton, a dietician, and Marcia Stiles, a nurse. U.S. Exh. 641 (Wagner Dep.) at 17. A nurse was not added to the Team until November 1992, after Ms. McGowan conducted her first tour of Ebensburg. U.S. Exh. 641 (Wagner Dep.) at 18.^{58/} Mary Frye has been the occupational therapy representative on the Dysphagia Team since it was formed in June 1990. U.S. Exh. 613 (Frye Dep.) at 12, 13, 14. She is an occupational therapy assistant. U.S. Exh. 613 (Frye Dep.) at 8. There is no occupational therapist on the Team, only an occupational therapy assistant.

^{57/} Mr. Bellomo testified that as of the time of his testimony, Tom Huber had replaced Kathy Wagner as the head of the Dysphagia Team. Tr. 10/13/93 (Bellomo) at 185.

^{58/} Ms. Sponsky had input into selection Ms. Stiles as a nurse representative on the Dysphagia Team. U.S. Exh. 637 (Sponsky Dep.) at 71. Ms. Sponsky, however, does not know anything about Ms. Stiles' specific training or qualifications in the area of dysphagia and does not know if she had any training to carry out her responsibilities on the Dysphagia Team. Id.

Mr. Bellomo created the Dysphagia Team:

1. to review every individual in the facility who was on a texture modified diet;
2. to assess any individual who had a swallowing disorder; and
3. to gain enough skill at Ebensburg in the area of dysphagia that Ebensburg's Dysphagia Team would be looked to as a resource for the Commonwealth of Pennsylvania.

Tr. 10/14/93 (Bellomo) at 47-48.

As of the time of their depositions on January 6 and 7, 1993, both Ms. Wagner and Ms. Frye confirmed that none of these objectives had been accomplished two and a half years later:

1. Ms Frye testified that the Dysphagia Team had never been responsible for evaluating everyone in the facility on a texture modified diet. U.S. Exh. 613 (Frye Dep.) at 189;

2. Instead of assessing every individual who had a swallowing disorder, Ms. Wagner's best estimate was that as of January 7, 1993, Ebensburg had only evaluated five per cent of all individuals at Ebensburg who had a swallowing disorder. U.S. Exh. 641 (Wagner Dep.) at 121; and

3. Ebensburg's Dysphagia Team does not function as a consultant to other mental retardation facilities throughout the Commonwealth. U.S. Exh. 641 (Wagner Dep.) at 173. No other State facilities have contacted Ebensburg's Dysphagia Team for consultation in the area of dysphagia. U.S. Exh. 641 (Wagner Dep.) at 174.

The Dysphagia Team only operates on a part-time basis at Ebensburg. Its only regularly scheduled meeting time is once a week for three hours. U.S. Exh. 641 (Wagner Dep.) at 26. This meeting time was not established until October 1992 and the Team had to get special permission from Mr. Bellomo to establish it. U.S. Exh. 641 (Wagner Dep.) at 26, 38, Wagner Dep. Exh. 14. The Team members have limited amounts of time that they can devote to the Team because of their other job responsibilities. U.S. Exh. 641 (Wagner Dep.) at 38. Ms. Wagner believes that if the members of the Dysphagia Team had more

time to devote to dysphagia issues, the Team could provide more staff training, could follow up on clients assessed by the Team, and could establish networks with other hospitals and with other health care professionals at Ebensburg. U.S. Exh. 641 (Wagner Dep.) at 116. Ms. Frye admits that if the Dysphagia Team had more time to fulfill its responsibilities it could get involved in positioning during mealtimes. U.S. Exh. 613 (Frye Dep.) at 75. With more time, the Dysphagia Team could ensure that individuals are "upright, symmetrical, [in a] safe position, breathing." U.S. Exh. 613 (Frye Dep.) at 75, lines 11-12. Ms. Frye also believes that the Dysphagia Team needs more time to respond to any questions that staff may have about the appropriate way to feed individuals and whether individuals are in the safest position for them to be eating. U.S. Exh. 613 (Frye Dep.) at 75.

Key members of the Dysphagia Team have been absent for significant portions of time since the Team was created. For example, Ms. Frye was absent from the Team during a three to five month period in the winter of 1991. U.S. Exh. 641 (Wagner Dep.) at 85. Ms. Fulton did not work on the team for six months from April through the fall of 1992. U.S. Exh. 641 (Wagner Dep.) at 84.

Until the United States took the deposition of Ms. Wagner on January 7, 1993:

- Ebensburg did not have a system for keeping track of dysphagia evaluations;
- Ebensburg did not have a system for referring individuals who had been hospitalized with either aspiration pneumonia or suspected aspiration pneumonia;
- The Dysphagia Team at Ebensburg did not have a mission statement; and
- The Dysphagia Team did not keep any minutes of its meetings.

U.S. Exh. 10004; U.S. Exh. 641 (Wagner Dep.) at 24, 42, 72.

Mr. O'Brien admits that some members of the Dysphagia Team are "just trying out their wings at this point." They need more training and are just now starting to work as a group. U.S. Exh. 624 (O'Brien Dep.) at 185. Mr. O'Brien further admits that even though problems existed for some time, it probably took this lawsuit to get the Dysphagia Team going. U.S. Exh. 624 (O'Brien Dep.) at 188. Wagner Deposition Exhibit 3 is a comprehensive list of all referrals to and assessments by the Dysphagia Team since it was created. U.S. Exh. 641 (Wagner Dep.) at 48-50. There were no referrals to the Dysphagia Team prior to January 1, 1991. U.S. Exh. 641 (Wagner Dep.) at 48.

Dr. Sulkes concluded that Ebensburg Center did not satisfactorily address the medical needs of the residents who are at risk of aspirating because of feeding and swallowing problems with the creation of the Dysphagia Team. Tr. 7/27/93 (Sulkes) at 141. He indicated that he was encouraged when he heard that the Dysphagia Team had been formed in 1990, but after reviewing the Team's performance through record review and observation of the residents, he concluded that nothing had really changed. Tr. 7/27/93 (Sulkes) at 114.

b. Ebensburg's Attempts To Develop And Revise Feeding Plans In Late 1992 Were Not Professionally Grounded.

Mr. O'Brien admits that the Justice Department's concerns with aspiration relating to feeding positions forced Ebensburg to look more closely at the issues sooner than they might have otherwise. U.S. Exh. 624 (O'Brien Dep.) at 52. Mr. Bonfanti, Unit Manager for Keystone, thinks that Ebensburg did not identify problems with feeding practices before they were highlighted during the litigation because Ebensburg wasn't "see[ing] the forest for the trees. . . There it was in front of us all these years, but now we see it." U.S. Exh. 604 (Bonfanti Dep.) at 74, lines 2-4.

At the suggestion of the Justice Department's experts, Ebensburg reviewed and revised feeding plans and took pictures of Keystone residents in the fall of 1992 to illustrate the position in which they should be fed. U.S. Exh. 641 (Wagner Dep.) at 181-182. The Dysphagia Team members along with the Director of Occupational Therapy were responsible for this effort. Ms. Wagner felt that this effort was "all very beneficial," "a fine idea." U.S. Exh. 641 (Wagner Dep.) at 181, line 24 through 182, line 5.⁵⁹/ The pictures taken reflected the revised feeding plans and the consensus of the group reviewing the procedures that the feeding position was appropriate. U.S. Exh. 641 (Wagner Dep.) at 188, 194. No one outside of Ebensburg was consulted in this process. U.S. Exh. 629 (Schofield Dep.) at 69-70.

The pictures in fact demonstrate extremely poor positions for feeding. Tr. 7/29/93 (McGowan) at 149-150. Ms. McGowan identified pictures for twenty-five Keystone residents that illustrate them being fed with their heads hyper-extended, hyper-extended and rotated, and with their trunks improperly aligned. *Id.*; U.S. Exh. 137. This effort thus failed to accomplish correct positioning during mealtimes.

The pictures reflect the poor process that Ebensburg used to develop them. Tr. 7/29/93 (McGowan) at 151. They were taken in a very brief period of time. The entire process of reviewing each resident's feeding plan to determine if it was adequate, deciding on the appropriate position, and taking the picture took between five to ten minutes for each individual. U.S. Exh. (Frye Dep.) at 175. In Keystone, the process of reviewing the plans

⁵⁹/ Mr. Bonfanti feels that recommendations made by Department of Justice consultants about mealtimes have "absolutely" been useful and helpful. U.S. Exh. 604 (Bonfanti Dep.) at 73. Mr. Devine agrees that Ms. McGowan's feedback during her tours "was helpful to us." U.S. Exh. 608 (Devine Dep.) at 80, line 4.

and taking the pictures only took a total of approximately 6 hours over one and a half days. U.S. Exh. (Frye Dep.) at 182.

The timeline for accomplishing this project was very short. In Kathleen Wagner's words, "[i]t appeared imperative that this be done and get done." U.S. Exh. 641 (Wagner Dep.) at 196-197, lines 1-2. Ms. Graham confirmed that there was a directive to complete the project at Keystone within several work days. U.S. Exh. 618 (Graham) at 43-44. She felt that there should have been more time to complete the project because some of the feeding plans later had to be revised. U.S. Exh. 618 (Graham) at 43.

Once the team completed the process of revising procedures and taking pictures, it did not provide any formal or competency based training to staff in the mealtime supplemental procedures. U.S. Exh. 641 (Wagner Dep.) at 201-202. At best, staff were informed by the QMRP to read the revised supplemental procedures and the Dysphagia Team was available if staff had questions. U.S. Exh. 641 (Wagner Dep.) at 201.

c. The Dining Observation Form Was Implemented Without Adequate Understanding.

Following Ms. McGowan's tour in August 1992 and at her recommendation, Ebensburg developed a form to observe residents during mealtimes. U.S. Exh. 637 (Sponsky Dep.) at 14-15. The dining observation form was not implemented until October 19, 1992. U.S. Exh. 604 (Bonfanti Dep.) at 78; U.S. Exh. 604 (Bonfanti Dep.) Exh. 5. Unit Managers did not receive any instructions when they received the form about how to complete it. U.S. Exh. 604 (Bonfanti Dep.) at 79. Mr. Bonfanti did not understand such key terms on the form as "eating with head in extension" or "sitting in posterior pelvic tilt." U.S. Exh. 604 (Bonfanti Dep.) at 79. At the time that he asked QMRP's to make the

assessments on the form, he was not satisfied that they were qualified to make the assessments called for by the form such as head in extension and posterior pelvic tilt. U.S. Exh. 604 (Bonfanti Dep.) at 80. Indeed, Claire Domino was one of the individuals responsible for filling out the forms that were developed for dining observations. U.S. Exh. 609 (Domino Dep.) at 67. She did not receive any instructions with the form. U.S. Exh. 609 (Domino Dep.) at 67. At the time that she completed the form, she did not know what sitting in posterior pelvic tilt meant. She asked Sue Fagan, the occupational therapy aide assigned to Keystone, what the term meant and was provided with the wrong definition. U.S. Exh. 609 (Domino Dep.) at 69. In fact, based upon her conversation with the occupational therapy aide, Ms. Domino thought that posterior pelvic tilt was a correct sitting position which staff should be striving to achieve. U.S. Exh. 609 (Domino Dep.) at 70. It was not until her conversation with Ms. McGowan during her tour of Ebensburg in November 1993, that Ms. Domino learned the correct definition of posterior pelvic tilt. U.S. Exh. 609 (Domino Dep.) at 71-72. Ms. Domino learned other new information, as well, from her conversation with Ms. McGowan at that time. Id.

Ms. Malloy, a nurse supervisor at Keystone who has written a number of feeding plans for Keystone residents, filled out the dining room observation form for all 24 individuals at Keystone for whom she is the QMRP. U.S. Exh. 622 (Malloy Dep.) at 90-91. She was not given any instructions in how to fill out the form other than a cover memo detailing the timeline for completion U.S. Exh. 622 (Malloy Dep.) at 91. At the time that she completed the form, she did not know what eating in posterior pelvic tilt meant. U.S. Exh. 622 (Malloy Dep.) at 91-92. She also did not think it was possible for individuals in

carts to have their head in extension. U.S. Exh. 622 (Malloy Dep.) at 92. Staff completing the form in Keystone did not think that the items regarding amount of food or fluid lost while eating and drinking were applicable to individuals who were fed. U.S. Exh. 622 (Malloy Dep.) at 93. Ms. Malloy participated in a discussion with Ms. McGowan on November 12, 1992, where Ms. McGowan explained what posterior pelvic tilt was. U.S. Exh. 622 (Malloy Dep.) at 105. Ms. Malloy thought that Ms. McGowan is "a very fascinating person." U.S. Exh. 622 (Malloy Dep.) at 106, line 2. Ms. Malloy also found "very useful" Ms. McGowan's demonstration of how to reposition individuals during mealtimes. U.S. Exh. 622 (Malloy Dep.) at 106. Ms. Malloy is "sure that there are things that we have yet to learn" about how to safely and effectively feed individuals at Keystone. U.S. Exh. 622 (Malloy Dep.) at 109, line 4. Ms. Malloy found the recommendations by Justice Department experts to be helpful and she is "willing to learn some more." U.S. Exh. 622 (Malloy Dep.) at 109, line 19.

Mr. Hauenstein, an Ebensburg physical therapist, agreed that staff responsible for filling out the dining observation forms did not understand what key terms meant. U.S. Exh. 619 (Hauenstein Dep.) at 108. In his conversations with staff, including nurses or QMRP's, staff admitted that they were confused. U.S. Exh. 619 (Hauenstein Dep.) at 109. Mr. Hauenstein agrees that if staff were using the form, they should have known what the terminology meant, including "eating with head in extension" and "sitting in posterior pelvic tilt." U.S. Exh. 619 (Hauenstein Dep.) at 128.

Staff in living units other than Keystone also did not understand what terms on the form meant. For example, Mr. McGuire, Unit Manager of Horizon, who was responsible

for overseeing the process in his building, did not understand what sitting in posterior pelvic tilt was. U.S. Exh. 623 (McGuire Dep.) at 130. In yet other living units, such as Laurel House, the staff responsible for filling out the Dining Observation Forms were told to just ignore the sections on positioning. U.S. Exh. 631 (Seymour Dep.) at 85, 86, lines 1-10. At least nineteen people in Laurel are confined to a wheelchair. U.S. Exh. 1015.

No one was responsible for following up to ensure that appropriate action was taken based upon information from the Dining Observation Form. U.S. Exh. 631 (Seymour Dep.) at 90. Ebensburg's Director of Nursing participated in developing the form but did not review a single completed form. U.S. Exh. 637 (Sponsky Dep.) at 17. She was not aware that staff did not have adequate knowledge to complete the dining observation form until Ms. McGowan returned to Ebensburg in November 1992 and pointed it out. U.S. Exh. 637 (Sponsky Dep.) at 19. Ms. Graham has never used information from the dining observation form to assist her in conducting evaluations of individuals in the area of feeding, positioning or oral motor status but thinks it would be important information to taken into consideration in conducting these types of evaluations. U.S. Exh. 618 (Graham) at 62. Information from the dining observation forms was also not used when a team was constituted in the fall of 1992 to review and develop feeding plans. U.S. Exh. 613 (Frye Dep.) at 176.

C. Ebensburg's Treatment Of Jeff K. Is Illustrative Of Medical And Nutritional Management Issues.

Jeff K. died of aspiration pneumonia during the course of this trial on September 30, 1993. U.S. Exh. 1108. Dr. Rubin describes the story of his life and death as a "sad one" which is illustrative of systemic interdisciplinary issues, including "issues of seizure management, issues of nutrition, issues of feeding, issues in the evaluation of

gastroesophageal reflux, issues in the monitoring of health and well-being, in the securing of consultants, on a regular basis, in working with it and working closely with the regional hospitals to adequately deal with the patients who are referred to them." Tr. 12/13/93 (Rubin) at 110.

One of the factors contributing to Jeff's death identified by Ebensburg is "underweight compounded by his poor eating ability and dysphagia" which was "complicated by muscle relaxation from high dose Klonopin in attempt to relieve his absence seizures." U.S. Exh. 1108, Death/Discharge Summary at 10. Jeff was on Klonopin for the eleven months leading up to his death. U.S. Exh. 1108, Death/Discharge Summary at 6. In Ebensburg's review of Jeff's death, the Mortality and Morbidity Committee notes that one of the side effects of Klonopin is increased secretions, a weakening of the swallowing muscle, and dysphagia. U.S. Exh. 1108, M. & M. Comm. Mtg. Minutes at 5. In the eight months prior to his death while he was on Klonopin, Jeff went from an "independent feeder, to the staff having to feed him, to the staff being afraid to feed him, to supervisors feeding him, then to a G-tube." *Id.* During the summer before Jeff died, Ebensburg "let the staff feed him again. He started to develop more aspiration." *Id.* In fact, during her tour of Ebensburg in July 1993, Dr. Sheppard observed a direct care staff person feeling Jeff K. thin liquids despite the fact that his feeding procedure states in big capital letters "No THIN LIQUIDS" and specifically instructs staff to thicken his liquids to a "pudding consistency." Tr. 10/18/93 (Sheppard) 88-89; U.S. Exh. 1002.^{60/}

^{60/} Dr. Sulkes notes that even a small amount of aspiration is an irritant which is "always a set up for potentially a bigger problem." Tr. 7/27/93 at 107.

Ebensburg's physician acknowledges that Jeff's dysphagia problems "at the end were due to the Klonopin." Id. Despite the difficulties that Jeff was having, he was not screened by the Dysphagia Team until May 14, 1993. The Dysphagia Team determined that he had severe dysphagia and observed him coughing more than forty-four times during the mealtime. U.S. Exh. 970. The Team did not note that he was on Klonopin.^{61/} At the time of his dysphagia evaluation, Jeff's BMI was 15.21, this is more than 25% below the lowest number of the acceptable BMI range of 21-27. Id. Dr. Sheppard believes that an individual with this low a body weight is at significant risk due to their low body weight and compromised nutritional status. Tr. 10/18/93 (Sheppard) at 67-68.

During his review of the Mortality and Morbidity Committee review of Jeff K.'s death, Dr. Rubin was "frustrated" that the clinical management issues discussed during the review had not been explored by the group prior to Jeff K.'s death. Tr. 12/13/93 (Rubin) at 106. For example, during the Mortality and Morbidity Committee review of Jeff's death, Mr. Bellomo determined that it was important that Ebensburg's pharmacist provide the Dysphagia Team with a list of medications that can cause dysphagia. U.S. Exh. 1108, M. & M. Comm. Mt. Minutes at 5. This same issue had previously been raised by the United States during the deposition of John Fris, Ebensburg's pharmacist some eleven months earlier. During his deposition, Mr. Fris admitted that the Ebensburg pharmacy does not

^{61/} As noted earlier, no one on the Dysphagia Team is responsible for reviewing medications when evaluating a resident for potential dysphagia. U.S. Exh. 641 (Wagner Dep.) at 106. The Team never directly consults with Ebensburg's pharmacist. U.S. Exh. 641 (Wagner Dep.) at 107. At most, the Team only refers to the pharmacist's annual report in the resident's chart. U.S. Exh. 641 (Wagner Dep.) at 107. Although Ms. Wagner is aware that seizure medications and anti-psychotics can cause dysphagia and use of these medications is one of the most common reasons that dysphagia occurs in Ebensburg residents, she is unaware of the specific types of seizure medications and anti-psychotics that are more likely to cause dysphagia. U.S. Exh. 641 (Wagner Dep.) at 14.

keep a list of the individuals who are prone to aspiration. U.S. Exh. 612 (Fris Dep.) at 89-90. Although he agreed that there are a number of medications that can contribute to chewing or swallowing difficulties, he was not aware of those individuals with chewing or swallowing difficulties at Ebensburg. U.S. Exh. 612 (Fris Dep.) at 92. Moreover, he has never tried to find out which individuals have serious medical conditions that could be adversely affected by medications. U.S. Exh. 612 (Fris Dep.) at 93. Mr. Fris further admitted that it is important to have a list of all of the presenting conditions of all of the individuals at Ebensburg, but there are not enough pharmacists to maintain such a list. U.S. Exh. 612 (Fris Dep.) at 90, 93. To not have such a list is "obvious risk." U.S. Exh. 612 (Fris Dep.) at 90, line 16.

XI. MEALTIMES AT EBENSBURG ARE UNSAFE AND DO NOT MEET ACCEPTED PROFESSIONAL STANDARDS.

A. Overview

There are four major areas of systemic deficiencies at Ebensburg that represent dangerous and unprofessional practices during mealtimes:

1. Ebensburg residents are eating and being fed in unsafe positions;
2. Ebensburg staff are feeding residents using unsafe practices;
3. Ebensburg residents are eating unsafely with no staff intervention; and
4. The dining environment at Ebensburg is generally unsafe.

Tr. 7/29/93 (McGowan) at 91-92. Ms. McGowan observed these problems to be pervasive throughout her three visits to Ebensburg during 1992 and 1993. *Id.* at 92. Dr. Sulkes has had similar concerns throughout his many tours of Ebensburg beginning in 1989. Tr. 7/27/93 (Sulkes) at 99-106. Dr. Sheppard admits that there were occasions during her tours of Ebensburg, as well, where residents were at risk or danger of harm due to feeding practices. Tr. 10/12/93 (Sheppard) at 106. Despite the fact that Ms. McGowan held a special session with Ebensburg's facility director, the Director of Nursing, and other Ebensburg administrators at the end of her first tour in August 1992 to express significant concern about these dangerous practices, the same problems continue and pose "life-threatening" conditions. Tr. 7/29/93 (McGowan) at 138, 139, 142, 143, 194. The only changes that were apparent during Ms. McGowan's subsequent tours were five new stools in Keystone for staff to sit on during feeding, only one of which was used, and, six months later, a marginal increase in the amount of time that some Ebensburg residents took to

consume their meals. Tr. 7/29/93 (McGowan) at 139, 142, 229.^{1/} Ms. McGowan also specifically recommended that Ebensburg bring in outside consultants to help the facility address the unsafe practices that she identified. Tr. 7/29/93 (McGowan) at 139.

Ebensburg's Director of Occupational Therapy strongly agreed that there was a need to bring in consultants with special expertise in mealtime positioning and expressed this need during her deposition in January 1993 when Mr. Bellomo was present. U.S. Exh. 617 (Graham Dep.) at 155. Ebensburg failed, however, to bring in any such consultants. Tr. 10/15/93 (Bellomo) at 14.

B. Ebensburg Residents Are Experiencing Obvious Harm From Unsafe Mealtime Practices.

During the course of her observations of 21 mealtimes at Ebensburg during August 1992, November 1992, and February 1993, Ms. McGowan observed "an overwhelming amount of visible evidence" of individuals experiencing problems from these unsafe mealtime practices by coughing, vomiting, and demonstrating respiratory distress. Tr. 7/29/93 (McGowan) at 91, 96-97, 128-132. As far back as February 1990, the Commonwealth was on notice through the United States' CRIPA investigation of grave concerns about Ebensburg's mealtime practices because residents were coughing and choking on food during mealtimes and suffering aspiration. U.S. Exh. 638 (Sponsky Dep.) Exh. 50 at 3.^{2/} The

^{1/} Instead of residents consuming their meals in two to four minutes, the time increased in some instances to eight to nine minutes, although Ms. McGowan continued to see some individuals eat at unsafe paces, such as two and five minute meals. Tr. 7/30/93 (McGowan) at 33.

^{2/} Coughing is a compensation for food that is entering the airway and is a visible sign of choking. Tr. 12/13/93 (Rubin) at 101; U.S. Exh. 641 (Wagner Dep.) at 58. When someone chokes, it means that food is entering the larynx. U.S. Exh. 641 (Wagner Dep.) at 58. If food or liquid penetrates the trachea and lungs, aspiration results. U.S. Exh. 641 (Wagner Dep.) at 58, 65.

following examples are among the many instances of coughing and other forms of distress that Ms. McGowan observed and documented during her mealtime observations at Ebensburg several years after the Commonwealth was put on notice of the United States' concerns:

- On August 17, 1992, James M. was being fed by a LOTA. He was spitting out almost every bite and coughing. Tr. 7/29/93 (McGowan) at 98. On August 21, 1992, he is shown on the videotape repeatedly coughing as a result of being fed with his head in extension. *Id.* at 129-130. The head of Ebensburg's Dysphagia Team has also observed James frequently coughing and possibly choking during meals. U.S. Exh. 641 (Wagner Dep.) at 60, 61.

- On August 18, 1992, Frank H. was coughing significantly and losing liquid out of both sides of his mouth as he was being fed fluids. Tr. 7/29/93 (McGowan) at 98. The head of Ebensburg's Dysphagia Team has also observed Frank frequently coughing and possibly choking during meals. U.S. Exh. 641 (Wagner Dep.) at 60, 61. Dr. Sheppard also observed Frank during July 1993 "distressed" and "ejecting food," almost one year after Ms. McGowan's similar observations. Tr. 10/18/93 (Sheppard) at 92. In light of Frank's history of hospitalizations for lung related problems, Dr. Sulkes also had concerns about Frank's position in his cart when he has observed Frank being fed. Tr. 7/27/93 (Sulkes) at 105.

- On August 18, 1992, Ron E. was coughing with almost every swallow and having difficulty breathing. Tr. 7/29/93 (McGowan) at 99-100. On August 20, 1992, he was coughing and spurting out food during the mealtime. Immediately after the meal, he was kept flat on his back in his living unit and continued coughing in an attempt to expel what was trapped in his airway. *Id.* at 112, 113, 128; U.S. Exh. 229. Three months later, in November 1992, Ebensburg's Director of Occupational Therapy noted that Ron was having difficulty during mealtimes and thought that until Ebensburg got an expert in to assist with Ron, all staff can do is "trial and error." U.S. Exh. 617 (Graham Dep.) at 179. The head of Ebensburg's Dysphagia Team also observed Ron frequently coughing and possibly choking during meals. U.S. Exh. 641 (Wagner Dep.) at 60, 61.

- On February 22, 1993, Patti W. was fed with additional mouthfuls before she had swallowed what was in her mouth. She was repeatedly coughing and regurgitating. Tr. 7/29/93 (McGowan) at 100.

- On August 21, 1992, Beth S. is pictured on the United States' feeding videotape (U.S. Exh. 258) immediately after her meal, continuously coughing in an attempt to clear her airway. Tr. 7/29/93 (McGowan) at 121-122. On February 22, 1993, Ms. McGowan again observed Beth coughing as she was fed with her head in extension. Tr. 7/29/93 (McGowan) at 100.

- On November 12, 1992, Andrea S. is pictured on the feeding videotape, biting the spoon and, at one point, spurting out food as she is being fed with her head in extension. U.S. Exh. 258.^{3/}

- On both August 21, 1992 and November 12, 1992, Tony (Anthony) R. was coughing, regurgitating, and refluxing during and after his meals. Tr. 7/29/93 (McGowan) at 128-129. He has been hospitalized for aspiration pneumonia and has an area of tissue death on the top palate of his mouth from constant regurgitation. *Id.* at 128. By July 1993, Tony had a gastrostomy tube and was being fed orally as a supplement to his tube feeding. Tr. 10/18/93 (Sheppard) at 132. Dr. Sheppard continued to see Tony coughing repeatedly throughout his meal with copious oral secretions during July 1993. Tr. 10/18/93 (Sheppard) at 100, 102. The head of the Dysphagia team at Ebensburg also admits that she has observed Tony frequently coughing and possibly choking during meals. U.S. Exh. 641 (Wagner Dep.) at 60, 61.

- On November 12, 1992, Raymond W. is shown on the feeding videotape persistently and forcefully coughing with his head back in extension. Tr. 7/29/93 (McGowan) at 130-131. The head of Ebensburg's Dysphagia Team has observed Raymond frequently coughing and possibly choking during meals. U.S. Exh. 641 (Wagner Dep.) at 60, 61. Raymond has a history of aspiration pneumonia. U.S. Exh. 144. When the Dysphagia Team finally screened him on June 22, 1993, it found that he was coughing and distressed throughout the meal, his positioning was problematic, he had severe dysphagia, and was more than 50% below the lowest range of acceptable body weight. U.S. Exh. 970. See discussion on body weight *supra* § X.B.1.

- On August 21, 1992, David K. appears on the feeding videotape, coughing profusely with food still in his mouth after he was fed with his head in extension. Tr. 7/29/93 (McGowan) at 131-132. Dr. Sheppard agrees that "he is getting himself in trouble." Tr. 9/12/93 (Sheppard) at 68.

- On August 18, 1993, Ron L. ate very rapidly and immediately vomited into his tray at the conclusion of his meal. He vomited again as he left the dining room. Tr. 7/29/93 (McGowan) at 133.

Ms. McGowan summarized thirty-three additional instances where she observed residents coughing, vomiting, ejecting food, and experiencing respiratory problems at various mealtimes during her tours. U.S. Exh. 535.

^{3/} Andrea S. is incorrectly identified as Beth S. in the July 29, 1993 Transcript (McGowan) describing the feeding videotape at 119. Tr. 7/30/93 (McGowan) at 22.

Dr. Sheppard agrees that frequent episodes of prolonged coughing during a meal is a problem, possibly indicating that the individuals are having difficulty under the circumstances in which they are being fed. Tr. 10/12/93 (Sheppard) at 195. She acknowledges that there were residents on the United States' feeding videotape who were experiencing distress or difficulty (Ron E., Tim P., Duane P., Beth S., Ellen H., David K.). Tr. 10/12/93 (Sheppard) at 47, 50, 57, 60, 61, 68.^{4/} Dr. Sheppard also observed residents coughing and in "distress" during the mealtimes that she observed as recently as July 1993, including John H., Jeff K., Frank H., Duane P., Barry D., and Anthony (Tony) R. Tr. 10/18/93 (Sheppard) at 86, 88, 92 (line 20), 95, 99, 100.

In some cases, residents experience distress at mealtimes even without any outward symptoms. This is the case, for example, with silent aspiration syndrome. Tr. 12/13/93 (Rubin) at 128; Tr. 7/29/93 (McGowan) at 118. Other residents indicate their distress by demonstrating a resistance to eating which could potentially be attributable to medical problems. Tr. 7/29/93 (McGowan) at 119. For example, Paul G. had just returned to Ebensburg from a hospitalization for surgery for bowel obstruction shortly before he is shown on the United States' videotape. Id. at 116-117. He is exhibiting significant resistance to being fed. Id. The feeder, however, persists in feeding him by placing the spoon and glass into his mouth with his head thrust back. Id.; U.S. Exh. 235. Ms. McGowan had particular concerns about Paul because several months earlier he had the

^{4/} Although the feeding videotape shows six residents coughing repeatedly, in her comments on these segments Dr. Sheppard only acknowledged that one of the residents (David K.) was experiencing difficulty. Tr. 10/12/93 (Sheppard) at 68. Instead of recognizing the distress, Dr. Sheppard instead commented on such things as the "productive cough" and the ability of the resident to "compensate." Tr. 10/12/93 (Sheppard) at 65.

ability to feed himself and walk. Tr. 7/30/93 (McGowan) at 21. At the time the videotape was taken, he required total assistance, was confined to a wheelchair, and no longer able to walk, indicating that he was having difficulty controlling his muscles. Id. It is likely that his ability to control the complex muscles inside his mouth to adequately manage food and fluid were also affected. Id. Consequently, the feeder's insensitivity to Paul's difficulties by failing to assist him in keeping his head and trunk in good alignment posed significant risks. Id. at 21-22.

C. Ebensburg Residents Are Eating And Being Fed In Unsafe Positions.

Throughout their numerous observations of mealtimes at Ebensburg, Dr. Sulkes, Ms. McGowan, and Ms. McAllister all repeatedly observed individuals eating and being fed in positions which were unsafe. Tr. 7/27/93 (Sulkes) at 99-105; Tr. 7/28/93 (McAllister) at 206; Tr. 7/29/93 (McGowan) at 91-92. In fact, Ms. McAllister did not see anyone at Ebensburg who was in an appropriate position during the meal times that she observed. Tr. 7/28/93 (McAllister) at 206. Ms. McGowan also did not observe any Ebensburg resident who was in appropriate positioning equipment during mealtimes. Tr. 7/29/93 (McGowan) at 148. Dr. Sulkes observed inappropriate feeding positions and practices at every meal that he observed at Ebensburg. Tr. 7/27/93 (Sulkes) at 99, 105-106. These inappropriate practices did not change substantially from his first tour in 1989 to his most recent tour in 1992. Id. Dr. Sheppard agreed that there were Ebensburg residents whose positions were "very difficult cases to manage" during mealtime and Ebensburg's "solutions were not yet good solutions." Tr. 10/12/93 (Sheppard) at 87. She had particular problems with the inadequate headrests in carts and "very definitely felt that the headrests in carts should have brought the

individuals into better alignment." Tr. 10/18/93 (Sheppard) at 103. Ms. Frye, the LOTA on Ebensburg's Dysphagia Team, also admits that residents are not always properly positioned during mealtimes. U.S. Exh. 613 (Frye Dep.) at 209. If there were proper equipment and an adequate number of staff she thinks that all Ebensburg residents might be able to always be properly positioned during mealtimes. U.S. Exh. 613 (Frye Dep.) at 209. Ms. Frye does not know if anyone is currently assigned to work at Keystone who has sufficient expertise to address positioning issues. U.S. Exh. 613 (Frye Dep.) at 213.

The unsafe positions in which individuals are eating and being fed include positions where individuals' airways are at risk, creating the potential for aspiration, and positions that do not allow food to be processed through the rest of the system in a way that is safe for the individual and allows it to be absorbed adequately and without untoward consequences, such as gastroesophageal reflux. Tr. 7/29/93 (McGowan) at 92. In particular, Ebensburg residents are eating and being fed in the following unsafe positions:

- flat on their backs during the meal and immediately afterwards
- with their heads hyper-extended
- with their heads hyper-extended and rotated
- with their trunks in improper alignment.

Tr. 7/29/93 (McGowan) at 92, 94-95.

1. There Are General Standards For Safe Eating Positions

The general standard for safe eating is a position in which the individual is sitting upright, the trunk is symmetrical, and the head is in a "neutral" position. Tr. 7/29/93 (McGowan) at 93. Proper positioning of the body as well as the neck and head are critical during the eating process. Tr. 7/27/93 (Sulkes) at 96; Tr. 7/29/93 (McGowan) at 102. Inappropriate positioning can lead to aspiration. Tr. 7/27/93 (Sulkes) at 96, 99. Eating is a

complex process which requires precise coordination as food is processed in the mouth and travels down to the stomach. Tr. 7/29/93 (McGowan) at 102. An individual's ability to safely process food is dependent upon proper position of both the body and head. *Id.* Mr. Bellomo agrees that it is "important that people be fed in the optimum position." U.S. Exh. 602 (Bellomo Dep.) at 157, lines 23-25. He claims that in October 1992, following tours by Dr. Sulkes and Ms. McGowan and his review of the United States' proposed consent decree highlighting feeding issues, he insisted that nursing and physical therapy staff "insure that proper position is maintained during meal times and, specifically that meals shall never be fed with a person who's [sic] head is in extension and never while sitting in posterior pelvic tilt." Tr. 10/14/93 (Bellomo) at 30. These practices continued, however, up until the defendants' expert's last tour of Ebensburg in July 1993. Tr. 10/18/93 (Sheppard) at 86-87, 93, 96. Moreover, contrary to Mr. Bellomo's assertion that he personally "insisted" on the physical therapist's involvement in positioning during mealtimes, Mr. Arnall has made it clear that the physical therapists are in no way involved with meal time positioning. Tr. 10/14/93 (Bellomo) at 30; Tr. 10/13/93 (Arnall) at 95.

2. Ebensburg Residents Are Fed On Their Backs, Contrary To Accepted Practice.

Feeding people flat on their backs is an unsafe practice that can result in aspiration and gastrointestinal problems. Tr. 7/27/93 (Sulkes) at 95; Tr. 7/28/93 (McAllister) at 199; U.S. Exh. 762. The Commonwealth's sur-rebuttal expert in feeding agrees that feeding people flat on their backs is an unsafe practice. Tr. 12/16/93 (Hinkle) at 33; U.S. Exh. 1120. It is also difficult for a person to adequately manage food and fluids where the head is in a flat position because gravity pulls the jaw down and the tongue back, thereby affecting

the mobility of the tongue and the ability to retain food in the mouth and properly process the bolus. Tr. 7/29/93 (McGowan) at 98. Virtually every Ebensburg administrator, professional and paraprofessional who was deposed on the topic, including Mr. Bellomo, agreed that it is an inappropriate and dangerous practice to feed people on their backs. U.S. Exh. 602 (Bellomo Dep.) at 139; U.S. Exh. 604 (Bonfanti Dep.) at 74; U.S. Exh. 610 (Fagan Dep.) at 79; U.S. Exh. 613 (Frye Dep.) at 205; U.S. Exh. 629 (Schofield Dep.) at 30; U.S. Exh. 641 (Wagner Dep.) at 68. Ms. McGowan, however, observed Ebensburg staff feeding residents flat on their backs. Tr. 7/29/93 (McGowan) at 94, 97. For example, on August 17, 1992, she observed Joe T. being fed flat on his back despite a feeding program which required his head to be elevated at least thirty degrees. Tr. 7/29/93 (McGowan) at 97. On that same day, she saw Barry D. also being fed in a perfectly flat position despite requirements in his feeding program for elevating both his cart and his head. Tr. 7/29/93 (McGowan) at 97. The foster grandmother who was responsible for feeding him reported that she always fed him in this position. Id. Barry had just returned from the hospital where he had been admitted for a GI bleed. Id. Several years earlier, Dr. Sulkes had observed Barry being fed flat on his back in a cart. Tr. 7/27/93 (Sulkes) at 102.^{5/} Mr. O'Brien confirms that there are individuals who have been fed in a flat position at Ebensburg "for years and years and years." U.S. Exh. 624 (O'Brien Dep.) at 53. Ms. Fagan, a LOTA in Keystone, has also seen Ebensburg residents being fed flat on their backs.

^{5/} At that time, Barry was also being fed by a foster grandmother who received tips on how to feed him from another foster grandmother, not from professional staff. Tr. 7/27/93 (Sulkes) at 102.

U.S. Exh. 610 (Fagan Dep.) at 74, 77. In particular, she confirms that both Barry D. and Joe T. were fed flat on their backs during 1992. U.S. Exh. 610 (Fagan Dep.) at 77-78.

Ms. McGowan specifically advised Mr. Bellomo of her concerns about people being fed flat on their back during her tour in mid-August 1992. U.S. Exh. 602 (Bellomo Dep.) at 139. As of at least several months later, however, individuals at Keystone continued to be fed on their backs, including specific residents about whom Ms. McGowan had concerns in August. For example, Mr. Bellomo observed Barry D. continuing to be fed flat on his back as late as October 1992. U.S. Exh. 604 (Bonfanti Dep.) at 66-67; U.S. Exh. 604 (Bonfanti Dep.) Exh. 4. "He didn't even have a wedge under him or pillow or anything, to have that head elevated." U.S. Exh. 604 (Bonfanti Dep.) at 67, lines 16-17. The staff person feeding Barry was assigned to the 11:00 - 7:30 shift and was working overtime. U.S. Exh. 604 (Bonfanti Dep.) at 66. The staff person was not familiar with feeding Barry and did not consult his supplemental feeding procedure. U.S. Exh. 604 (Bonfanti Dep.) at 66. Mr. Bellomo also had concerns in mid-October 1992 that Ron P. was continuing to be fed in a position which was almost flat on his back. U.S. Exh. 184; U.S. Exh. 604 (Bonfanti Dep.) at 65; U.S. Exh. 604 (Bonfanti Dep.) Exh. 3. Ron P. can no longer eat orally and now has a feeding tube. Tr. 7/29/93 (McGowan) at 116. Ms. Wagner confirms that Ron has a chronic history of choking and was placed on a gastrostomy tube as a result of his repeated aspirations. U.S. Exh. 641 (Wagner Dep.) at 36, 56. A nursing supervisor also advised Mr. Bellomo in October 1992 that she saw Keystone residents being fed flat on their backs. U.S. Exh. 172. Even after the supervisor instructed a staff person to elevate a resident, she observed the same staff person subsequently feeding another resident in a flat position. Id.

Staff have also placed Ebensburg residents flat on their backs immediately after their meals. This is a dangerous practice because it contributes to gastroesophageal reflux and poses the risk of aspirating residual food in the mouth and airway. Tr. 7/27/93 (Sulkes) at 96; Tr. 7/29/93 (McGowan) at 112-113. For example, Ron E. is shown on the United States' feeding videotape in a flat position in his cart with his head hyper-extended immediately after his meal. Tr. 7/29/93 (McGowan) at 112; U.S. Exhs. 229, 258. He is experiencing respiratory difficulty and coughing in an attempt to clear his airway. Tr. 7/29/93 (McGowan) at 112-113. He has a history of choking and emesis and hospitalizations for bowel obstruction. Id. at 111. Ron P. is also shown on the feeding videotape in a flat position in his cart immediately after his meal in August 1992. Tr. 7/29/93 (McGowan) at 116; U.S. Exhs. 234, 258. He has been hospitalized twelve times since 1990 for pneumonia, bowel paralysis, and respiratory insufficiency. Tr. 7/29/93 (McGowan) at 116. When Ms. McGowan returned to Ebensburg during November 1992, Ron had just returned from the hospital for aspiration pneumonia and was being fed through a gastrostomy tube. Tr. 7/28/93 (McAllister) at 115; Tr. 7/29/93 (McGowan) at 116; U.S. Exh. 697. He continues to vomit and experience a great deal of medical problems. Tr. 7/29/93 (McGowan) at 116.

Even where staff make an attempt to elevate the person's head by propping it up, if the rest of the body is flat or fairly flat during the feeding process, as is the case with Ron E., a high risk remains that the food can travel back out of the esophagus or stomach and aspiration can result. Tr. 7/28/93 (McAllister) at 199; U.S. Exhs. 228, 761. In addition, where Ebensburg staff raise the carts in which individuals are being fed to elevate the trunk of the body, often the individual's head is still in the equivalent of a "flat" position, because

it is parallel to the ceiling, as is the case with the way in which Barry D is fed. Tr. 7/29/93 (McGowan) at 94, 111; U.S. Exhs. 227, 258. Dr. Sheppard agrees that feeding someone in a reclining position who is already having difficulty managing swallowing can potentially compromise the health of the person and creates a risk of aspiration. Tr. 10/18/93 (Sheppard) at 56.

Elevated right sidelying is an alternative feeding position for individuals with significant physical disabilities who can not sit up. Tr. 7/28/93 (McAllister) at 199; U.S. Exhs. 763, 764. In this position, gravity assists with bringing the food into the stomach and with the stomach emptying. Id. It is also more difficult for the head to be in hyperextension in this position. Tr. 7/28/93 (McAllister) at 200. A sidelying position thus assists people with severe scoliosis and contractures to handle food more efficiently. Id. No one at Ebensburg is fed in a sidelying position nor has it ever been considered. Id.; U.S. Exh. 610 (Fagan Dep.) at 94; U.S. Exh. 613 (Frye Dep.) at 213; U.S. Exh. 641 (Wagner Dep.) at 154. Ms. Wagner, however, admits that feeding someone in sidelying is a "bona fide technique" and might be a useful technique for some Ebensburg residents who are currently fed on their backs in carts. U.S. Exh. 641 (Wagner Dep.) at 156.

3. Ebensburg Residents Are Being Fed With Their Trunks Improperly Aligned And Their Heads In Extension Contrary To Accepted Professional Practice.

The best position for a safe swallow in which the airway is protected is to place the individual in as midline and symmetrical position as possible where the person's back is at a 90 degree angle, hips anchored to the chair, and feet planted on the floor. U.S. Exh. 641 (Wagner Dep.) at 138, 144. Where an individual is sitting in a wheelchair or regular chair

but is in a slouched position where the trunk is forward (known as "posterior pelvic tilt"), pressure is placed on the diaphragm which interferes with the person's ability to breathe during the eating process. Tr. 7/29/93 (McGowan) at 95, 101, 163. Dr. Rubin explains that the "feeding process is a complex one" which requires good coordination between the muscles involved in swallowing and the muscles involved in breathing. Tr. 12/13/93 (Rubin) at 98-99. He further explains that the breathing apparatus is intimately related to the swallowing apparatus and coordination between the two is essential to preclude the possibility of breathing in food. Tr. 12/13/93 (Rubin) at 99.

Dr. Sheppard recognizes that a person's ability to coordinate breathing and swallowing is critical during the eating process. Tr. 10/12/93 (Sheppard) at 208. Dr. Sheppard further agrees that sitting in posterior pelvic tilt also makes it more difficult to swallow. Tr. 10/18/93 (Sheppard) at 30. This is because when a person is sitting in posterior pelvic tilt, the neck, and consequently the head, are automatically placed in extension, even though the head may appear to be in a neutral position. Tr. 7/29/93 (McGowan) at 101. An improperly aligned trunk during the feeding process also impedes the digestive process and makes it more likely that gastroesophageal reflux will occur, where the food travels back up the esophagus. Tr. 7/29/93 (McGowan) at 95. Ms. McGowan observed individuals in wheelchairs and chairs improperly positioned during mealtimes throughout her tours of Ebensburg in 1992 and 1993. Tr. 7/29/93 (McGowan) at 92, 93, 94, 95, 143. For example, despite the fact that Mr. Bellomo was aware of specific concerns by outside surveyors about the way in which Michael F. was positioned some six months prior to Ms. McGowan's first tour of Ebensburg, she nevertheless observed him being fed in

a grossly inappropriate position. Id. at 152-153; U.S. Exh. 162. His pelvis was tilted up at least forty-five degrees and his shoulder and pelvis were rotated to almost a ninety degree angle to one another. Tr. 7/29/93 (McGowan) at 152-153. His wheelchair was so low that his head barely reached above the table. Id. at 152. Moreover, the picture accompanying his feeding plan to instruct staff in how to feed him illustrates him being fed with his head in extension. Id. at 149; U.S. Exh. 137.

Each and every expert for both parties who testified on the topic of feeding uniformly agree that it is critical that the head is in good alignment during eating and feeding to enable the food to travel properly into the esophagus and stomach. Tr. 7/27/93 (Sulkes) at 96; Tr. 7/28/93 (McAllister) at 197; U.S. Exhs. 753, 758; Tr. 7/29/93 (McGowan) at 93; Tr. 10/12/93 (Sheppard) at 206-208; Tr. 12/16/93 (Hinkle) at 15; 33; U.S. Exh. 1120. All experts further agree that when the head and neck are tipped back into hyperextension, the airway is open and there is a risk that instead of going down through the esophagus, the food will enter into the trachea and the lungs, resulting in aspiration. Tr. 7/27/93 (Sulkes) at 96; Tr. 7/28/93 (McAllister) at 197; U.S. Exh. 756; Tr. 7/29/93 (McGowan) at 93; Tr. 10/12/93 (Sheppard) at 206; Tr. 12/16/93 (Hinkle) at 16. The ability of an individual to safely and adequately swallow is made even more difficult when an individual's head is hyper-extended and rotated to one side. Tr. 7/29/93 (McGowan) at 94.

Many Ebensburg residents are unable to independently hold their heads in a proper position during feeding and they need the assistance of staff or a positioning device to maintain their head in appropriate alignment. Tr. 7/29/93 (McGowan) at 94. Both of the Commonwealth's feeding experts agree that these residents must have adequate staff and

equipment support to position them safely during mealtimes. Tr. 10/12/93 (Sheppard) at 23-24; Tr. 12/16/93 (Hinkle) at 21-22. Often, however, Ebensburg residents are not properly positioned in their wheelchairs during mealtimes, losing the benefit of whatever support the wheelchair is intended to provide. For example, Andrea S.^{6/} appears on the feeding videotape with her head below the headrest in her wheelchair during the mealtime. Tr. 7/29/93 (McGowan) at 119-120; U.S. Exh. 239. Dr. Sheppard agrees that she was not appropriately positioned in her wheelchair. Tr. 10/12/93 (Sheppard) at 58. Despite the fact that Dr. Sheppard claims that this is an "isolated incident," Andrea was in the same position during a mealtime three months earlier and is pictured in this position in the pictures that Dr. Sheppard reviewed. Tr. 10/12/93 (Sheppard) at 58; U.S. Exh. 239. Raymond W. is also pictured being fed with his head below the headrest in the pictures Dr. Sheppard reviewed. U.S. Exh. 248. Beth S. is also being fed on the feeding videotape without her head in the headrest. Instead, her head is left to drop over on top of her shoulder as she is leaning to the side in her wheelchair, making it very difficult to swallow. Tr. 7/29/93 (McGowan) at 121.

Overall, the wheelchairs and carts at Ebensburg are so deficient that it is difficult to position residents properly during mealtimes. Tr. 7/29/93 (McGowan) at 95. Ms. Graham, Ebensburg's Director of Occupational Therapy, agrees that it is very difficult to get some Ebensburg residents into the correct, upright position and maintain them in that position during feeding because of deficient wheelchairs. U.S. Exh. 617 (Graham Dep.) at 166-167.

^{6/} Andrea S. is incorrectly identified as Beth S. in the July 29, 1993 Transcript at 119. Tr. 7/30/93 (McGowan) at 22.

When Ms. McGowan attempted to demonstrate to staff how to position Beth S. properly in her wheelchair by positioning her pelvis against the back of the wheelchair, she found that the wheelchair was too deep to allow Beth to sit in a proper position. Tr. 7/29/93 (McGowan) at 121. Ms. Graham has concerns about the wheelchairs in Keystone and whether they are adequate to enable safe and effective feeding of individuals. U.S. Exh. 618 (Graham Dep.) at 23-24. She thinks that the wheelchairs should be reassessed and that the safety and well-being of clients would be better protected with more knowledge at Ebensburg about appropriate positioning. U.S. Exh. 618 (Graham Dep.) at 23-24.

Dr. Sulkes, Ms. McAllister, Ms. McGowan, and Dr. Sheppard all saw people at Ebensburg eating or being fed with their head in extension. Dr. Sulkes observed residents being fed with their head in extension on many occasions during his multiple tours of Ebensburg. Tr. 7/27/93 (Sulkes) at 99. Ms. McAllister observed Barry D. and Raymond W. being fed with their heads in extension. Tr. 7/28/93 (McAllister) at 197-198; U.S. Exhs. 754, 755. As recently as July 1993, Dr. Sheppard saw staff tipping Duane P.'s head back as he was being fed. Tr. 10/18/93 (Sheppard) at 93. Ms. McGowan also repeatedly saw individuals being fed with their heads in extension and in extension and rotated, including Paul G., Harold B., William A., Duane P., Andrea S., Lois S., Beth S., and Sam B.. Tr. 7/29/93 (McGowan) at 94, 116-123. The Commonwealth's sur-rebuttal feeding expert agrees with Ms. McGowan that even if residents thrust their heads backward when food is placed in their mouths and then subsequently bring their heads forward, this is a potentially dangerous practice that should be avoided where possible. Tr. 7/29/93 (McGowan) at 225-226; Tr. 12/16/93 (Hinkle) at 16-17. Dr. Sheppard also agrees that this practice can be

problematic. Tr. 10/12/93 (Sheppard) at 67-68. For example, she admitted that when David K. thrusts his head back but brings it forward for reception on the feeding videotape that "he's getting himself in trouble with that movement" and moderation of his head movement and modification of his feeding plan should be considered. Tr. 10/12/93 (Sheppard) at 68; U.S. Exhs. 249, 250. Ms. Graham also noted that he was not positioned properly nearly every time he came into the dining room in late 1992, months after the videotape was taken. U.S. Exh. 617 (Graham Dep.) at 165. Dr. Hinkle believes that when this practice is observed "you owe it to such individuals" to evaluate them and teach them some other way of handling food and liquids rather than simply tilting their head back to receive food and liquids. Tr. 12/16/93 (Hinkle) at 17. Dr. Hinkle knows of no articles that address tilting the head back to receive food and then up-righting the head for the swallow as a safe technique. Tr. 12/16/93 (Hinkle) at 22.

Ms. Wagner, the head of Ebensburg's Dysphagia Team, confirms that the goal in positioning during feeding is to keep a protected airway. U.S. Exh. 641 (Wagner Dep.) at 145. In order to protect the airway, the head should never be in hyperextension (chin to the air) during the feeding process. U.S. Exh. 641 (Wagner Dep.) at 145, 146. Ms. Wagner explained the dangers of the head being in hyperextension as follows:

By putting the head in hyperextension you are physiologically opening the airway wide open. You just do not do that and then put food in the mouth. You are increasing that person's chances [for aspiration].

U.S. Exh. 641 (Wagner Dep.) at 153, lines 19-23. According to Ms. Wagner, it is important when you are feeding someone to "control all factors that you can possibly control

to ensure a protected airway" for that person. U.S. Exh. 641 (Wagner Dep.) at 145, lines 7-8.

Unlike Ms. McGowan who was qualified in physical and nutritional management for this case, Dr. Sheppard was only qualified in nutritional management and feeding, not physical management or positioning. Tr. 10/12/93 (Sheppard) at 7. Dr. Sheppard admits that she is not an expert in the best positions for maintaining skeletal alignments. Tr. 10/12/93 (Sheppard) at 213. She is also not an expert in situations where complex solutions are needed for mealtime positioning. Tr. 10/12/93 (Sheppard) at 213. Dr. Sheppard did not evaluate the position of residents' bodies from the neck down to evaluate whether they were in the most appropriate position for feeding. Tr. 10/12/93 (Sheppard) at 3, 4. Dr. Sheppard therefore relied on Ebensburg's "professional judgments" about positioning during feeding. Tr. 10/12/93 (Sheppard) at 213; Tr. 10/18/93 (Sheppard) at 3. Dr. Sheppard acknowledges that there is no physical therapist on the Dysphagia Team. Tr. 10/18/93 (Sheppard) at 4. She did not know, however, that the physical therapists were not involved at all with positioning during mealtimes. Tr. 10/12/93 (Sheppard) at 210-211; Tr. 10/13/93 (Arnall) at 95. Although Dr. Sheppard assumes that occupational therapists are adequate to make these types of decisions, there is no occupational therapist on the Dysphagia Team, only an occupational therapy assistant. Tr. 10/12/93 (Sheppard) at 209; Tr. 10/18/93 (Sheppard) at 4-5, 123. Dr. Sheppard was also unaware that the Director of Occupational Therapy at Ebensburg felt that there was a need to bring in consultants with special expertise in mealtime positioning. Tr. 10/12/93 (Sheppard) at 133; U.S. Exh. 617 (Graham Dep.) at 155. Mary Frye, the LOTA on the Dysphagia Team admits limitations in her knowledge

about positioning. For example, she does not know what sitting in posterior pelvic tilt is. U.S. Exh. 613 (Frye Dep.) at 208. She also does not know about positioning for an individual with gastroesophageal reflux and does not know whether improper positioning can cause reflux. U.S. Exh. 613 (Frye Dep.) at 186, 204. Ms. Wagner also does not know whether improper positioning while feeding can cause reflux. U.S. Exh. 641 (Wagner Dep.) at 153-154. Mr. Frye does not know whether it is possible to aspirate after refluxing. U.S. Exh. 613 (Frye Dep.) at 84. She also does not know that silent aspiration syndrome is. U.S. Exh. 613 (Frye Dep.) at 198. In addition, Ms. Frye has never read any literature on sidelying as a position during feeding. U.S. Exh. 613 (Frye Dep.) at 213.

D. Ebensburg Residents Are Being Fed Unsafely By Staff.

Both Dr. Sulkes and Ms. McGowan also repeatedly observed Ebensburg staff using unsafe practices in feeding individuals. Tr. 7/27/93 (Sulkes) at 99; Tr. 7/29/93 (McGowan) at 92, 95-100. In particular, Ebensburg residents are fed with the following types of unsafe practices:

- staff feed residents at an excessively rapid rate;
- staff feed residents food or fluid in too large a quantity for them to swallow;
- staff feed residents with spouted cups which do not allow staff to control the volume of liquid;
- staff do not allow residents sufficient time to swallow in between bites;
- staff feed residents food or fluids while residents are coughing;
- staff feed residents by pushing their heads back into hyperextension;
- staff feed residents by standing above their eye level, forcing residents to place their head in extension to look up at the feeder;

- staff feed residents by scraping food off of their faces;
- staff do not follow feeding programs; and
- too many different staff feed residents with complex needs.

Tr. 7/27/93 (Sulkes) at 99-105; Tr. 7/29/93 (McGowan) at 95-96, 103, 114, 118.

1. Ebensburg Staff Feed Residents At An Excessively Rapid Rate And With Overloaded Spoons Which Are Dangerous Practices.

During his testimony, Dr. Rubin explained that the complex eating process involves many muscles of the face, including the lips to open and close, the jaw to chew, the tongue to move the food around and to move the food back to the back of the throat, and the muscles of swallowing which must be coordinated with breathing. Tr. 12/13/93 (Rubin) at 98-99. In people with developmental disabilities who have significant physical limitations, any or all of these functions may be impaired. Tr. 12/13/93 (Rubin) at 99. They are also influenced by the position in which they are fed, the manner in which they are fed, the medications they are receiving, and by their feeling of well-being on a particular day. Tr. 12/13/93 (Rubin) at 100; Tr. 7/27/93 (Sulkes) at 96-98. Individuals with developmental disabilities who have these impaired functions, have a very limited range of options to respond to both the volume as well as rate of food that they can take in. Tr. 12/13/93 (Rubin) at 99-100. They do not have the choices that other people have in moderating their intake of food if they are dependent upon a caregiver to feed them. Tr. 12/13/93 (Rubin) at 100. If they are unable to express their discomfort with being fed too large an amount or too fast, their options are to spit it out or to cough, gag, and choke. Tr. 12/13/93 (Rubin) at 100-101. Dr. Rubin saw examples on the United States' feeding videotape of individuals

with limited abilities being fed large volumes and acting in a "protective manner to avoid difficulty or pain or discomfort or aspiration." Tr. 12/13/93 (Rubin) at 87. These "protective" reactions, which Dr. Sheppard described as "compensatory" mechanisms, include spitting some of the food out, coughing, and swallowing with tremendous difficulty. Tr. 12/13/93 (Rubin) at 87. The residents on the videotape were put in a position where they had to exhibit protective responses because of the manner in which they were being fed. Tr. 12/13/93 (Rubin) at 86-87.

Throughout her numerous observations of mealtimes at Ebensburg, Ms. McGowan repeatedly observed staff feeding residents at an unsafe pace or in amounts that they were not able to handle. Tr. 7/29/93 (McGowan) at 95-96. Often, residents were not allowed sufficient time to swallow the food or liquid in their mouths before forcing another spoonful of food or sip of liquid. Ms. Sponsky admitted that she, too, had a concern about the pace of feeding as she toured with Ms. McGowan in August 1992. U.S. Exh. 636 (Sponsky Dep.) at 100. Dr. Hinkle, the Commonwealth's sur-rebuttal feeding expert admitted that after reviewing the United States' feeding videotape he had concerns about the size of the bolus that was being fed to individuals. Tr. 12/16/93 (Hinkle) at 15. Ms. Wagner, the head of Ebensburg's Dysphagia Team, acknowledges that aspiration can result from feeding someone at an excessive rate or with an excessive volume so that the person can not breathe without also breathing in food. U.S. Exh. 641 (Wagner Dep.) at 68. Among the examples that both Dr. Sulkes and Ms. McGowan observed where staff were feeding residents at excessive rates or with an excessive volume are:

- Frank H. on August 21, 1992 on the feeding videotape being forced to eject excess food and fluid that staff was attempting to feed him and he was not able to swallow.

Tr. 7/29/93 (McGowan) at 114; U.S. Exhs. 231, 232. At one point, the piece of food that staff tried to feed him was so large that it fell off the spoon and landed on Frank's chest before it even got to his mouth. Frank was also unable to manage the amount of fluids that he was being fed and it dribbled out of both sides of his mouth. Tr. 7/29/93 (McGowan) at 114; U.S. Exh. 258. Despite the obvious difficulties that Frank was experiencing, the Commonwealth's expert characterized this sequence in the United States' videotape as Frank appearing "fairly comfortable in terms of ease of eating." Tr. 10/12/93 (Sheppard) at 49. The Commonwealth's sur-rebuttal feeding expert, however, does not think it is "acceptable" to just continue to allow a person to eject food. Tr. 12/16/93 (Hinkle) at 27. He thinks that it is important that the amount of food that a person is fed in each spoonful is an appropriate size so that the food remains in the mouth. Tr. 12/16/93 (Hinkle) at 24. When Dr. Hinkle was presented with a description of Frank's history during his testimony (including the fact that he had been hospitalized for aspiration pneumonia), Dr. Hinkle agreed that he would have concerns if Frank was ejecting food while being fed. Tr. 12/16/93 (Hinkle) at 30. Dr. Hinkle did not think it would be appropriate to continue feeding Frank in this fashion without an assessment by a qualified professional. Tr. 12/16/93 (Hinkle) at 30. Frank was not assessed by the Dysphagia Team until July 6, 1993 -- eleven months after the feeding videotape in which he was ejecting food. Tr. 10/18/93 (Sheppard) at 119.

- Ron E., who also has a history of aspiration pneumonia, was fed in ten minutes. Tr. 7/29/93 (McGowan) at 100.

- Barry D. was persistently not swallowing before another spoonful of food was placed in his mouth. Tr. 7/29/93 (McGowan) at 98. Claire Domino, a supervisor at Keystone admitted that there have been problems with Barry not eating and letting the food run back out of his mouth. U.S. Exh. 609 (Domino Dep.) at 55. Dr. Sulkes had concerns about Barry when he observed him in November 1992. Tr. 7/27/93 (Sulkes) at 103. Dr. Sulkes observed him to be "very emaciated" and was concerned about his nutritional status. Tr. 7/27/93 (Sulkes) at 103, lines 2-3. When Dr. Sheppard observed him in July 1993, Barry was coughing during the meal, coughing repeatedly after his meal, and ate very little. Tr. 10/18/93 (Sheppard) at 99. He was not being fed by the person who regularly feeds him. Tr. 10/18/93 (Sheppard) at 104.

- James M. was not permitted sufficient time to swallow in between bites of food. Tr. 7/29/93 (McGowan) at 99.

- Neal S. had spoonfuls of food pushed into his mouth before he had swallowed what was already in his mouth. Tr. 7/29/93 (McGowan) at 99.

- Patti W. was being fed additional bites of food before swallowing what was in her mouth. Tr. 7/29/93 (McGowan) at 100.

- Harold B. received 14 spoonfuls of food in 96 seconds, with an average of six seconds between spoonfuls. Tr. 7/29/93 (McGowan) at 117-118. Many of the spoonfuls

feeding prescription, it would not reflect accepted professional judgment." Tr. 10/18/93 (Sheppard) at 44, 45, lines 2, 11-12.

- Ms. McGowan observed staff feeding Harold M. by cupping his chin and pulling his head back. Tr. 7/29/93 (McGowan) at 99.

- Ms. McGowan observed staff feeding William A. fluids by cupping his chin and pushing it up. Tr. 7/29/93 (McGowan) at 118.

- Dr. Sulkes observed staff feeding Jeanne D. in both September and November 1992 by holding her chin up and pushing her head back. Tr. 7/27/93 (Sulkes) at 100.

- Dr. Sulkes also observed staff feeding Denise D. by pushing her head back. Tr. 7/27/93 (Sulkes) at 103.

- Dr. Sheppard observed a feeder in July 1993 cradling Duane P.'s head and tipping it back. Tr. 10/18/93 (Sheppard) at 93.

Mr. Tackett confirmed that unsafe staff techniques were not only used at Ebensburg, they were also taught to new staff. For example, Mr. Tackett was instructed by other direct care staff to feed Keith U. by cradling Keith's head in his arm and tilting Keith's head back to roughly a forty-five degree angle. Tr. 8/3/93 (Tackett) at 12. While holding Keith in this position, Mr. Tackett was taught to feed him by using the following technique:

continue shoveling and shoveling and shoveling until he can't hold any more, and then he will swallow. It's the same way with drinking. His head has to be tilted back and you have to pour the milk, or what have you, until he can't hold any more in his mouth, and then he will swallow.

Id. Mr. Tackett "definitely" did not feel that he had sufficient knowledge to safely feed Keith U. Id. at 13:

I was faced with an individual who would not swallow until his mouth was overflowing. I had to tilt his head back, and I was scared to death, quite literally, he was going to start choking; and if he was choking, then what would I do. No, I didn't feel I had the proper training whatsoever.

agrees that scraping the face can cause the potential for involuntary reflexes in individuals whose oral motor skills are already compromised. Tr. 10/12/93 (Sheppard) at 43-44.

5. Ebensburg Staff Do Not Follow Requirements In Residents' Feeding Plans.

Both the United States' and Commonwealth's feeding experts who looked at implementation of feeding programs, as well as Ebensburg staff and administrators, agree that there have been and continue to be problems in staff actually implementing the requirements of feeding plans.^{7/} Ms. Graham found that during her observations at Keystone in late December 1992, some staff were not looking at residents' feeding plans on a regular basis and that there were some situations where staff should have been referring to the plans but were not. U.S. Exh. 618 (Graham Dep.) at 27-28. The Unit Manager of Keystone admits staff were not consistently implementing procedures for feeding individuals at least through the late fall of 1992. U.S. Exh. 604 (Bonfanti Dep.) at 59. Mr. Tackett admits that he did not follow the feeding plan of Keith U., a Keystone resident whom "he was scared to death" to feed, and that he observed other staff also not following his plan. Tr. 8/3/93 (Tackett) at 14, 23.

Both Dr. Sulkes and Ms. McGowan repeatedly saw Ebensburg staff not following residents' feeding programs during her mealtime observations. For example:

- James M. was fed on multiple occasions by LOTA's with his head in significant extension despite a Mercy Hospital evaluation, Ebensburg occupational therapy evaluation, and feeding plan warning against feeding him in this position and requiring the feeder to use manual pressure to keep his head in a neutral position. Tr. 7/29/93 (McGowan) at 99, 125; Tr. 7/27/93 (Sulkes) at 144.

^{7/} Feeding plans at Ebensburg are called "supplemental procedures." Because this term is also used for nursing and behavioral interventions, for purposes of clarity the term "feeding plan" will be used throughout these findings of fact.

- The head of the Dysphagia Team feeding John H. in August 1992 allowed him to hyper-extend his head despite a Mercy Hospital evaluation and feeding plan specifically instructing staff not to permit him to hyper-extend his head. Tr. 7/29/93 (McGowan) at 127-126. When Dr. Sheppard observed John being fed nearly one year later, in July 1993, she again observed him being fed with his head in extension and thought that this represented unsafe eating which placed him at risk for distress during the mealtime. Tr. 10/18/93 (Sheppard) at 86-87.

- The LOTA feeding Ellen H. failed to ensure that she was positioned properly for eating. Tr. 7/29/93 (McGowan) at 123. Her feeding plan required Ellen to be stabilized and sitting upright but she was slouched in her chair with her feet unsupported. Id.

- Duane P., who has gastroesophageal reflux and had inflammation of the lower part of his esophagus following a GI bleed in June 1992, was flailing his hands and head while being fed on the feeding videotape in August 1992. Tr. 7/29/93 (McGowan) at 119. His feeding plan specifically calls for his arms to be kept down, including affixing a weight to one of his arms. Id. In addition, staff are supposed to place a hand on his head and apply gentle pressure to his forehead to stabilize his head. Id. None of these procedures were being followed. Id. These procedures were also not being followed nearly one year later when Dr. Sheppard observed Duane being fed in July 1993 and the same feeding plan was in effect. Tr. 10/18/93 (Sheppard) at 93; U.S. Exh. 1002. Instead, Dr. Sheppard observed the feeder "cradling his head," with "his face tipped back in varying degrees, from fifteen degrees to thirty degrees." Tr. 10/18/93 (Sheppard) at 93. Dr. Sheppard observed Duane coughing during this meal. Tr. 10/18/93 (Sheppard) at 95. Ms. Wagner has also observed Duane frequently coughing and possibly choking during meals. U.S. Exh. 641 (Wagner Dep.) at 60, 61.

- David V., who had been hospitalized earlier in the year for aspiration pneumonia, was being fed without any head support by a staff person who did not pay any attention to his feeding program which specifically required such support while he swallowed. Tr. 7/27/93 (Sulkes) at 143.

- Harold B. was fed with his head back 45 degrees without staff attempting to keep his head in an erect position. His feeding plan requires staff to place gentle pressure to maintain his head at midline. Tr. 7/29/93 (McGowan) at 118; U.S. Exh. 236.

- Jeanne D. was fed during both September and November 1992 by staff who were pushing her head back by pulling up her chin. Tr. 7/27/93 (Sulkes) at 100. Her feeding plan requires staff to place a hand on Jeanne's head to stabilize it in a midline position. Tr. 7/27/93 (Sulkes) at 100.

- Andrea S. was fed with her neck in significant extension despite the fact that her feeding plan requires staff to give her neck support to maintain her in an appropriate position. Tr. 7/27/93 (Sulkes) at 104.

- On August 18, 1992, Frank H. was fed in his cart at approximately a twenty degree angle. Tr. 7/29/93 (McGowan) at 98. On August 21, 1992, Frank was fed with his cart at less than thirty degrees. Id. at 113-114. His feeding plan required the cart to be elevated to forty-five to sixty degrees. Id. Dr. Sulkes has had concerns about Frank's position in his cart while he is being fed. Tr. 7/27/93 (Sulkes) at 105. Claire Domino, a supervisor at Keystone, admits that there have been problems keeping Frank adequately elevated and positioned during mealtimes. U.S. Exh. 609 (Domino Dep.) at 55.

- Joe T. was fed flat on his back despite a feeding program which requires his head to be elevated at least thirty degrees. Tr. 7/29/93 (McGowan) at 97.

- Barry D. was also fed in a perfectly flat position despite requirements in his feeding program for elevating his cart and his head. Tr. 7/29/93 (McGowan) at 97. The staff person feeding him reported that she always fed him in this position. Id.

- Nearly one year later, staff were still not raising carts to the level of elevation required in their feeding plans. Dr. Sheppard observed Tim. P. being fed in July 1993 with his cart not elevated in accordance with his feeding plan. Tr. 10/18/93 (Sheppard) at 96.

As late as July 1993, staff were failing to implement feeding plans as written at least 35% of the time, even as the Commonwealth's own feeding expert was observing them.^{8/} This means that more than one out of every three Ebensburg residents still were not being fed in accordance with their feeding plans as this case was going to trial.

The results of the "informal statistics" that Dr. Sheppard computed on her observations are suspect. She had not yet analyzed a rate of compliance with feeding plans as of September 3, 1993, which was a week before she testified and several months after the

^{8/} Out of the 22 residents she observed, Dr. Sheppard omitted the data for one resident because he fell asleep during the meal. Tr. 10/18/93 (Sheppard) at 100. Another resident did not have a feeding plan. U.S. Exh. 1002. Therefore, the total number of residents on which Dr. Sheppard took data was 20 residents. Of these 20 residents, Dr. Sheppard observed staff not following all of the requirements in the feeding plan for at least seven people, including: Jeff K. (thin liquids), Tr. 10/18/93 (Sheppard) at 89; John H. (wrong technique for placing food in his mouth), Id. at 84-85; Tim P. (cart not elevated to specified height), Id. at 89; Duane P. (head cradled and tilted back into extension), Id. at 93, 96; Kathy M. (special cup not used), Id. at 97; Linda S. (staff "pouring liquid onto her tongue), Id. at 97; and Phyllis S. (feeding technique not followed), Id. at 98.

observations that were the basis of her data. Tr. 10/18/93 (Sheppard) at 83-84. Moreover, there were discrepancies between what Dr. Sheppard testified to at her deposition and at trial about how long after her observations she made any type of comparison between the procedures being used by staff and the requirements of feeding plans. Tr. 10/18/93 (Sheppard) at 83-84. Dr. Sheppard relied on her notes of mealtime observations to make this comparison and there are discrepancies, as well, between what she testified to at her deposition and at trial about the contents of her notes and how she interpreted them. Tr. 10/18/93 (Sheppard) at 78, 80-81, 90-92. At one point, she retracted a statement that she made at her deposition that staff were feeding Frank H. by dropping food on his lips, in violation of his feeding plan. Tr. 10/18/93 (Sheppard) at 92. She admits that there were aspects of the feeding plans that she did not evaluate for some residents, such as use of special utensils. Tr. 10/18/93 (Sheppard) at 77-78. Moreover, when Dr. Sheppard compiled her statistics about how well Ebensburg staff were following feeding plans, she counted as being in "full compliance" such instances as staff feeding Jeff K. with thin liquids despite the fact that his feeding procedure states in big capital letters "No THIN LIQUIDS" and specifically instructs staff to thicken his liquids to a "pudding consistency." Tr. 10/18/93 (Sheppard) 88-89; U.S. Exh. 1002.^{9/} She also rated as "full compliance" her observations of the way in which Duane P. was being fed. Tr. 10/18/93 (Sheppard) at 94. Dr. Sheppard observed the staff person "cradling his head," with "his face tipped back in varying degrees, from fifteen degrees to thirty degrees." Tr. 10/18/93 (Sheppard) at 93. This is not at all

^{9/} Dr. Sheppard notes that as she focused on Jeff, a supervisor intervened after staff had already begun feeding Jeff thin liquids. Tr. 10/18/93 (Sheppard) at 88. In Dr. Sheppard's mind, this did not count as staff not following the procedure. Instead, she rated staff as being in full compliance "for the portion of the meal they were correct." Tr. 10/18/93 (Sheppard) at 88.

what his feeding plan requires, which is for staff to "place gentle pressure on forehead for head stabilization." Tr. 10/18/93 (Sheppard) at 93; U.S. Exh. 1002. Despite these inconsistencies and questions about her informal statistics, Dr. Sheppard nevertheless found that as late as July 1993, Ebensburg staff were still not following more than one out of every ten prescriptive instructions in residents' feeding plans.

6. Staff Fail To Intervene Properly When Residents Are Exhibiting Distress During Mealtimes And Have Even Fed Residents While They Are Coughing.

Ms. McGowan repeatedly observed staff failing to intervene properly when residents are exhibiting distress during mealtimes. For example, following a meal in which he had difficulty, Tony (Anthony) R. appears on the feeding videotape continuing to cough and expectorate as he sat by himself at the table. U.S. Exhs. 247, 258. There were no staff around to even notice, let alone assist him. Tr. 7/29/93 (McGowan) at 129. When a staff person returned, she simply wheeled him back to his living unit without even noticing that he had been in distress. Staff jumped out of the way as James M. was coughing with his head in extension, rather than bringing his head forward. *Id.* at 129-130. Staff also did not assist Raymond W. in bringing his head forward as he persistently and forcefully coughed with his head in extension. *Id.* at 130-131. And Ebensburg staff did not assist David K. as he coughed thirteen times with residual food in his mouth. *Id.* at 132. Dr. Sheppard agrees that "certainly coughing should be attended to during the meal." Tr. 10/12/93 (Sheppard) at 195, lines 22-23. In some instances, staff have placed food in residents' mouths while they are hiccupping or coughing (Rhett T., David K.). Tr. 7/29/93 (McGowan) at 131-132. Ms. McGowan was so concerned about witnessing this practice that she immediately alerted

Carole Sponsky, the Director of Nursing. Id. at 131. Dr. Sulkes has also observed Ebensburg residents being fed while coughing as recently as November 1992 (after Ms. McGowan expressed her concerns to Ms. Sponsky), including Sam B., who died in March 1993 from complications of pneumonia, and Tim P., who now has a feeding tube. Tr. 7/27/93 (Sulkes) at 99, 101.

7. There Is No Consistency In Staff Feeders Of Residents With Complex Feeding Needs.

Knowing the unique needs and characteristics of the individual who staff are feeding is particularly important in terms of making decisions about pacing the timing of feeding and teaching eating-related skills. Tr. 7/29/93 (McGowan) at 96; Tr. 7/30/93 (McGowan) at 32. Ms. McGowan saw problems in staff consistency during her mealtime observations. Tr. 7/28/93 (McGowan) at 96. Mr. Bonfanti admits that there is no consistency in terms of which direct care staff feed particular individuals in Keystone. U.S. Exh. 604 (Bonfanti Dep.) at 61. Ms. Graham believes that consistency in staff feeders would help at Keystone. U.S. Exh. 618 (Graham Dep.) at 57. Moreover, when other staff, such as supervisors and nurses, assist with feeding in Keystone, there is no procedure for deciding who they feed. Instead, they go to the living area, "ask the staff who hasn't been fed and they would just bring the person out and feed them." U.S. Exh. 604 (Bonfanti Dep.) at 64, lines 7-8. Ms. Malloy, who is the nurse supervisor at Keystone and feeds people there, explains the process of deciding who she will feed on any given day as follows: "It doesn't matter. I can feed whoever has to be fed. There might be -- sometimes when I get back from lunch there might be six or seven left to be fed and so I will feed one of them." U.S. Exh. 622 (Malloy Dep.) at 83, lines 9-12. In Horizon, the process works a bit differently. In a September 14,

1992 memorandum, Mr. Bellomo questioned Horizon's system of having staff at the door of the dining room who call down the hall for the staff assigned to the door of each living area to "send me one" when there is room for another person in the dining room. U.S. Exh.

164. One month earlier, Mr. Bellomo had asked Mr. Devine, who is in charge of all residential services, to look into why this same practice of staff standing at the doors in "guardlike fashion" existed. Id.

During her July 1993 tour, Dr. Sheppard found several instances where a resident was not being fed by the staff person who regularly feeds the resident. Tr. 10/18/93 (Sheppard) at 104. The staff person feeding John H. during Dr. Sheppard's observations in July 1993 left half-way through the meal time and was replaced by another feeder. Tr. 10/18/93 (Sheppard) at 105-106.

8. Even Where Ebensburg's Professional And Paraprofessional Staff Feed Residents, They Use Unsafe And Professionally Unsound Practices.

There are only three residents in Keystone who are fed by LOTA's: Tim P., Ellen H., and James M. U.S. Exh 617 (Graham Dep.) at 117-118. Each of these residents is pictured on the feeding videotape with LOTA's feeding them using unacceptable practices.

Tim P. is shown being fed additional fluid and food by a LOTA while his mouth was still full of food that he was unable to swallow. Tr. 7/29/93 (McGowan) at 115; U.S. Exh. 233. Dr. Sulkes also had concerns when he saw Tim being fed during both September and November 1992. Tr. 7/27/93 (Sulkes) at 100-101. In September 1992, Dr. Sulkes saw a LOTA feeding Tim by pouring fluid from a spouted cup into Tim's mouth without ensuring that Tim's mouth had closed. Tr. 7/27/93 (Sulkes) at 100-101. When Dr. Sheppard viewed Tim being fed on the United States' feeding videotape she admitted that "certainly there is a

problem here." Tr. 10/12/93 (Sheppard) at 51. Dr. Sheppard also agreed that given Tim's "marked" and "complex" problems, there should be an assessment to determine whether he was experiencing oral motor difficulties because another feeding technique might make his eating better. Tr. 10/12/93 (Sheppard) at 51, 52; Tr. 10/18/93 (Sheppard) at 7. Although the head of Ebensburg's Dysphagia Team agreed during her deposition in January 1993 that she had observed Tim frequently coughing and possibly choking during meals, Tim did not even have a screening by Ebensburg's Dysphagia Team until June 1993 -- 6 months later. U.S. Exh. 641 (Wagner Dep.) at 60, 61; U.S. Exh. 970. In between the time the videotape was taken and June 1993, Tim was placed on a feeding tube. Tr. 7/29/93 (McGowan) at 115.

Ellen H. is being fed on the feeding videotape by the same LOTA feeding Tim P. The LOTA failed to follow Ellen's feeding plan, did not use techniques to control her tongue thrust, abandoned Ellen as she was exhibiting distress, and pushed her head back into extension as she was feeding her. Tr. 7/29/93 (McGowan) at 123-125; U.S. Exh. 1010. The supervisor (Dan Waltemire) who attempted to feed Ellen at the point that she was abandoned had never been trained in her feeding procedure. U.S. Exh. 1010.

James M. is shown on several occasions in the feeding videotape being fed by two different LOTA's with his head in extension in all of the segments despite a dysphagia evaluation at Mercy Hospital advising staff that if he is fed with his head in extension, he will aspirate. Tr. 7/29/93 (McGowan) at 125; U.S. Exh. 243(a). Dr. Sulkes also observed James during both September and November 1992 being fed with his head in extension. Tr. 7/27/93 (Sulkes) at 102. His Mercy Hospital evaluation specifically states that "under no

circumstances" should his head be allowed to extend backward during feeding. Id. An Ebensburg occupational therapy assessment confirmed that his head should be maintained in a midline position during feeding to assist with tongue mobility and lip closure. Id. James has a history of aspiration pneumonia and was hospitalized in May 1992 for respiratory problems. Id. In June 1992, an x-ray revealed a possible pneumonia and lung collapse. Id. An Ebensburg dysphagia evaluation identified that he is at high risk for aspiration pneumonia. Id. In the feeding videotape, he is spitting up food and coughing. Id. at 126, 129-130; U.S. Exh. 258. The LOTA's do not assist in keeping his head in midline and, at one point, one of the LOTA's actually jumps out of the way as James starts coughing. Tr. 7/29/93 (McGowan) at 129.

Cathy Wagner, a speech pathologist who is the head of the Dysphagia Team at Ebensburg, is shown on the feeding videotape feeding John H. Tr. 7/29/93 (McGowan) at 127; U.S. Exh. 245. She is engaging in conversations with other staff across the room during the feeding process and permits John's head to go back into extension. Id. John has been hospitalized eight times since 1989 for respiratory problems. Id. at 128. His most recent hospitalization, which occurred shortly after the videotape was taken, required removal of part of his lung and the use of a ventilator. Id. He was temporarily transferred to a nursing home. U.S. Exh. 144; Tr. 10/13/93 (Bellomo) at 150. A Mercy Hospital evaluation of John stresses that his head should not be allowed to extend during feeding. Tr. 7/29/93 (McGowan) at 127. This is because John has dysphagia and when he takes the food into his mouth and throws his head back, it leads to aspiration because of the lack of muscular control of the bolus. U.S. Exh. 370. In the videotape, Ms. Wagner is not

following John's feeding plan which specifically requires the feeder to use "firm pressure with your hands on John's head to keep it in slight flexion" (tipped forward); "do not allow . . . [John] to hyper-extend his head during the swallow. Tr. 7/29/93 (McGowan) at 127; U.S. Exh. 370. Ms. Wagner is also not following her own written precautions in feeding John. In Ms. Wagner's evaluation of John, she specifically states that he should never be permitted to extend his head. Tr. 7/29/93 (McGowan) at 19. Instead of following her own requirements, Ms. Wagner allowed John to extend his head. Tr. 7/29/93 (McGowan) at 20.

Claire Domino, a Keystone QMRP who is responsible for monitoring staff practices during mealtimes, is shown on the videotape feeding Joseph R.^{10/} with his head in extension. Tr. 7/29/93 (McGowan) at 126-127; U.S. Exh. 244; U.S. Exh. 609 (Domino Dep.) at 8, 9, 13-15.

9. The Defendants Were Aware Of Problems In The Way In Which Ebensburg Residents Were Being Fed Prior To The United States Filing Its Lawsuit.

As far back as February 1990, the Commonwealth was on notice through the United States' CRIPA investigation that Ebensburg staff were failing to feed residents safely, thereby creating serious risks of aspiration and malnutrition. U.S. Exh. 638 (Sponsky Dep.) Sponsky Dep. Exh. 50 at 3. The United States advised defendants about concerns regarding the prevalence of aspiration pneumonia at Ebensburg and the fact that residents were coughing and choking during mealtimes. Id. At the time Ebensburg's Dysphagia Team was created in June 1990, the head of the team was aware that Ebensburg needed to improve its practices in the areas of "body positioning, placement of food in the mouth, rate of feeding, and attention

^{10/} Joseph R. is incorrectly identified as James R. in the transcript.

to potential problems during feeding" in order to conform with general guidelines of which she was aware. U.S. Exh. 641 (Wagner Dep.) at 21. Since at least April 1990, Ebensburg was also aware of other types of problems in the way residents were being fed based upon medical assistance deficiencies for which the facility had been cited by State surveyors. A memo at that time was sent to all direct care staff about necessary corrective actions, including the need to feed residents at eye level rather than standing above them, to follow feeding plans, and to interact with residents. Tr. 7/29/93 (McGowan) at 153-154; U.S. Exh. 169.

In addition, nearly six months before Ms. McGowan conducted her first tour of Ebensburg and advised administrators of her significant concerns about the way in which Ebensburg residents were positioned and being fed, Mr. Bellomo specifically recognized that these problems existed. For example, in a memo dated March 4, 1992, Mr. Bellomo advised Ebensburg staff of his "disheartenment" and "embarrassment" that even with two weeks' advance notice of a tour by outside surveyors and a pre-determined tour route, the "mealtime in Keystone was rushed," "there was little interaction" between staff and residents, and residents were improperly positioned. Tr. 7/29/93 (McGowan) at 152; U.S. Exh. 162.

E. Ebensburg Residents Are Eating Unsafely With No Staff Intervention.

Throughout her observations of mealtimes at Ebensburg, Ms. McGowan repeatedly saw residents engaging in unsafe eating behaviors without staff intervention. These behaviors include Ebensburg residents:

- eating at an excessively rapid rate, e.g., literally consuming their entire meal in two to four minutes;
- taking heaping large, overfilled spoonfuls of food;
- shoveling food into their mouths;
- stuffing large chunks of food into their mouths, e.g. an entire piece of cheese cake, an entire piece of celery;
- overloading their mouth with food without adequate time to swallow;
- drinking cups of fluid without any visible pause;
- swallowing whole food without chewing;
- stealing food from other residents;
- eating food that had fallen to the floor; and
- jabbing utensils, such as knives and spoons deep into the mouth.

Tr. 7/29/93 (McGowan) at 91, 103-106, 134.

These behaviors were pervasive throughout Ms. McGowan's tours. Tr. 7/29/93 (McGowan) at 103. She identified, by name, at least 57 Ebensburg residents who exhibited these behaviors, a number of whom had documented recent choking episodes. Tr. 7/29/93 at 104-105, 145; Tr. 10/12/93 (Sheppard) at 122-123; U.S. Exh. 938 at 100-102, 108-112. For example, Ms. McGowan observed Fred G. consume his entire meal on August 19, 1992 in four minutes. Tr. 7/29/93 (McGowan) at 104. Four days later, Fred choked on a piece of meat during dinner. U.S. Exh. 273 at 2. On another occasion, Ms. McGowan observed Fred scooping up and eating food that had fallen to the floor. Tr. 7/29/93 (McGowan) at 105. He had a choking episode in March 1992 requiring abdominal thrusts after he grabbed food from another residents' tray and stuffed it in his mouth. U.S. Exh. 273 at 3. Ms.

McGowan saw Joyce Y. stuffing food into her mouth during November 1992. Tr. 7/29/93 (McGowan) at 105. Joyce had a choking episode during May 1992 where she choked on a chunk of meat and the Heimlich maneuver had to be performed. U.S. Exh. 273 at 3. Ms. McGowan also observed Estelle M. stuff an entire piece of shortcake into her mouth on August 19, 1992. Tr. 7/29/93 (McGowan) at 105. Less than one month later, Estelle had a choking episode at Ebensburg. U.S. Exh. 273 at 2.

Dr. Sheppard agrees that "there are certainly individuals at Ebensburg, and those individuals mentioned by McGowan, who are eating quickly." Tr. 10/12/93 (Sheppard) at 18. During her tour of Ebensburg in February 1993, Dr. Sheppard also saw instances of residents overstuffing and eating too quickly without appropriate staff intervention. Tr. 10/12/93 (Sheppard) at 165-166. During her follow-up tour in July 1993, Dr. Sheppard continued to see "unsafe eaters," including Phyllis S. who was "stuffing her mouth with bread." Tr. 10/18/93 (Sheppard) at 110. During July 1993, Dr. Sheppard further observed Joe C. taking "big spoonfuls" of food without staff attempting to moderate the amount that he was scooping up. Tr. 10/18/93 (Sheppard) at 108.

The feeding videotape also demonstrates examples of residents in need of assistance but no staff monitoring or intervention takes place. For example, Ron L. is eating heaping spoonfuls of food and throwing his head back into extension. At one point he spits into his tray. No staff are anywhere to be seen. Tr. 7/29/93 (McGowan) at 133.; U.S. Exh. 258. Donald P. is tilting his head all the way back and jabbing an empty spoon deep into his mouth as staff just walk by him. Id. at 133-134. Dr. Sheppard estimates that he has as much as four inches of the spoon in his mouth and agrees that "it's a lot." Tr. 10/12/93

(Sheppard) at 69. William C., who is blind, sat by himself without any staff intervention for fifteen to twenty minutes. For at least ten minutes, he persistently brought the spoon to his mouth empty with no staff assistance. Id. at 135-136. Lee V. is hitting himself repetitively with no staff intervention, even though a staff person is standing beside him. Tr. 7/29/93 (McGowan) at 135. Jerry Mc. is eating in a poorly aligned position where he is leaning significantly to one side and has his face in his plate without any staff intervention. Id.^{11/} Dr. Sheppard agreed that this is "not a great position." Tr. 10/12/93 (Sheppard) at 72. Jerry Mc. has had serious medical problems and multiple hospitalizations. In 1992, he was hospitalized four times for gastrointestinal bleeding, acute gastritis, colectomy, and partial bowel obstruction. U.S. Exh. 144. In the first several months of 1993, he was hospitalized for pneumonia and fecal impaction. U.S. Exh. 144.

Even when staff are specifically assigned to monitor a resident one-on-one, they fail to intervene when the resident is exhibiting unsafe behavior. Kathy W., for example, whom Ms. McGowan observed eating at a rapid rate and stuffing her mouth on several occasions, is pictured on the feeding videotape with a psychologist sitting at the table facing her. Despite the fact that she is overloading her spoon, stuffing her face, and completes her entire meal in several minutes, the psychologist's only actions were to twice interrupt her -- once to offer her a napkin and once when she was eating with her hands. Tr. 7/29/93 (McGowan) at 134-135. The psychologist does not intervene at the point where Dr. Sheppard agreed Kathy was "stuffing." Tr. 10/12/93 (Sheppard) at 71. Dr. Sheppard has observed Kathy W.

^{11/} Although Ms. McGowan did not identify Jerry Mc. by name, Dr. Sheppard subsequently identified him, but incorrectly stated his first name as John, rather than Jerry. Tr. 10/12/93 (Sheppard) at 71.

eat on different occasions and agreed that "there are times when this individual does eat too rapidly, when she does stuff." Tr. 10/12/93 (Sheppard) at 70.

1. Ebensburg Administrators And Staff Acknowledge That Residents Exhibit Unsafe Behaviors During Mealtimes And Staff Do Not Intervene.

Both Mr. Bellomo and Mr. O'Brien confirm that Ebensburg residents are engaging in the same types of dangerous behaviors without staff intervention that Ms. McGowan repeatedly witnessed during her tours. For example, in one month, alone, between the end of August and the end of September 1992, they documented pervasive problems during mealtimes, including approximately 20 residents whom they identified as eating at an excessively rapidly rate without staff intervention. U.S. Exhs. 165 and 165 (a)-(h). Based upon his observations, Mr. Bellomo concluded that staff needed to encourage residents to slow down during eating. U.S. Exh. 165. For example, Mr. Bellomo saw Kathryn P. eating one spoonful every two and a half to three seconds. Tr. 7/29/93 (McGowan) at 140; U.S. Exh. 165(a). He also observed Anthony M. eating at a rate of twenty spoonfuls per minute. Even after Mr. Bellomo called this to staff's attention, Anthony continued to eat at this rate. Tr. 7/29/93 (McGowan) at 140; U.S. Exh. 165(f). In addition, Mr. Bellomo watched Richard P., who has a history of choking, consume his meal in four minutes. Tr. 7/29/93 (McGowan) at 141; U.S. Exh. 165(h). During the course of one meal, Mr. O'Brien saw Gary K. finish his meal in less than two minutes, Ed Q. finish in four minutes "without coming up for air," and C.S. "just shoveled food in." Tr. 7/29/93 (McGowan) at 140; U.S. Exh. 165(b). At one point during this meal, there were 29 residents with only three staff and Mr. O'Brien had to stop one of the staff from leaving the dining room because of his

concern about the staff ratios. Id. In addition to concerns about residents gulping their food, Mr. Bellomo and Mr. O'Brien also documented residents engaging in uninterrupted self-injurious behaviors and refusing meals without staff assistance. Tr. 7/29/93 (McGowan) at 141.

Ms. Ferut, a direct care staff person who has worked at Laurel House since 1984, has repeatedly witnessed the same types of unsafe behaviors at Ebensburg documented by Mr. Bellomo, Mr. O'Brien, and Ms. McGowan. She has voiced her concerns to management. Tr. 7/29/93 (McGowan) at 106; U.S. Exh. 611 (Ferut Dep.) at 29. Residents exhibit dangerous behaviors during mealtimes, such as jumping up and taking a plate and throwing it across the room, biting, and pica. Tr. 7/29/93 (McGowan) at 107; U.S. Exh. 611 (Ferut Dep.) at 29-30. She has seen both residents and staff get injured during mealtimes. Id. There are "a lot" of clients who choke in Laurel House. Id. She states that staff "really have to watch them because they stuff their mouth with the food." Id. In sum, in Ms. Ferut's words: "It's mind-boggling how many behaviors you have ... It's mind-boggling what you have." Id. Ms. Ferut thinks that there should be more staff assigned to mealtimes to address behaviors that occur. Id. The majority of other RSA's share her belief that more staff are needed, particularly at mealtimes. Id.; U.S. Exh. 611 (Ferut Dep.) at 30. When Mr. Bellomo issued a memorandum on September 8, 1992 reflecting concerns about the rapid rate of eating of individuals at Laurel House, it did not come as a surprise to Mr. Seymour, the Unit Manager of Laurel. U.S. Exh. 631 (Seymour Dep.) at 77; Seymour Dep. Exh. 18. In fact, Mr. Seymour was aware of concerns that Mr. Bellomo had about individuals at Laurel House eating too quickly as far back as February of 1991. U.S. Exh.

631 (Seymour Dep.) at 73. Mr. Seymour was present during the breakfast that Ms. McGowan observed at Laurel House on November 12, 1992. U.S. Exh. 631 (Seymour Dep.) at 98. He observed individuals at that time whom he acknowledges were eating too quickly and stuffing their mouths with too much food. Id. at 98, 100. There are individuals at Laurel House who continue to consume too much food with each spoonful or forkful. Id. at 81. In addition, dining room monitors often report to him that residents are eating at a rapid rate. Id. at 80. As late as April 1993, the Dysphagia Team identified 42 of the 96 residents in Laurel House as "unsafe eaters." Tr. 10/12/93 (Sheppard) at 181-182.

Mr. McGuire, Unit Manager at Horizon House, has also noticed problems with meal times at Horizon, including the speed of eating and gulping drinks since he came to Horizon in February 1991. U.S. Exh. 623 (McGuire Dep.) at 9, 109-110. He has seen staff fail to intervene when an individual was eating too quickly. U.S. Exh. 623 (McGuire Dep.) at 112. Mr. McGuire knows that eating too quickly presents the potential of choking or aspiration which are obvious health risks "up to and including death." U.S. Exh. 623 (McGuire Dep.) at 112-113. There are individuals at Horizon who stuff their mouths with food. U.S. Exh. 623 (McGuire Dep.) at 113. Mr. McGuire does not think he has enough staff to intervene and prevent behaviors in which clients should not engage during meal times, such as eating too fast. U.S. Exh. 623 (McGuire Dep.) at 113, 123. There are not enough staff to address the behaviors consistently so that the behaviors change. U.S. Exh. 623 (McGuire Dep.) at 123-124.

Mr. Ratchford, Director of Therapeutic Activity Services, admits that there are Ebensburg residents who eat lunch during day programs at Old Main who eat too fast and

stuff their mouths with food. U.S. Exh. 628 (Ratchford Dep.) at 160, 169. To Mr. Ratchford's knowledge, the staff at Old Main have not informed the psychologists about the problems with certain known feeding problems. U.S. Exh. 628 (Ratchford Dep.) at 162-163. There is no PSA assigned to lunch at Old Main to help address eating too fast, although Mr. Ratchford agrees that it probably would help. U.S. Exh. 628 (Ratchford Dep.) at 176.

Ms. Frye, a member of the Dysphagia Team, thinks that the number of choking episodes would be reduced at Ebensburg if there were more staff to interact with residents and to provide one-to-one supervision. U.S. Exh. 613 (Frye Dep.) at 54. With one-to-one attention, staff could teach residents that are eating at a rapid pace to slow down. U.S. Exh. 613 (Frye Dep.) at 54. If more residents were given one-to-one attention during mealtimes, staff could also work on hand guidance skills with residents who are not feeding themselves. U.S. Exh. 613 (Frye Dep.) at 54.

2. Ebensburg Residents' Unsafe Behaviors During Mealtimes Have Resulted In Life-Threatening Risks.

Ebensburg residents' dangerous mealtime behaviors have directly resulted in harm. Both Ms. Wagner, the head of Ebensburg's Dysphagia Team, and Ms. Frye, the LOTA on the Team, admit that residents' behaviors, such as overstuffing and eating too quickly, are the most common reason why Ebensburg residents choke. U.S. Exh. 641 (Wagner Dep.) at 48; U.S. Exh. 613 (Frye Dep.) at 13. In a sixteen week period of time at the beginning of 1993, there were at least seventeen documented instances where residents choked as a result

of their unsafe behaviors.^{12/} U.S. Exh. 273 (attached). This averages to more than one choking each week. The rate of choking at Ebensburg is increasing dramatically. Tr. 7/29/93 (McGowan) at 144. In 1992, there were at least twenty-nine choking incidents and in 1991 there were at least eighteen chokings. Id.; U.S. Exh. 273.^{13/} This represents more than a 60% increase in chokings between 1991 and 1992. Id. Even in the face of this significant increase, the rate of choking at Ebensburg in early 1993 continued to escalate. In Ms. McGowan's vast experiences over the past ten years, she has never seen a facility where chokings have been as systemic a problem as they are at Ebensburg. Tr. 7/29/93 (McGowan) at 204.

The only comparative information about choking of which Dr. Sheppard was aware and was able to provide to the Court during her testimony was data from 1979-1980 at Letchworth Village, another mental retardation facility. Tr. 10/12/93 (Sheppard) at 83. Between May 1979 and June 1980, Letchworth had thirty chokings on both edible and non-edible substances out of a population of 2,299 residents. Tr. 10/12/93 (Sheppard) at 159-160. This is a choking rate of 1.3% for mealtime chokings and pica episodes. In 1992, the

^{12/} United States' Exhibit 273 summarizes sixteen chokings during this period of time. It does not include an additional choking on February 23, 1993 where John B. stole a pancake from another resident's tray, stuffed it in his mouth, and started choking. U.S. Exh. 1033 at 00395370. Despite the fact that this choking occurred while Dr. Sheppard's tour was taking place, she was unaware of this choking and no one at Ebensburg brought it to her attention. Tr. 10/19/93 (Sheppard) at 137-138. This incident took place less than two weeks after John B. stole whole pieces of chicken from another resident's tray, stuffed them into his mouth, and started choking. U.S. Exh. 1033 at 00395368; U.S. Exh. 273. Dr. Sheppard also did not review the two choking episodes that took place in July 1993, around the time of her second tour of Ebensburg, including one choking episode that required an emergency hospitalization. Tr. 10/12/93 (Sheppard) at 173; U.S. Exh. 988.

^{13/} Because Ebensburg does not always complete an occurrence report for a choking episode, there is no way of knowing the total number of chokings. See, e.g., U.S. Exh. 136 (no occurrence reports for John B.'s choking on February 16 and 23, 1993).

choking rate at Ebensburg for mealtime chokings was 6.2 percent -- not including pica chokings -- a rate of five times that of Letchworth Village.^{14/} By extrapolating the seventeen mealtime chokings at Ebensburg during the first sixteen weeks of 1993 to a year's worth of data, the choking rate is 11.7 percent.

The computerized list provided to Dr. Sheppard by Ebensburg that she relied on to form her opinion about the number and type of choking episodes at the facility was not complete or accurate. Tr. 10/12/93 (Sheppard) at 148, 150, 154. She did not review the circumstances surrounding the choking episodes at Ebensburg. Tr. 10/12/93 (Sheppard) at 164.

Nearly one-half of the chokings at Ebensburg in 1993 required the Heimlich maneuver or some other emergency intervention for the resident to recover from the episode. U.S. Exh. 273. For example, in an incident on April 22, 1993, Edward S. had to be transported to the emergency room at Mercy Hospital because he was gagging and cyanotic after stealing meat from another resident's tray and stuffing it in his mouth. He is on a pureed diet. Id. Vickie W. choked on January 13, 1993 after she stuffed an entire piece of cake into her mouth. She was "limp and purplish" and it took the concerted efforts of two registered nurses to revive her. One nurse finger swept Vickie's mouth while the other performed the heimlich. Oxygen had to be administered following the incident. U.S. Exh. 273 at 2. During 1991 and 1992, Ebensburg residents required the Heimlich maneuver or had to be sent to the emergency room for chokings on at least twenty-three occasions. U.S.

^{14/} This number does not include chokings due to pica episodes during 1992, such as when Brian B. choked during lunch and was found to have a thermometer ear tip lodged in his throat or when he was drooling and unable to swallow during breakfast because he had a paper dixie cup in his throat. U.S. Exh. 590.

Exh. 273. For instance, Robert Y. required emergency hospitalization when he lost consciousness and experienced acute respiratory distress from a choking incident where he stole food from another resident's tray. Id. at 4.

Ebensburg is failing to prevent residents with a history of choking from repeated further chokings. Charles M. had three choking episodes in five months between late 1992 and early 1993. U.S. Exh. 273. Pamela R. also had three choking episodes during roughly the same period of time. Id. Other residents have also had multiple choking episodes, including the following twelve people: Mary Lou F., Mary Ann R., Deborah S., Griffith S., Fred G., John B., Alan G., Elliot G., Sylvia B., Albert K., Sandra S., and Gary W. U.S. Exh. 273. Staff are simply not paying adequate attention to repetitive chokers with known unsafe eating behaviors as evidenced by the residents with choking histories whom both Mr. Bellomo and Ms. McGowan have documented as engaging in continuing dangerous mealtime behaviors. Tr. 7/29/93 (McGowan) at 145.

The reasons why Ebensburg residents are choking are consistent and preventable. There are common themes apparent in Ebensburg's own reports of the choking incidents:

- staff are not monitoring, moderating, and intervening when residents are overstuffing their mouths and/or eating too fast (Charles M., Vickie W., Mary Lou F., Vincent P., Mary Ann R., Ibrahim D., James S., Larry D., David G., Alice W., and Sandra S.). Tr. 7/29/93 (McGowan) at 145; U.S. Exh. 273;
- staff are not adequately monitoring residents during mealtimes and residents are stealing food that either is not on their diet or that they then stuff into their mouth (Mary Ann R., Edward S., John B., Robert Y., and Fred G.). Id.; and
- Ebensburg is not following physician's orders imposing dietary restrictions and is giving residents food that is strictly prohibited, such as large chunks of meat given to residents on chopped diets (Pamela R., Alan G., Fred G., Eileen G., Joyce Y., Judith L., Mary Lou F., Richard P., Francis R., Jacqueline H., and Benita B.). Tr. 7/29/93 (McGowan) at 146; U.S. Exh. 273.

Even as this case was proceeding to trial, these same types of preventable chokings persisted. On July 13, 1993, Mary Lou F., who lives in Laurel House and has a history of prior chokings, required an emergency hospitalization after she began gagging and choking on a cookie. U.S. Exh. 988. Her occurrence report notes that deserts should be chopped before being given to residents and staff did not notice that she had whole cookies on her dish. Id. Less than one week later, on July 19, 1993, Mary B., another Laurel House resident, vomited and coughed up a chunk of meat. She is only supposed to receive ground meat. Id. Staff surmise that the chunk of meat was either mistakenly placed on her tray or that she may have stolen the meat from another tray. Id. Mr. Seymour, the Unit Manager of Laurel House, knew as far back as December 1992 that problems with the consistency of food, including chopped salad, shredded salad, and beef cubes, were common reasons for choking in Laurel House. U.S. Exh. 631 (Seymour Dep.) at 83.

3. The Defendants Have Been Aware Of Problems At Ebensburg Where Individuals Are Eating At Too Rapid A Pace And Stuffing Their Mouths With Food For The Past Decade.

As far back as December 1983, State surveyors advised Ebensburg that staff were failing to intervene when residents were engaged in dangerous mealtime behaviors such as overstuffing food in their mouths. Tr. 7/29/93 (McGowan) at 154; U.S. Exh. 668 (attached). Throughout the years between 1983 and the most recent medical assistance survey that took place in October 1993, State surveyors have repeatedly cited Ebensburg for the precise type of deficiencies and unsafe practices noted by Ms. McGowan throughout her tours of Ebensburg. Tr. 7/29/93 (McGowan) at 154-156. For example, in October 1989, State surveyors saw an underweight resident shoveling food onto her bib and into her hair.

Rather than assisting her, staff pushed her tray aside before she had finished her tray and told her she was done. Tr. 7/29/93 (McGowan) at 155; U.S. Exh. 668. In the same year but at a different mealtime, State surveyors saw a blind resident who had his mouth down into his tray and was scooping food with his hands. His head, face, and hands were covered with food. Even though staff were standing close to the resident, they offered no assistance. Tr. 7/29/93 (McGowan) at 155; U.S. Exh. 668 at 2. In a memo sent to all direct care staff dated April 6, 1990, Ebensburg administrators specifically acknowledged that there have been problems identified by State surveyors with staff failing to monitor residents, to intervene in unsafe behaviors, and to provide assistance to residents who need it. Tr. 7/29/93 (McGowan) at 153-154; U.S. Exh. 169. In October 1991 as well as November 1992, State surveyors observed residents literally "lapping up" their meals with no intervention by staff. Tr. 7/29/93 (McGowan) at 155-156; U.S. Exh. 668 at 2-3. As recently as October 1993, even after Ms. McGowan testified in this case, State surveyors still found "little staff intervention" where individuals were eating rapidly, using their fingers instead of utensils, and taking food from other residents' meal trays during mealtimes in Sunset, Villa and Laurel House. U.S. Exh. 1103 at 4, 10.

The common theme throughout the medical assistance deficiencies is that staff simply fail to intervene. They do not teach residents safe eating techniques. They do not provide assistance to underweight residents who need help with eating. They do not follow feeding plans. And they do not intervene even in the face of potentially life-threatening behavior.

F. The Dining Environment At Ebensburg Is Itself Unsafe.

Throughout her observations of mealtimes, Ms. McGowan found that the dining environment was unsafe. Tr. 7/29/93 (McGowan) at 92. There are too many people congregated together in what often becomes a very loud cacophonous environment, where it is difficult for staff to pay attention to what it is going on and for residents to concentrate on eating. Id. It is impossible to control the stimulus and there are too many distractions. Id. at 142. The environment does not lend itself to teaching appropriate eating behavior and observing individuals' eating practices. Id. at 143. Dr. Sheppard agrees that it is important to have a calm, relaxing atmosphere that allows for optimum concentration on eating, particularly where individuals have difficulty eating. Tr. 10/12/93 (Sheppard) at 162. Dr. Hinkle is in agreement, as well, that a quiet environment without distractions lends itself to safe feeding. Tr. 12/16/93 (Hinkle) at 34; U.S. Exh. 1120. Dr. Sulkes believes that meal times should be made a pleasure for dysphagic individuals with developmental disabilities. Tr. 7/27/93 (Sulkes) at 98. It is important to have the staff interact with the individual being fed. Tr. 7/27/93 (Sulkes) at 98. It is a dehumanizing experience to have to be fed by staff who are shovelling food into your mouth while talking to other staff members. Tr. 7/27/93 (Sulkes) at 98.

The persistent existence of flies in the dining rooms also poses "genuine health hazards." Tr. 7/29/93 (McGowan) at 92. Ms. McGowan observed flies at every mealtime in every dining room in August 1992 and frequently during November 1992. Id. at 208-209. One year later, State surveyors continued to find flies on residents and residents' food during

mealtimes at multiple locations and on multiple days at Ebensburg during October 1993.

U.S. Exh. 1103 at 10.

G. The United States' Feeding Videotape Demonstrates Systemic Deficient Practices That Depart From Accepted Professional Standards.

Ms. McGowan selected excerpts of videotapes taken under her direction by a FBI photographer of mealtimes at Ebensburg during her August and November 1992 tours. Tr. 7/29/93 (McGowan) at 108; U.S. Exh. 258. The videotape segments are illustrative of what she observed repeatedly throughout not only her 1992 tours but also her February 1993 tour of Ebensburg. Tr. 7/29/93 (McGowan) at 137. She selected the videotape segments to demonstrate significant problems that she found to be systemic during mealtimes at Ebensburg. Id. Each of the four expert witnesses who reviewed and testified about the videotape had concerns about feeding practices. Tr. 7/29/93 (McGowan) at 111-137; Tr. 10/12/93 (Sheppard) at 58, 67-87; Tr. 12/13/93 (Rubin) at 86; Tr. 12/16/93 (Hinkle) at 15. When Dr. Rubin viewed the United States' feeding videotape, he "had a number of concerns about feeding practices" that he saw in "many of the individuals who were being fed." Tr. 12/13/93 (Rubin) at 86. In particular, he was "struck by and concerned by the degree to which [he] saw individuals having difficulty with swallowing." Tr. 12/13/93 (Rubin) at 86. Dr. Rubin concluded that the "feeding practices were seriously jeopardizing the comfort, the well-being and certainly placing the individuals at risk." Tr. 12/13/93 (Rubin) at 86. It further concerned Dr. Rubin that "an appearance of distress may not be recognized as such." Tr. 12/13/93 (Rubin) at 87.

The videotape illustrates the following major deficiencies for 28 Ebensburg residents:

- Residents being fed with unsafe practices in unsafe positions in carts where their bodies and heads are not sufficiently elevated and are improperly aligned (Barry D., Ronald E., Joseph T., Frank H., Timothy P., and Ronald P.). Tr. 7/29/93 (McGowan) at 111-116;

- Residents being fed with their necks and head in extension and in extension and rotated (Paul G., Harold B., William A., Duane P., Andrea S., Lois S., Beth S., and Sam B.). Tr. 7/29/93 (McGowan) at 116-123;

- Professional and paraprofessional staff feeding residents in unsafe positions and using unsafe practices (Ellen H., James M., Joseph R.,^{15/} Tim G., and John H.). Tr. 7/29/93 (McGowan) at 123-128;

- Residents experiencing distress as a result of these unsafe practices and positions (Ronald E., Tony R., James M., Raymond W., Rhett T., and David K.). Tr. 7/29/93 (McGowan) at 128-132; and

- Ambulatory residents engaging in unsafe behaviors and experiencing difficulty eating with no staff intervention (Ron. L., Lee V., Jerry Mc.,^{16/} Donald P., Kathy W., and William C.). Tr. 7/29/93 (McGowan) at 133-136.

Dr. Sheppard was not present while the mealtimes in the United States' videotape took place. Tr. 10/18/93 (Sheppard) at 42. She did not know the nutritional and respiratory status of residents on videotape or their hospitalization histories. Tr. 10/18/93 (Sheppard) at 52. Although she believes that "one can make judgments about adequacy of feeding techniques from observations of the individual's reaction to the techniques." (Tr. 10/18/93 (Sheppard) at 126, lines 22-24), the Commonwealth's sur-rebuttal expert witness in feeding strongly disagrees. Tr. 12/16/93 (Hinkle) at 19. For example, Dr. Hinkle believes that the only way you can make a certain determination about whether an individual is in danger when they receive food or fluid with their head in extension is by conducting a comprehensive evaluation by a swallowing specialist. Tr. 12/16/93 (Hinkle) at 19-20, 21.

^{15/} Joseph R. is incorrectly identified as James R. in the transcript.

^{16/} Jerry Mc. was subsequently incorrectly identified as John Mc. by Dr. Sheppard during her narration of the videotape. Tr. 10/12/93 (Sheppard) at 71.

Dr. Sheppard admitted that she could not evaluate a number of aspects of the feeding videotape. For example, she could not ascertain the elevation of carts. Tr. 10/12/93 (Sheppard) at 46. She could not determine the angle of residents' heads. Tr. 10/12/93 (Sheppard) at 48, 65. Her ability to comment on the photographs taken from the feeding videotape (U.S. Exhs. 227-250) was even more limited. She agreed that "photographs are even more difficult to draw conclusions from than videotapes" and that she didn't even know who the residents were. Basically, all she was able to conclude about the photographs is that "these are pictures of severely handicapped individuals." Tr. 10/12/93 (Sheppard) at 75.

XII. EBENSBURG IS HARMING ITS RESIDENTS BY FAILING TO PROVIDE THEM WITH PROACTIVE, PREVENTIVE CONTINUITY OF MEDICAL AND HEALTH CARE IN VIOLATION OF GENERALLY ACCEPTED PROFESSIONAL STANDARDS.

A. Medical And Health Care Is Inadequate.

"Continuity of care" is the "essence of primary care" and it simply involves making an effort to foresee and envision medical and health problems so as to prevent them before they arise. Tr. 7/27/93 (Sulkes) at 146, lines 7-8. It is generally accepted that medical care is to be preventive and "proactive," not reactive. Tr. 7/27/93 (Sulkes) at 146. A doctor or medical staff is always to provide long-term management and care that is consistent, thoughtful and planned. Tr. 7/27/93 (Sulkes) at 146. This philosophy of medicine applies to everyone -- the general population and those with developmental disabilities living in an institution. Tr. 7/27/93 (Sulkes) at 147.^{1/} The emphasis on preventive medicine is likely to continue to intensify in the future because proactive continuity of care is so fundamental to the care of everyone. Tr. 7/27/93 (Sulkes) at 147. Dr. Kastner agreed that in medicine in general, there is a growing emphasis on disease prevention and health promotion. Tr. 9/13/93 (Kastner) at 237-8.

Providing preventive continuity of care in a facility like Ebensburg requires good communication among the medical staff, adequate documentation, and thoughtful long-term

^{1/} For example, outside the developmental disabilities context, today's health maintenance organizations ("HMO's") look to prevent problems in the future rather than just respond to problems when they come up or when a person gets sick. Tr. 7/27/93 (Sulkes) at 146-7.

planning. Tr. 7/27/93 (Sulkes) at 147.^{2/} However, Ebensburg does not provide its residents with continuity of care that would meet generally accepted standards. Tr. 7/27/93 (Sulkes) at 146, 148. Specifically, communication and documentation about long-term medical planning are not adequately undertaken and completed at Ebensburg. Tr. 7/27/93 (Sulkes) at 148-9. In addition, the documentation and communication between Ebensburg physicians and the medical staff at the local hospital, and the documentation and communication between the Ebensburg doctors and the outside consultants who work at Ebensburg are insufficient and problematic. Tr. 7/27/93 (Sulkes) at 149. Finally, Ebensburg is consistently failing to maintain sufficient physician staffing levels to adequately address its residents' acute and chronic medical needs. Tr. 7/27/93 (Sulkes) at 148. As a result continuity of medical and health care at Ebensburg has suffered. The poor coordination of care at Ebensburg potentially affects all the residents in the facility in one way or another. Tr. 7/28/93 (Sulkes) at 22.

1. Ebensburg Is Not Adequately Documenting Long-Term Care For Its Residents.

Medical documentation is essential for providing medical care to individuals, like those at Ebensburg, with a chronic condition, because the medical professionals need to address health and medical conditions over the course of years, constantly monitoring the tempo and status of the person's health. Tr. 7/27/93 (Sulkes) at 147, 157. In fact, a medical provider like Ebensburg cannot provide an institutional resident with developmental

^{2/} Dr. Sulkes added that proactive care is the very reason to have full-time physicians working at Ebensburg; if all the Ebensburg physicians are going to do is respond to sickness or an acute event and then end up sending the individual to the hospital, there is no point in having physicians working full-time at the institution. Tr. 7/27/93 (Sulkes) at 147.

disabilities with appropriate medical care without adequate medical documentation as reflected in the charts. Tr. 7/27/93 (Sulkes) at 84-5, 156. An oral tradition does not lend itself to the chronic care of people with disabilities. Tr. 7/27/93 (Sulkes) at 84. Thinking and talking about the residents with other doctors and colleagues to plan what will happen in the future is not enough; the product of this communication and discussion must be written down in the medical record in order to provide continuity of care. Tr. 7/27/93 (Sulkes) at 149. Otherwise, the medical discussion just becomes a conversation between two people. Tr. 7/27/93 (Sulkes) at 149. It is generally accepted that without adequate documentation, chronic care cannot take place. Tr. 7/27/93 (Sulkes) at 157; Tr. 7/28/93 (Sulkes) at 5. Dr. Kastner agreed that if a health care provider does not maintain comprehensive medical records, it cannot effectively manage a patient over time. Tr. 9/13/93 (Kastner) at 185.^{3/}

The medical record plays an important role in the active treatment of a resident receiving chronic care because the medical chart in essence tells the story of the person's life. Tr. 7/27/93 (Sulkes) at 84. It enables any new staff member to understand the resident's needs and past medical history. Tr. 7/27/93 (Sulkes) at 84. Documentation also allows a professional to communicate with other professionals on other shifts about what happened that day with this individual medically. Tr. 7/28/93 (Sulkes) at 2. As a result, the written record must be accurate, readable and complete. Tr. 7/27/93 (Sulkes) at 84. Dr. Kastner agreed that the record should serve as a means of communication between the physicians. Tr. 9/13/93 (Kastner) at 186. Dr. Kastner testified that the medical record

^{3/} Kastner agreed that a health care provider should maintain comprehensive medical records and that if the provider does not, it is difficult to evaluate the adequacy of that care over time. Tr. 9/13/93 (Kastner) at 185.

should be able to stand on its own, so a physician who assumes the care of a person would be able to provide continuity in the care based on the medical record. Tr. 9/13/93 (Kastner) at 186. He added that as the physician or other medical professional is less familiar with the patient, the medical record assumes a greater importance. Tr. 9/13/93 (Kastner) at 186. He testified that it is always important to maintain comprehensive records. Tr. 9/13/93 (Kastner) at 186. Ebensburg does not adequately document the long-term care provided to its residents so as to meet what is generally accepted in the medical community. Tr. 7/28/93 (Sulkes) at 5. Whatever documentation is taking place is episodic and reactive rather than proactive. Tr. 7/27/93 (Sulkes) at 149. Experts for both the Commonwealth and the United States found problems in this area. Tr. 7/28/93 (Sulkes) at 5; Tr. 9/13/93 (Kastner) at 143-5, 186-90. Dr. Sulkes found multiple instances where the records just were not clear. Tr. 7/28/93 (Sulkes) at 5. In addition, he found discussions of medical procedures that might take place, but the record is not clear as to whether or not they actually took place. Tr. 7/28/93 (Sulkes) at 12. In the end, the record does not show evidence of follow-up or closure. Tr. 7/28/93 (Sulkes) at 12. He concluded generally that there are multiple inadequacies in charting for both acute and long-term care. Tr. 7/28/93 (Sulkes) at 11. Ebensburg does not even meet its own policies requiring adequate medical documentation.^{4/}

^{4/} In its paper policies at least, Ebensburg recognizes the need for adequate medical documentation. For example, Ebensburg Policy 147 entitled Physician's Progress Notes provides: "It is the policy of Ebensburg: That physicians will write progress notes in clients' charts for all treatments, reviews, consultations and drugs." U.S. Exh. 20. The Reference Policy states that the physician will "write progress notes in association with 60-day medication reviews which shall include an assessment of the client's condition, all medications currently used, the reason for use and the results expected or obtained; write a progress note in association with 30-day behavior modifying agent reviews which shall include the target behavior for their use and the results expected or obtained." U.S. Exh. 20. Finally, the Reference Policy provides that the physician will "write a progress note at the termination (continued...)

Dr. Kastner agreed that the "most significant deficiency at Ebensburg was the organization of the record." Tr. 9/13/93 (Kastner) at 145. He indicated that the Ebensburg medical records were somewhat "disorganized and confusing." Tr. 9/13/93 (Kastner) at 186-7. Dr. Kastner testified that based upon his review of the medical records at Ebensburg, some improvements could be made. Tr. 9/13/93 (Kastner) at 186. He then cited a long list of areas in the charts that could be improved. For example, Dr. Kastner indicated that he thought they should "emphasize the medical issues more." Tr. 9/13/93 (Kastner) at 143, 145. Dr. Kastner indicated that some of the annual summaries could be more complete. Tr. 9/13/93 (Kastner) at 188. Dr. Kastner indicated that occasionally summary notes made at the time of the annual review could be more complete. Tr. 9/13/93 (Kastner) at 188. Dr. Kastner testified that with respect to the progress notes and the physicians' input into the medical section, "the physicians at Ebensburg could do a better job." Tr. 9/13/93 (Kastner) at 143. Dr. Kastner indicated that progress notes in the medical record are infrequent. Tr. 9/13/93 (Kastner) at 188-9; Def. Exh. HH at 26. Dr. Kastner also indicated that abnormal laboratory data, incident reports, consultation reports, and health promotion activities are rarely documented in the physicians' section of the medical record. Tr. 9/13/93 (Kastner) at 144, 189. Dr. Kastner indicated that the documentation of tests, procedures and evaluations could be improved at Ebensburg. Tr. 9/13/93 (Kastner) at 189. Dr. Kastner indicated that rarely is a chart note entered by the physician documenting the results of the test procedure or evaluation. Tr. 9/13/93 (Kastner) at 189. He testified that he thinks "problem lists

⁴/(...continued)

of each acute health problem treatment program indicating that the problem has been resolved or if there is need for continuation of treatment." U.S. Exh. 20.

should be included, that there ought to be a greater effort to document lab results and transfers and procedures and things of that type." Tr. 9/13/93 (Kastner) at 143. Dr. Kastner indicated that there should have been an acute problem list in the front of everyone's chart for use in the case of an emergency. Tr. 9/13/93 (Kastner) at 190. Without such an acute problem list, Dr. Kastner indicated that it takes "a little bit of work to go through the record to find things" relating to important aspects of specific resident's health. Tr. 9/13/93 (Kastner) at 190. In his report, Kastner indicated that it would be valuable to maintain complete lists of active and inactive problems at the front of the resident's chart. Tr. 9/13/93 (Kastner) at 145, 190. Dr. Kastner also recommended that summary charts be placed near the front of the chart in order to provide a quick overview of the client's health status. Tr. 9/13/93 (Kastner) at 190. Dr. Kastner indicated that this would be particularly valuable during an emergency situation. Tr. 9/13/93 (Kastner) at 191. Dr. Kastner also mentioned in his report that food and medication allergies are not always clearly identified in the chart. Tr. 9/13/93 (Kastner) at 191.

Poor medical documentation has long been a problem at Ebensburg. As of its 1990 findings letter, the Department of Justice had notified defendants that Ebensburg's medical records were found to be incomplete, and frequently omitted essential and/or current information. U.S. Exh. 638 (Sponsky Dep.) Exh. 50. In addition, defendants were notified that Ebensburg records did not contain sufficient information about recent hospitalizations. U.S. Exh. 638 (Sponsky Dep.) Exh. 50.

In addition, Ebensburg has known since at least 1987 about problems in medical documentation because the Commonwealth of Pennsylvania, through its Inspection of Care

quality surveyors, has regularly found deficiencies in Ebensburg's documentation practices. Tr. 7/28/93 (Sulkes) at 11.^{5/} The findings of the IOC group have been quite consistent with Dr. Sulkes' findings on the inadequacy of documentation at Ebensburg. Tr. 7/28/93 (Sulkes) at 12-3. For example, one IOC survey, dated September 1988, indicates that Ebensburg did not meet the standard of providing physician's notes that were current, informative and justify the medical plan. Tr. 7/28/93 (Sulkes) at 13.^{6/} This IOC finding is consistent with Dr. Sulkes' findings. Tr. 7/28/93 (Sulkes) at 14. In addition, an IOC survey dated November 1987, indicates that again, as in the prior year, there are some discrepancies between the computerized physician's case management goals and the physician's documentation. Tr. 7/28/93 (Sulkes) at 14; U.S. Exh. 62. The surveyors suggest that these be reviewed by the physicians at intervals to ensure accuracy and consistency with current

^{5/} For example, in the IOC's most recent findings about Ebensburg dated January 1993, the IOC team concluded: "The documentation of Activity Progress Notes should appear in the recipients' records to address the related supplemental procedure and/or behavioral objective. This documentation was considered a "Needs Improvement" area for the 1991 review and will be again for this review period. The Progress Notes are required to be current with the observed condition of the recipient and therefore should reflect the types of activities attended, the level of participation, recipient's response and personal preferences." U.S. Exh. 67. The January findings also listed deficiencies such as no sequential documentation for one particular client. U.S. Exh. 67. For example, among their many findings in this area, the IOC team concluded "The assessment process, critical to the Active Treatment process, is frequently found to be incomplete and/or incongruent with established goals. If the recipient has achieved maximum potential or developmentally incapable of growth, then documentation must reflect medical evidence and/or historical efforts ... The documentation requirements for the Behavior Modification process continues to need improvement. Many plans continue to reflect little to no progress, lack of revision and documentation of and the number of reinforcements and interventions ... QMRP reviews are not consistently documenting changes, progress and overall status of the IHP." U.S. Exh. 67.

^{6/} The IOC concluded that there were "some discrepancies between physician documentation and case management goals. It appears that these goals are not consistently reviewed, and therefore, do not correlate with other physician documentation." U.S. Exh. 63. So there was a discrepancy between what the physicians are saying and what the staff are doing. Tr. 7/28/93 (Sulkes) at 13. It appears that the goals are not consistently reviewed and therefore do not correlate with other physician documentation. Tr. 7/28/93 (Sulkes) at 13.

medical plans of care. Tr. 7/28/93 (Sulkes) at 14; U.S. Exh. 62. Again, this IOC finding is quite consistent with the conclusions of Dr. Sulkes. Tr. 7/28/93 (Sulkes) at 14.

The following are just a few representative examples of poorly documented long-term care at Ebensburg. The examples below are not the only examples of poor documentation that Dr. Sulkes found reviewing the Ebensburg medical records. Tr. 7/28/93 (Sulkes) at 11.

- Ann R. had pneumonia identified by x-ray on January 3, 1992. Tr. 7/28/93 (Sulkes) at 5-6. Ann's condition appeared quite serious.^{7/} On January 10, 1992, she was admitted to the hospital and on January 20, 1992, she died. Tr. 7/28/93 (Sulkes) at 6. For the entire two-week period leading up to her death, including the week prior to her hospital admission, there were only two physician's notes: one on January 3rd that says: "pneumonia, right upper lobe," and one on the 9th which says: "lungs clear to A&P, will continue present treatment." Tr. 7/28/93 (Sulkes) at 6; U.S. Exh. 852BB.^{8/} There was no note about sending her to the hospital, no note about what was happening in the hospital. Tr. 7/28/93 (Sulkes) at 6; U.S. Exh. 852BB. The doctor's notes were inadequate here because one cannot tell from reading them whether the doctor looked at her on any days other than the 3rd and the 9th. Tr. 7/28/93 (Sulkes) at 7. This is true even when one looks at the nursing notes. U.S. Exh. 852AA. One cannot tell whether anyone listened to her lungs or examined her. Tr. 7/28/93 (Sulkes) at 7. Even though she continued to cough and run a fever, she never had her respiratory rate measured. Tr. 7/28/93 (Sulkes) at 6; U.S. Exh. 852AA. That is a fundamental measure of respiratory status. Tr. 7/28/93 (Sulkes) at 6. For a person with pneumonia, the doctor has to order respiratory rates if they are not being done as a matter of course. Tr. 7/28/93 (Sulkes) at 8. There was no indication that that was done here for Ann. Tr. 7/28/93 (Sulkes) at 8.

^{7/} She had pneumonia and a high fever on January 3-4, 1992; on January 5, she had "a deep harsh cough this p.m.; breath sounds on auscultation reveal coarse rales bilaterally and diminished breath sounds in bases bilaterally"; she often refused meals or ate poorly at meals that week; on January 9, she was noted to have a "deep harsh cough ... wheezing this afternoon"; the "deep harsh cough" continued on the 10th. U.S. Exh. 852AA.

^{8/} Dr. Kastner testified that he reviewed Ann R.'s death record, but he did not know that she had suffered a right lower lobe pneumonia on January 3, 1992, just seventeen days before her death. Tr. 9/13/93 (Kastner) at 233. He also did not know whether or not the medical staff at Ebensburg took or noted her respiratory rate during the time between suffering the earlier bout of right lower lobe pneumonia on January 3, 1992 and her death of bilateral pneumonia on January 20, 1992. Tr. 9/13/93 (Kastner) at 234. Dr. Kastner similarly did not know if the Ebensburg nursing notes and doctors notes were adequate for Ann R. during the crucial period of time between January 3 and January 20, 1992. Tr. 9/13/93 (Kastner) at 235.

- Nancy L., as of September 1992, was having frequent changes in her anticonvulsant or anti-seizure medications, but under the medication change section of the sixty day notes there were no medication changes listed. Tr. 7/28/93 (Sulkes) at 8.

- William P. lost thirty pounds over a sixteen month period and had known gastroesophageal reflux and yet there are no notes in his record about his weight loss. Tr. 7/28/93 (Sulkes) at 8.

- Alan G. had known GER and he was being treated with anti-reflux medications. Tr. 7/28/93 (Sulkes) at 9. Ebensburg maintained a list of residents with identified GER and yet Alan was not on this list. Tr. 7/28/93 (Sulkes) at 9. Further, in reviewing his medical chart, there was no indication that Alan's physician was aware of the problem even though the doctor was ordering medication for it. Tr. 7/28/93 (Sulkes) at 9. There was also one hospitalization that was not noted in a sixty day note. Tr. 7/28/93 (Sulkes) at 9.

- Ethel M., in 1989, had been hospitalized five times and yet had gone for 19 months without an annual medical evaluation or summary. Tr. 7/28/93 (Sulkes) at 10.

- Neal S. suffered from complex seizures and yet had no long-term plan to address this problem. Tr. 7/28/93 (Sulkes) at 10. His annual medical evaluation did not mention his admission for status epilepticus. Tr. 7/28/93 (Sulkes) at 10. In fact, even though he had stopped breathing during this episode, the annual review described his seizure control as fair. Tr. 7/28/93 (Sulkes) at 10. Neal died in January 1993. Tr. 7/28/93 (Sulkes) at 10.

- Brian B. had vomited a piece of wood that he had ingested, and yet Brian was not included on Ebensburg's list of those individuals with identified pica behavior. Tr. 7/28/93 (Sulkes) at 11.

2. Ebensburg Is Not Adequately Documenting Or Coordinating The Input From Outside Consultant Doctors Into The Residents' Long-Term Plan Of Care.

As part of providing proactive continuity of long-term care, it is generally accepted that good communication among the primary physicians in an institution and the outside medical consultants is necessary. Tr. 7/28/93 (Sulkes) at 16. It is important so that all physicians treating an individual know what the medical plan is for that individual to ensure consistency. Tr. 7/28/93 (Sulkes) at 16.

The communication that takes place between the Ebensburg doctors and the outside consultants can be written and need not take place face-to-face. Tr. 7/28/93 (Sulkes) at 44. Nonetheless, it is generally accepted that a real dialogue must take place even if in written form so that it is clear that the primary care physician has read and understood the recommendation of the outside consultant and either adopted and implemented the recommendation or rejected it with an explanation of the reasons for the rejection. Tr. 7/28/93 (Sulkes) at 45. Poor communication can negatively affect the residents because if an appropriate recommendation is not adopted by the primary care physician, then the individual's care will suffer. Tr. 7/28/93 (Sulkes) at 18. Dr. Shertz admitted that a progress note should be entered discussing what recommendations have been made by a consultant and whether or not the primary care physician agrees with the recommendations. U.S. Exh. 632 (Shertz Dep.) at 139.^{9/}

However, the communication between the Ebensburg primary care physicians and the outside medical consultants is not adequate to meet generally accepted standards in the field. Tr. 7/28/93 (Sulkes) at 17. There was no evidence that the doctors and the outside consultants were talking to each other even in written form. Tr. 7/28/93 (Sulkes) at 17.

^{9/} On paper at least, Ebensburg recognizes this. For example, Reference Policy 20 provides that the Ebensburg physician will "write progress notes summarizing results of consultations with outside specialists. Date and sign progress notes including appropriate degree/ title following name." U.S. Exh. 20. Ebensburg Reference Policy 118 provides that the Ebensburg physician will "review consultant's or team's report, initial and date it ... the team will be apprised of consultant's recommendations and asked for input ... a progress note must be written in the client's chart summarizing the report and any necessary orders must be written, if physician is in agreement with recommendations submitted ... if not in agreement with recommendation, physician must document on the IPN the reason for his decision not to follow the recommendation and develop appropriate alternate medical program to handle the problem." U.S. Exh. 178.

facility and a hospital is essential in making acute care at the hospital a real part of the individual's long-term medical plan of care. Tr. 7/28/93 (Sulkes) at 20.

This aspect of the coordination of care at Ebensburg is inadequate. Tr. 7/28/93 (Sulkes) at 21. Experts for both the Commonwealth and the United States recognized problems in this area. Tr. 7/28/93 (Sulkes) at 21; Tr. 9/13/93 (Kastner) at 187. Sometimes there are notes written in the individual's medical chart prior to being sent to the hospital and often there are not. Tr. 7/28/93 (Sulkes) at 21. Often there are no notes entered when the person returns from the hospital. Tr. 7/28/93 (Sulkes) at 21. Even if the Ebensburg doctor speaks with the doctors at the hospital, without properly documenting the oral conversations, there is no record for other professionals -- on other shifts or covering for a doctor when he is on vacation -- to rely on in terms of future care. Tr. 7/28/93 (Sulkes) at 21. This does not meet generally accepted standards in the field or Ebensburg's own policies. Dr. Sulkes stressed that verbal communication with the hospital is "very nice," but verbal communication alone without documentation only has an impact on those people who were involved in the conversation. Tr. 7/28/93 (Sulkes) at 42.

Upon readmission, Dr. Shertz acknowledged that it is Ebensburg policy for the physician to write a progress note. U.S. Exh. 632 (Shertz Dep.) at 132.^{10/} However, Dr. Shertz admitted that there are probably resident medical charts that do not contain progress notes upon readmission from the hospital. U.S. Exh. 632 (Shertz Dep.) at 132. Thus,

^{10/} Ebensburg Reference Policy 20 provides that the physicians will "write all progress notes legibly and on the approved forms in the client's record ... write a progress note with every client evaluation, new order, or order renewal, consultation review, hospital admission and discharge. A physician note is required with any significant change in the client or any significant change in the medical care program." U.S. Exh. 20.

Ebensburg is not meeting its own policies with respect to medical documentation of a resident's return from the hospital. Tr. 7/28/93 (Sulkes) at 43.

In addition, the Ebensburg staff relies too often on the information contained in the hospital discharge summaries; however, this practice is misguided because the summaries hardly ever return back to Ebensburg at the same time the individual returns. Tr. 7/28/93 (Sulkes) at 43. Dr. Shertz admitted that when a resident returns to Ebensburg from the hospital, the discharge summary written by the attending physician will follow later. U.S. Exh. 632 (Shertz Dep.) at 131. Further, the fact that a doctor may have simply read the discharge summary does not mean that he or she has processed the information and incorporated it into the person's medical plan of care. Tr. 7/28/93 (Sulkes) at 43.

Dr. Kastner agreed that documentation of transfers between units or between Ebensburg and Mercy Hospital were often incomplete or non-existent. Tr. 9/13/93 (Kastner) at 187. Dr. Kastner added that there are instances "when the documentation, the transfers between Ebensburg and Mercy Hospital, aren't included in the progress notes and the medical records aren't as frequent as they should be." Tr. 9/13/93 (Kastner) at 144. Dr. Kastner testified that the recording and documenting of these transfers ought to be featured more prominently in the Ebensburg medical records. Tr. 9/13/93 (Kastner) at 187. Dr. Kastner testified that this should be improved because the level of documentation available within the chart was not always sufficient to guarantee continuity of care for clients who are moved to acute care settings. Tr. 9/13/93 (Kastner) at 187. In short, he indicated that the hospitalization records could be improved. Tr. 9/13/93 (Kastner) at 163. He indicated that the Ebensburg physicians are "just going to have to make a better effort to write their notes."

Tr. 9/13/93 (Kastner) at 163 Dr. Kastner testified that they are "just going to have to do a better job." Tr. 9/13/93 (Kastner) at 163. There are many examples of this type of deficiency at Ebensburg.

- Neal S. was admitted to the hospital for unremitting seizures. Tr. 7/28/93 (Sulkes) at 21. He was being closely followed by the Ebensburg neurology consultant, but when he went to the hospital, a different neurologist was in charge of his care. Tr. 7/28/93 (Sulkes) at 21-2. From reviewing the written record, Dr. Sulkes could discern no coordination between the hospital neurologist, the Ebensburg consultant neurologist and the Ebensburg primary care physician. Tr. 7/28/93 (Sulkes) at 22.

- Charles S. was admitted to the hospital with unremitting seizures. Tr. 7/28/93 (Sulkes) at 22. He had had his seizure care completely reworked in the hospital with no discussion in the record about what the plan had been at Ebensburg in terms of managing his anticonvulsants. Tr. 7/28/93 (Sulkes) at 22.

- Raymond W. was admitted to the hospital with aspiration pneumonia and was vomiting blood. Tr. 7/28/93 (Sulkes) at 22. His diagnosis was aspiration. Tr. 7/28/93 (Sulkes) at 22. When he was readmitted to Ebensburg, there was no evidence or suggestion that this event was going to result in a change in his medical plan of care or that there had even been a discussion with the hospital about this. Tr. 7/28/93 (Sulkes) at 22.

- Darlene F. had significant problems with pica behavior where she would ingest non-food sorts of objects like cigarettes. Tr. 7/28/93 (Sulkes) at 9. As a result of eating cigarettes, she developed blood tinged vomiting. Tr. 7/28/93 (Sulkes) at 9. When she was sent to the hospital, there was no note prior to her transfer to the hospital and the note written upon her return from the hospital did not describe why she had been sent to the hospital. Tr. 7/28/93 (Sulkes) at 9. In addition, there was no plan about how to address her problem pica behavior. Tr. 7/28/93 (Sulkes) at 9. Also, the taper of one of Darlene's psychotropic medications was stopped with no explanation. Tr. 7/28/93 (Sulkes) at 9-10.

- Mary Ann R. was hospitalized but her sixty day note that followed the hospitalization did not mention it. Tr. 7/28/93 (Sulkes) at 10.

- George N. was admitted to the hospital on January 10 with upper gastrointestinal bleeding and was discharged from the hospital on the 19th. Tr. 7/28/93 (Sulkes) at 10. There was no description in the record of how George looked when he came out of the hospital. Tr. 7/28/93 (Sulkes) at 10. In fact, there was no progress note written until the 29th, ten days later, when he was having respiratory distress. Tr. 7/28/93 (Sulkes) at 10. Respiratory distress is a condition serious enough to possibly have him re-admitted to the hospital. Tr. 7/28/93 (Sulkes) at 10. Yet, because there was no description of how George

looked immediately after the hospitalization, there was no way to tell if he had deteriorated, improved or stayed the same while back at Ebensburg. Tr. 7/28/93 (Sulkes) at 10.

The actual list of examples of deficient recordkeeping practices at Ebensburg is far more numerous than the examples above. Tr. 7/28/93 (Sulkes) at 22.^{11/}

4. Ebensburg Is Consistently Failing To Maintain Sufficient Physician Staffing Levels.

The current overall physician staffing level at Ebensburg negatively impacts on its ability to provide proactive care to its residents. Tr. 7/27/93 (Sulkes) at 149. A ratio of one doctor to one hundred residents is a reasonable average for a facility like Ebensburg. Tr. 7/27/93 (Sulkes) at 150. A ratio of one to one hundred twenty would be an outside limit of what was reasonable. Tr. 7/27/93 (Sulkes) at 150. Currently, however, there are only four doctors on staff full-time at Ebensburg and the current doctor to client ratio at Ebensburg is approximately one doctor to 120-125 clients. U.S. Exh. 632 (Shertz Dep.) at 28. Having four physicians to cover medical responsibilities for the residents at a facility the size of Ebensburg is thus at the outer limit of what is reasonably acceptable. Tr. 7/28/93 (Sulkes) at 26.

^{11/} Dr. Kastner testified that he did not see any problems in terms of coordination between Ebensburg and Mercy Hospital as it related to patient care. Tr. 9/13/93 (Kastner) at 162. However, Kastner did not review the medical records of any individuals discussed above. Further, Dr. Kastner based this conclusion upon an assumption that the staff of Mercy Hospital was "comfortable" with the Ebensburg residents, based upon their "familiarity" with them. Tr. 9/14/93 (Kastner) at 40; Tr. 9/13/93 (Kastner) at 163; Def. Exh. HH at 14. However, this assumption is faulty because it does not take into account residents never before hospitalized or the addition of new doctors at Mercy; Dr. Kastner also testified that he has never personally interviewed anyone at Mercy Hospital to verify that the staff there was in fact "familiar" and "comfortable" with the Ebensburg residents. Tr. 9/14/93 (Kastner) at 40. Dr. Kastner indicated that in fact, he had never even been to Mercy Hospital. Tr. 9/14/93 (Kastner) at 40-1.

The Ebensburg physician staffing levels regularly fall below what is acceptable however, when one doctor is absent from the facility. When one doctor is on vacation, for example, Dr. Shertz acknowledged that the other doctors need to cover for the absent one. U.S. Exh. 632 (Shertz Dep.) at 32. Dr. Shertz acknowledged that this increases each doctor's caseload to a ratio well above the 1:120-125 ratio when all four doctors are present. U.S. Exh. 632 (Shertz Dep.) at 32. In fact, when there are only three doctors present, the physician to resident ratio leaps up to 1:150 or 160. Tr. 7/27/93 (Sulkes) at 150.^{12/}

Dr. Sulkes concluded that this number is "too high." Tr. 7/27/93 (Sulkes) at 150. The difficulty in handling 150 or 160 residents as opposed to 100 or 120 is that the physician will have less time to pay attention to the residents who require chronic care. Tr. 7/27/93 (Sulkes) at 151. Dr. Kastner agreed that if a doctor in an institution becomes responsible for a greater number of patients, the time he has to devote to the care and treatment of each individual necessarily decreases. Tr. 9/14/93 (Kastner) at 36. Dr. Kastner indicated that there is a point at which this has a negative effect on the doctor's ability to chart and maintain medical records and this has an effect on medical care. Tr. 9/14/93 (Kastner) at 36. Making the rounds to see every resident becomes much tougher because every physician has to see that many more people. Tr. 7/27/93 (Sulkes) at 151. When the day-to-day acute problems arise, it becomes "impossible" for the doctors to adequately address the residents' long-term medical needs. Tr. 7/27/93 (Sulkes) at 151, line 6. Dr. Sulkes characterized this

^{12/} Individual doctors may end up assuming responsibility for even more residents. For example, Dr. Shertz admitted that if Dr. Reyes goes on vacation, Dr. O'Connor would assume responsibility for both buildings five (Laurel) and seven (Keystone) thereby doubling her normal caseload to serve about 192 individuals. U.S. Exh. 632 (Shertz Dep.) at 33, 34. In addition, Dr. Lightbourn would have to assume responsibility for buildings one (Villa) and two (Horizon) also increasing her caseload to serve about 192 clients. U.S. Exh. 632 (Shertz Dep.) at 34.

situation as one where "[a]ll you can do is chas[e] your tail, trying to keep up with what's happening today; planning the long-term becomes very difficult." Tr. 7/27/93 (Sulkes) at 151, line 7-9.^{13/}

When Dr. Sulkes first visited Ebensburg, there were five full-time doctors on staff. Tr. 7/27/93 (Sulkes) at 150. He was "troubled" when the number of physicians dropped to four because that means whenever any doctor is on vacation, is sick, or is away at a meeting, there are only three physicians around to care for and treat the residents. Tr. 7/27/93 (Sulkes) at 150.

Pursuant to their contract with the Commonwealth of Pennsylvania, the Ebensburg physicians are entitled to four weeks of vacation each year. U.S. Exh. 632 (Shertz Dep.) at 31; Tr. 7/27/93 (Sulkes) at 150. Dr. Shertz and the other three Ebensburg doctors took the full four weeks of vacation they were entitled to in 1992. U.S. Exh. 632 (Shertz Dep.) at 32. In addition to vacation days off, physicians are entitled to take days off for holidays, meetings out of town like national meetings of medical societies, and continuing medical education. Tr. 7/27/93 (Sulkes) at 151. The doctors are also entitled to sick days. Tr. 7/27/93 (Sulkes) at 150. Four weeks of vacation multiplied by four doctors is sixteen weeks, and when combined with days off for meetings and sick days equates to about a third of the year when there are only three doctors in place at Ebensburg to address the residents' medical needs. Tr. 7/27/93 (Sulkes) at 150.

^{13/} On cross-examination, Dr. Sulkes had difficulty understanding the suggestion by opposing counsel that the Ebensburg Medical Director would turn down an offer for a fifth physician as "unnecessary" because when Dr. Sulkes first toured the facility, five physicians were employed at Ebensburg. Tr. 7/28/93 (Sulkes) at 26. Obviously someone thought a fifth physician was necessary at that time; the facility's recognition of the need for a fifth physician is bolstered by the facility's recent renewed efforts to hire an additional doctor. Tr. 7/28/93 (Sulkes) at 26; Tr. 10/19/93 (O'Brien) at 82, 113.

Caseload and primary care responsibilities have had an impact on the Ebensburg staff doctors' ability to juggle their many responsibilities. For example, Dr. Shertz implied that he does not attend some committee meetings at Ebensburg because his primary care responsibilities take priority and he does not have time to attend. U.S. Exh. 632 (Shertz Dep.) at 81.

The care provided to Patricia S. just before her death is a troubling example of where an Ebensburg doctor was unable to or did not attend to the medical needs of a resident. Tr. 7/27/93 (Sulkes) at 151-2. From this example, Dr. Sulkes concluded that the Ebensburg physicians are so overtaxed with responsibilities that they cannot attend to residents' needs when they are acutely deteriorating. Tr. 7/27/93 (Sulkes) at 156(2-5).

- On March 11, 1992, at 9:15 a.m., Patricia S. was found to be in shock. Tr. 7/27/93 (Sulkes) at 152; U.S. Exh. 474AA, 474BB. Her temperature was 93.5 degrees, her blood pressure was low (64/40) and her pulse was high (130 beats per minute). Tr. 7/27/93 (Sulkes) at 152, 153; U.S. Exh. 474AA, 474BB. Dr. Kastner agreed that Patricia was in shock. Tr. 9/13/93 (Kastner) at 236. He agreed that a person in this condition should be treated medically as soon as possible. Tr. 9/13/93 (Kastner) at 236.

Shock is a life threatening, emergency condition where the person is getting ready to die. Tr. 7/27/93 (Sulkes) at 152. The person in shock needs immediate attention. Tr. 7/28/93 (Sulkes) at 29. Dr. Kastner agreed that shock is an emergency condition requiring swift and immediate medical attention. Tr. 9/13/93 (Kastner) at 235-6. When the body is in shock, it is doing all it can to hold on. Tr. 7/28/93 (Sulkes) at 29. The longer a person is in shock prior to getting to the operating room for what ultimately becomes the bottom line corrective treatment, the less chance there is that the treatment is going to be effective. Tr. 7/28/93 (Sulkes) at 30. Certainly, if the person is dead on arrival to the emergency room, the surgeon cannot fix the problem. Tr. 7/28/93 (Sulkes) at 30. Advanced life support is needed before successful treatment is possible. Tr. 7/28/93 (Sulkes) at 30-1.

That morning at Ebensburg, a physician was notified of Patricia's condition, but no Ebensburg physician ever made it over to see her. Tr. 7/27/93 (Sulkes) at 152; U.S. Exh. 474AA, 474BB. There was a second call to the doctor and the doctor advised that an ambulance should be called, but again, the doctor did not go to personally see, care for, or treat Patricia. Tr. 7/27/93 (Sulkes) at 152; U.S. Exh. 474AA, 474BB. Patricia eventually left Ebensburg at 10:00 a.m. Tr. 7/27/93 (Sulkes) at 152. Dr. Kastner also indicated that this person should not be treated by telephone. Tr. 9/13/93 (Kastner) at 236.

At no time from the time the shock was discovered at 9:15 a.m. to her departure via ambulance at 10:00 a.m., did an Ebensburg physician personally go to Patricia's side to help care for her during her life threatening emergency. Tr. 7/27/93 (Sulkes) at 152; U.S. Exh. 474BB. For forty-five minutes while Patricia was suffering from a life threatening emergency, no Ebensburg doctor could make it to her side to care for and treat her. Tr. 7/27/93 (Sulkes) at 154. It is clear from this example that the doctors at Ebensburg did nothing in the time that Patricia was in shock before the ambulance arrived. Tr. 7/28/93 (Sulkes) at 30. An Ebensburg incident report of the event, clearly reveals that no doctor personally examined Patricia that day before being sent to the hospital via the ambulance. Tr. 7/27/93 (Sulkes) at 154; U.S. Exh. 474BB. On the incident report, the box labelled "examination by physician" is marked "no." Tr. 7/27/93 (Sulkes) at 154; U.S. Exh. 474BB.^{14/}

At 9:15 or 9:30 in the morning, when the physicians are present in the facility, no physician is too far away to get to a person's side who is in shock. Tr. 7/27/93 (Sulkes) at 155. The farthest away any doctor could be from a patient at Ebensburg is about five minutes. Tr. 7/27/93 (Sulkes) at 155. Dr. Sulkes concluded therefore that the decision was made to let the ambulance staff manage this person's care. Tr. 7/27/93 (Sulkes) at 155. Dr. Kastner has toured the facility and agreed that at 9:15 a.m., if all the doctors are on duty, none of them are physically more than about three to five minutes away from any of their patients who might need emergency treatment. Tr. 9/13/93 (Kastner) at 236. Dr. Sulkes added, "putting the best face on it that I can put on it ... I have to conclude that physicians are so overtaxed with responsibilities that they can't get to people's sides when they are acutely deteriorating." Tr. 7/27/93 (Sulkes) at 156(2-5). He added that a less charitable interpretation of the situation would be that the doctors did not grasp the severity of her condition (which was pretty obvious) or that they just did not care. Tr. 7/27/93 (Sulkes) at 156.^{15/}

To further compound matters, the only physician note describing these events present in Patricia's medical record appears after her death and was written five full days after she died. Tr. 7/27/93 (Sulkes) at 152; U.S. Exh. 474CC. The Ebensburg physician's notes for Patricia clearly reveal that there is a note on March 3, and yet not another until March 16.

^{14/} In testifying about this issue, Dr. Kastner never addressed Dr. Sulkes' point about the poor response time of the overtaxed Ebensburg doctors caused by poor staffing ratios. Instead, Dr. Kastner testified at length about matters off the point, such as the fact that Patricia S. died of a ruptured viscus, that a ruptured viscus is a very difficult diagnosis to make, and that Patricia's parents would not consent to surgery at the hospital. Tr. 9/13/93 (Kastner) at 172, 174.

^{15/} On cross-examination, opposing counsel brought out the issue of the parent's consent to certain unrelated medical procedures. However, Dr. Sulkes testified that it is wholly irrelevant whether or not Patricia's family gave or withheld consent for the ultimate surgery at the hospital; or whether or not they gave or withheld consent for certain GI testing in the 1980s. Tr. 7/28/93 (Sulkes) at 31-32. Unless the family expressly withheld consent for life support to be provided, the presumption is that you provide it. Tr. 7/28/93 (Sulkes) at 32.

Tr. 7/27/93 (Sulkes) at 155; U.S. Exh. 474CC. The March 16 note was written five days after her death. Tr. 7/27/93 (Sulkes) at 155; U.S. Exh. 474CC.

B. Nursing Services At Ebensburg Are Inadequate.

1. **Acute And Chronic Nursing Care Do Not Meet Professional Standards.**

Nursing care at Ebensburg does not meet professionally accepted standards. Tr. 7/29/93 (McGowan) at 168. Significant health care problems of Ebensburg residents are not identified and therefore they are not addressed. This has resulted in serious illnesses and medical problems, hospitalizations, and death. Tr. 7/29/93 (McGowan) at 168-169. There are deficiencies in both acute and chronic nursing care. Id. at 168-169. Nurses do not adequately assess residents who are acutely ill. Id. at 168. Even when a resident is seriously ill, Ebensburg nurses frequently only take the resident's temperature without checking any other vital signs, which is standard nursing procedure. Id. at 170, 175. Ebensburg nurses do not conduct chest assessments and never listen to chest sounds at any time during or after a meal. Tr. 7/29/93 (McGowan) at 172; U.S. Exh. (Sponsky Dep.) at 24. They also do not conduct abdominal assessments and do not take abdominal girth measurements. Tr. 7/29/93 (McGowan) at 172, 177; U.S. Exh. 638 (Sponsky Dep.) at 19.

Ebensburg nurses also do not adequately identify and treat residents with clearly developing patterns of health deterioration which seriously compromise residents' health and/or place them at risk for hospitalization and death. Tr. 7/29/93 (McGowan) at 169. There are three particularly problematic areas of patterns of deterioration at Ebensburg where nurses fail to take steps for enhanced observation and intervention to prevent morbidity and mortality. These areas are where residents: (1) have histories of repetitive hospitalizations

for aspiration, reflux, and bowel obstruction; (2) have repeated injuries; and (3) are showing signs of loss of skills or deterioration in their abilities. Id. at 171.

Based upon her 400 hour review of 74 resident records, Ms. McGowan found an overall lack of adequate assessments, monitoring, and treatment interventions for residents with health care problems. Id. at 170-171. Marcia Stiles, who has been a registered nurse supervisor at Ebensburg for the past fourteen years and is a member of the Dysphagia Team, agrees that there is a need for more in-depth nursing assessment at Ebensburg. U.S. Exh. 638A (Stiles Dep.) at 85. She also sees a need for nurses to make rounds to check people who are sick during the night before the doctor comes in the morning. U.S. Exh. 638A (Stiles Dep.) at 86. The failure to adequately assess and treat residents with acute and chronic illnesses departs from accepted professional nursing standards. Id. at 169-170.

The following individuals are among the many examples of Ebensburg residents who have been hospitalized or died following the persistent deficiencies in nursing practices that Ms. McGowan identified:

- Steven S. died in May 1991 of pneumonia. Tr. 7/29/93 (McGowan) at 179, 181. On the night before his death, he was extremely pale, gagging, and vomiting. Tr. 7/29/93 (McGowan) at 180-181. Ebensburg nurses did not take any vital signs or conduct a chest or abdominal assessment. Tr. 7/29/93 (McGowan) at 181. In fact, a nurses did not evaluate him until 7:10 the next morning. At that time he appeared to be in shock. He was not transported to the hospital until several hours later, at 9:55 a.m. Tr. 7/29/93 (McGowan) at 181.
- Sam B. died on April 12, 1993. Tr. 7/29/93 (McGowan) at 177. Nurses did not conduct assessments of his health condition in the months prior to his death when he was vomiting, having difficulty swallowing, refusing meals, and had an elevated temperature. Tr. 7/29/93 (McGowan) at 177-178.
- Pat S. died on March 12, 1992 of a ruptured viscus. Tr. 7/29/93 (McGowan) at 176. Although she had a history of chronic abdominal distension, nurses did not record any abdominal girth measurements so there was no baseline data. Tr. 7/29/93 (McGowan) at

176. On the day of her death, Ebensburg nurses did not identify her signs and symptoms of an acutely distended abdomen and shock on a timely basis. Tr. 7/29/93 (McGowan) at 176.

- Marilyn C. died on January 1, 1990. Tr. 7/29/93 (McGowan) at 173. Prior to her death, she began having a low grade fever along with intermittent vomiting in early December 1989. Tr. 7/29/93 (McGowan) at 175. By December 11, 1989 she was unable to open her mouth. On December 15, she vomited a very large amount of dark brown liquid and was admitted to the Critical Care Unit at Mercy Hospital for a collapsed lung. Tr. 7/29/93 (McGowan) at 175. Prior to her hospitalization, Ebensburg nurses did not assess Marilyn's chest sounds. Tr. 7/29/93 (McGowan) at 175. They did not record her respiratory rate until a few days before her death and only intermittently noted that they contacted a physician in spite of her serious condition. Tr. 7/29/93 (McGowan) at 175-176.

- Ann B. required emergency hospitalization for a bowel obstruction on September 16, 1991. Tr. 7/29/93 (McGowan) at 181. While in the emergency room, she went into respiratory arrest and had to have part of her bowel removed. Tr. 7/29/93 (McGowan) at 181. Ebensburg nurses did not chart any vital signs prior to her hospitalization. Tr. 7/29/93 (McGowan) at 182. Contrary to accepted nursing practice, Ebensburg nurses treated her with Tylenol and fleet enemas despite the fact that there were clear signs and symptoms of an acute abdomen. Tr. 7/29/93 (McGowan) at 182.

- Paul G. was hospitalized for a bowel obstruction on July 22, 1992, which required a bowel resectioning operation. Tr. 7/29/93 (McGowan) at 183-184. Despite repeated vomiting episode in the days prior to his hospitalization, Ebensburg nurses only took his temperature. Id. They did not take any other vital signs and did not conduct an abdominal assessment. Id.

In the fifteen and-a-half months prior to Stephen S.'s death in May 1991, he vomited 212 times. Tr. 7/29/93 (McGowan) at 179. Despite the fact that he had a history of hospitalizations for GI bleeding, nurses only tested his vomitus for occult blood 23% of the time, which was 50 of his 212 instances of vomiting. Tr. 7/29/93 (McGowan) at 179. Moreover, even though in 48 of the 50 times that nurses tested his vomitus it was positive for occult blood, Ebensburg nurses only notified the physician in nine of those 48 instances. Tr. 7/29/93 (McGowan) at 179. Both the United States' and defendants' experts who were qualified and testified about gastrointestinal problems emphatically state that it is both important and accepted professional practice to test vomitus for occult blood where there is a

history of GI bleeding and to notify the physician of the results. Tr. 12/13/93 (Rosenthal) at 165-166; Tr. 12/13/93 (Rubin) at 85; Tr. 7/27/93 (Sulkes) at 115-6, 123-4. There is no written Ebensburg policy for testing occult blood. U.S. Exh. 638 (Sponsky Dep.) at 23. Ebensburg's Director of Nursing admits that Ebensburg nurses do not test vomitus for occult blood even when a resident has a history of GI bleeding. U.S. Exh. 638 (Sponsky Dep.) at 22.

2. There Have Been Delayed Nursing Responses To Injuries.

There are instances, as well, of a delayed nursing response to Ebensburg residents who have been injured. Tr. 7/29/93 (McGowan) at 186-187; U.S. Exh. 790. In some situations, direct care staff fail to notify the nurse when an injury occurs. In other cases, the nurse fails to recognize the seriousness of significant injuries. For example, despite the fact that Ebensburg staff have an obligation to contact a nurse immediately whenever a resident hits or kicks another resident, they did not notify a nurse when a resident was found hitting and kicking James W. in late September 1992. U.S. Exh. 790; U.S. Exh. 501 (cc); U.S. Exh. 638 (Sponsky Dep.) at 108. Instead, staff waited one-and-a-half hours to report this incident to the nurse after James started complaining of chest pain. U.S. Exh. 790; U.S. Exh. 501 (cc). Even though the nurse documented that he had bruising on his rib cage and there was a "clicking" sound when touching his ribs, all the nurse did was to give him tylenol. U.S. Exh. 501 (cc). The nurse did not notify the doctor until more than an hour later. 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. Id.

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. U.S. Exh. 638 (Sponsky Dep.) at 116. Despite the seriousness of this event, Ms. Sponsky did not even review the occurrence report until nine days later. U.S. Exh. 638 (Sponsky Dep.) at 109. As part her review, she did not investigate why the nurse was not notified for approximately 1 1/2 hours until after the incident occurred. Id. at 110. No one at Ebensburg has every evaluated whether direct care staff are reporting injuries to nurses on a timely basis and the Nursing Director does not think that it is her responsibility to look at the circumstances surrounding James' injury to determine why there was a delay in notifying the nurse. Id. at 114-115. Ms. Sponsky also does not know if anyone investigated why there was an additional 1 1/2 hour delay between the time the nurse examined James and his emergency transport to the hospital. Id. at 115. This was not an isolated incident at Ebensburg or for James. One year earlier, in late November 1991, James was found fighting with another client at 10:15 a.m. U.S. Exh. 501 (aa); U.S. Exh. 790. Despite the fact that James had a bloody mouth, staff did not report his injury to the nurse until 5:30 that evening when he complained of mouth pain and refused supper. Id. 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).

Inadequate nursing care also resulted in the amputation of Ronnie B.'s finger. Her finger necessitated seventeen sutures when it was lacerated and crushed during an aggressive episode in mid 1990. U.S. Exh. 283. Despite a continuing fever and agitation for several days following this incident, Ebensburg nurses did not examine her wound and did not notify

the physician. When the dressing on her finger was finally removed by the physician, there was a foul odor and gangrene on her finger. Her finger was amputated the next day. Tr. 7/29/93 (McGowan) at 182; Tr. 7/30/93 (McGowan) at 14. United States' Exhibit 790 summarizes nine additional recent events at Ebensburg in which there was a delayed nursing response to resident injuries. The defendants did not refute the accuracy of this exhibit.

3. Nursing Care Plans Are Inadequate.

Even where nurses document the existence of problematic health care symptoms, they fail to develop an adequate treatment plan. Tr. 7/29/93 (McGowan) at 174-175. In devising treatment plans, nurses select from a menu of 34 "supplemental procedures," most of which were developed prior to 1988. U.S. Exh. 638 (Sponsky Dep.) at 36; U.S. Exh. 31. These procedures do not constitute adequate nursing treatment plans and do not meet accepted nursing standards. Tr. 7/29/93 (McGowan) at 190. They consist of general instructions to direct care staff rather than detailing specific nursing objectives and interventions. Id. at 190-191. These are the same procedures that the United States notified the defendants were deficient as far back as 1987 during the United States' CRIPA investigation of Ebensburg. U.S. Exh. 638 (Sponsky Dep.) Exh. 49 at 3. The United States expressed the same concern to the Commonwealth at that time, i.e, the health care plans are not individualized to identify and provide for each resident's needs. Id.

Some Ebensburg residents have had the same generalized procedure for their health care problems for up to seven years without any changes. Id. at 191. Tim P., for example, has had the exact same nursing supplemental procedure for potential skin breakdown since March 1987. U.S. Exh. 973.

Even the canned content of these nursing supplemental procedures is questionable. For example, the procedure for residents who have impaired swallowing abilities requires staff "to place food in back of mouth." U.S. Exh. (Sponsky Dep.) at 43; U.S. Exh. 31 at 00542680. Ebensburg's Director of Nursing does not know why the procedure specifies this method and does not know whether the method is appropriate. U.S. Exh. 638 (Sponsky Dep.) at 43. In fact, Dr. Sheppard testified that mid-tongue is the "preferred site for placement" of food. Tr. 10/18/93 (Sheppard) at 124. On January 14, 1993, Ms. Sponsky was uncertain about whether there was even a specific nursing supplemental procedure for gastroesophageal reflux. U.S. Exh. 637 (Sponsky Dep.) at 63-64. When the United States requested that she bring all nursing supplemental procedures with her to the completion of her deposition one month later, the implementation date appearing on the one page reflux supplemental procedure is January 27, 1993 -- two weeks after Ms. Sponsky was asked about the procedure during her deposition. U.S. Exh. 638 (Sponsky Dep.) at 38; U.S. Exh. 31 at 00542677. Even this newly developed supplemental procedure is extremely general and cursory. Although Ms. Sponsky agrees that positioning is important in treating reflux and that an individual should be elevated in an upright position following mealtimes in all cases of reflux, this positioning is not part of the procedure. U.S. Exh. 636 (Sponsky Dep.) at 63; U.S. Exh. 638 (Sponsky Dep.) at 40. Ms. Sponsky does not know why this requirement has not been incorporated into the newly developed reflux supplemental procedure. U.S. Exh. 638 (Sponsky Dep.) at 39-40.

4. Nurse Recordkeeping Is Inadequate.

Throughout her extensive review of Ebensburg records, Ms. McGowan found systemic problems with inadequate nursing documentation. Tr. 7/29/93 (McGowan) at 186. Ebensburg nurses fail to document adequate health care assessments of residents. Tr. 7/29/93 (McGowan) at 168. Marcia Stiles, who has been a registered nurse supervisor at Ebensburg for the past fourteen years, agrees that Ebensburg nurses need to better document their nursing assessments. U.S. Exh. 638A (Stiles Dep.) at 85-86. Nurses also do not document and summarize bowel patterns. Tr. 7/29/93 (McGowan) at 171; U.S. Exh. 638 (Sponsky Dep.) at 15. Despite a directive from the Director of Nursing about where to record weights in the record (U.S. Exh. 638 (Sponsky Dep.) at 20), data about residents' weights is not consistently recorded in the record. Tr. 7/29/93 (McGowan) at 172. It sometimes took Ms. McGowan hours simply to track a resident's weight over time. Tr. 7/29/93 (McGowan) at 172. The nursing documentation system at Ebensburg is insufficient to track patterns of deterioration. Tr. 7/29/93 (McGowan) at 172-173, 180. There is no system, for example, of comparing weight, bowel, vomiting, and seizure patterns and tracking them in comparison to other events, such as medication changes and eating patterns. Tr. 7/29/93 (McGowan) at 172-173, 177, 180. Developing a system to detect these types of patterns is particularly important in a population such as that at Ebensburg where residents are unable to voice their health complaints. Tr. 7/29/93 (McGowan) at 177.

There is no policy at Ebensburg of how frequently a nurse must write a progress note. U.S. Exh. 637 (Sponsky Dep.) at 89. Consequently, nurses write progress notes erratically and recordkeeping is so inadequate that it is often difficult to track the course of

events. Tr. 7/29/93 (McGowan) at 181-182. Even in the few instances where Ebensburg nurses are expected to write progress notes for specific events, they fail to do so. For example, although nurses are responsible for writing a progress note when they notify a physician of a resident's condition (U.S. Exh. 638 (Sponsky Dep.) at 26), they often do not do this. Tr. 7/29/93 (McGowan) at 175. In addition, Ebensburg nurses are supposed to write a progress note each time a resident vomits or has a coughing episode during a mealtime. U.S. Exh. 637 (Sponsky Dep.) at 91, 94-95. Ms. McGowan summarized thirty-three instances where she observed residents coughing, vomiting, ejecting food, and experiencing respiratory problems at various mealtimes during her tours. Tr. 7/29/93 (McGowan) at 188-189; U.S. Exh. 535. Nurses only wrote progress notes acknowledging two of these thirty-three incidents. Id. There is no quality assurance mechanism at Ebensburg to even identify this type of deficiency. U.S. Exh. 637 (Sponsky Dep.) at 91-92.

5. Ebensburg Nurses Need Additional Training.

Ms. McGowan believes that Ebensburg nurses need additional training. Tr. 7/29/93 (McGowan) at 210. Ms. Sponsky concurs that "training is important for nurses." U.S. Exh. 637 (Sponsky Dep.) at 88-89. She believes that it would be beneficial for the nursing department at Ebensburg to have an annual training plan and wrote a memorandum to Mr. Bellomo on June 5, 1992 outlining her ideas about how to accomplish this. U.S. Exh. 637 (Sponsky Dep.) at 98; Sponsky Dep. Exh. 13. As of January 1993, six months later, there was no training plan for nurses at Ebensburg. U.S. Exh. 637 (Sponsky Dep.) at 89. As of 1990, the Commonwealth was on notice through the United States' CRIPA investigation that Ebensburg nurses needed additional training in order to carry out their responsibilities. U.S.

Exh. 638 (Sponsky Dep.) Exh. 50 at 4. Although there is money allocated for nurses each year for outservice training, it is not mandatory training. U.S. Exh. 637 (Sponsky Dep.) at 89. In fact, most nurses do not use the money. U.S. Exh. 624 (O'Brien Dep.) at 29-30.

There is no requirement that a nurse have any educational background or experience in working with people with mental retardation or other developmental disabilities prior to beginning work at Ebensburg. U.S. Exh. 637 (Sponsky Dep.) at 82. The nurse orientation training at Ebensburg does not cover physical assessments. U.S. Exh. 637 (Sponsky Dep.) at 84. The training also does not cover detecting and monitoring aspiration. U.S. Exh. 637 (Sponsky Dep.) at 85. Moreover, the training does not cover any specific topics related to feeding. U.S. Exh. 637 (Sponsky Dep.) at 85. Ebensburg nurses did not receive any training on gastroesophageal reflux until March 1993. Tr. 10/19/93 (O'Brien) at 85.

There is no money allocated for training Ebensburg's Director of Nursing. U.S. Exh. 637 (Sponsky Dep.) at 90. Ms. Sponsky believes that as Director of Nursing, it is important that she identify areas in which she needs training and be permitted to take the training. U.S. Exh. 637 (Sponsky Dep.) at 95. As of January 1993, the last outservice training Ms. Sponsky attended was in 1990. U.S. Exh. 637 (Sponsky Dep.) at 90. Between 1990 and 1992, there were at least three training opportunities that Ms. Sponsky identified where she was not permitted to take the training. U.S. Exh. 637 (Sponsky Dep.) at 95.

6. The Role Of The Ebensburg Director Of Nursing Is Too Limited.

Carole Sponsky has been a nurse at Ebensburg for the past thirty years. U.S. Exh. 637 (Sponsky Dep.) at 16. She has been Acting Director of Nurses since December 1988 and the Director of Nursing since June 1989. U.S. Exh. 637 (Sponsky Dep.) at 13. As

Director of Nursing at Ebensburg, she is the individual who is ultimately responsible for ensuring the adequacy of nursing care for individuals who live at Ebensburg. U.S. Exh. 637 (Sponsky Dep.) at 41. Ms. Sponsky is specifically responsible for quality assurance in nursing on a facility-wide basis. U.S. Exh. 637 (Sponsky Dep.) at 43-44. She does not investigate deficient nursing care practices, however. U.S. Exh. 637 (Sponsky Dep.) at 48. Although there is a nursing peer review committee at Ebensburg, it was dormant for a period of time and then reconvened in September 1992, following Ms. McGowan's first tour of Ebensburg. U.S. Exh. 638 (Sponsky Dep.) at 136. Even though the goal of the nursing peer review committee is to conduct peer reviews of nursing practices, as of February 1993, the committee had not conducted any peer review of nursing activities since at least 1990. U.S. Exh. 638 (Sponsky Dep.) at 137. Ms. Sponsky accompanied Ms. McGowan during her tour of Ebensburg in August 1992. She admits that the time she spent in the living units during Ms. McGowan's tour was more than the usual amount of time she spends actually on-site in the living units at Ebensburg. U.S. Exh. 637 (Sponsky Dep.) at 100.

Although she is the Director of Nurses, Ms. Sponsky does not supervise any of the nurses at Ebensburg. U.S. Exh. 637 (Sponsky Dep.) at 35. Staff nurses at Ebensburg are supervised by the Registered Nurse Supervisor, who, in turn, is supervised by the Unit Manager. U.S. Exh. 637 (Sponsky Dep.) at 36. Although the Unit Managers are responsible for clinical supervision of the Registered Nurse Supervisors, only one of the five Unit Managers has a background in nursing. U.S. Exh. 637 (Sponsky Dep.) at 37, 38. The Nursing Department at Ebensburg does not get together for regular meetings. U.S. Exh. 622 (Malloy Dep.) at 36.

Ebensburg nurses do not like to get "pulled" to a living unit to which they are not regularly assigned. U.S. Exh. 636 (Sponsky Dep.) at 77. In January 1993, nurses were pulled 40 times to a unit to which they were not regularly assigned. U.S. Exh. 636 (Sponsky Dep.) Exh. 25. Frequently, nurses are pulled to or from Keystone. Id. Ms. Malloy, the nursing supervisor at Keystone, admits that there have been times at Keystone where she needed an additional nurse because of the condition of residents and she has been unable to get additional help. U.S. Exh. 622 (Malloy Dep.) at 118. Some time between July 1992 and January 1993, the nurse who was working the third shift alone in Keystone reported that she was not given an orientation to Keystone and had to "feel" her way through things on the unit. U.S. Exh. 636 (Sponsky Dep.) at 75; Sponsky Dep. Exh. 11.

XIII. EBENSBURG IS FAILING TO PROVIDE ITS RESIDENTS WITH ADEQUATE NEUROLOGICAL CARE.

Defendants have failed to provide adequate medical care to the approximately 230-240 Ebensburg residents who have epilepsy -- about one half of the population of Ebensburg. Tr. 7/30/93 (Alvarez) at 48. Ebensburg is home to the highest number of individuals with epilepsy of any institution serving those with mental retardation in the Commonwealth of Pennsylvania. U.S. Exh. 633 (Shertz Dep.) at 9. Dr. Kastner found that seizures are highly prevalent at Ebensburg. Tr. 9/13/93 (Kastner) at 191-192. Dr. Chamovitz testified that, at Ebensburg, seizures are "the most prominent symptom and complaint that is seen." Tr. 9/14/93 (Chamovitz) at 245. Seizure disorders have and continue to be a significant cause of morbidity and mortality at Ebensburg. Ebensburg fails to provide residents who have seizures with the comprehensive care and management that they need and that the profession requires.

A. Ebensburg Fails to Provide Residents in Status Epilepticus Adequate Treatment.

Ebensburg's management of status epilepticus seizures does not meet generally accepted standards. Tr. 7/30/93 (Alvarez) at 56-7. Ebensburg's poor emergency management of status seizures potentially affects all residents with epilepsy at Ebensburg because anyone with epilepsy may go into status. Tr. 7/30/93 (Alvarez) at 75. Dr. Alvarez concluded that Ebensburg is a "dangerous place to have status" occur. Tr. 7/30/93 (Alvarez) at 165.

For example, Ebensburg turned out to be a dangerous place for Stephen C. Stephen suffered hours of status at Ebensburg before being sent to Mercy Hospital. Tr. 7/30/93

(Alvarez) at 61; Tr. 12/13/93 (Coulter) at 28. On January 22, 1990, Stephen suffered 25 visible seizures between 9:25 a.m. and 3:45 p.m., without gaining consciousness between seizures. U.S. Exh. 1109A. Stephen's seizure chart describes the period following each seizure as "sleep (deep)." Id. Staff did not call a doctor until 11:20 a.m. -- nearly two full hours after the onset of Stephen's status. Tr. 7/30/93 (Alvarez) at 62; U.S. Exh. 323AA. No Ebensburg physician ever saw Stephen, although three different physicians prescribed medications over the phone that day. Tr. 7/30/93 (Alvarez) at 63-64; U.S. Exh. 323AA. As the afternoon wore on, Stephen's seizures and condition became worse, with staff describing his "head and eyes turning to one side," "rhythmic jerking of extremities," and "cyanosis." U.S. Exh. 1109A. At 3:00 p.m., a physician was notified that things were not going well. Tr. 7/30/93 (Alvarez) at 63; U.S. Exh. 323AA, 653. Ebensburg treated Stephen's seizures with only intramuscular ("IM") and oral ("PO") medications, which did not work. Tr. 7/30/93 (Alvarez) at 61; U.S. Exh. 323AA, 653. Finally, at 5:42 p.m. -- eight hours after the onset of his status -- an ambulance was called to take Stephen to Mercy Hospital for treatment of his uncontrolled seizures. Tr. 7/30/93 (Alvarez) at 63; U.S. Exh. 323AA, 653. Stephen died at Mercy a few days later. Tr. 7/30/93 (Alvarez) at 61; U.S. Exh. 323AA. Dr. Alvarez testified that the medical care Stephen received at Ebensburg was deficient. Tr. 7/30/93 (Alvarez) at 65.^{1/}

^{1/} Dr. Kastner did not review Stephen C.'s record. Def. Exh. HH. Without any comments about the particulars of Stephen's care, Dr. Chamovitz concluded that he felt that professional judgment was exercised in the case of Stephen C. Tr. 9/15/93 (Chamovitz) at 189. Dr. Chamovitz took a similarly broad conclusory approach in testifying about other individuals. However, at the end of his cross-examination, when asked to define "professional judgment," Dr. Chamovitz testified that he "hadn't thought about that." Id. at 239.

1. Status Epilepticus Is A Serious Medical Emergency.

The field recognizes that status epilepticus is a serious medical emergency associated with substantial morbidity and mortality. Tr. 7/30/93 (Alvarez) at 50; Tr. 12/13/93 (Coulter) at 17, 21-22; U.S. Exh. 1107. Dr. Coulter testified that "the field has recognized and certainly has published that the major consequence ... with status epilepticus is ... on the one hand, the risk of serious injury and death, but also the risk of brain damage from the seizure itself." Tr. 12/13/93 (Coulter) at 17.^{2/}

In addition to the risks of serious injury, brain damage from the seizure itself, and death, status may result in other medical problems like impaired breathing, resulting in brain damage due to lack of oxygen in the brain. Tr. 7/30/93 (Alvarez) at 50-51. In addition, individuals in status may lose the ability to swallow or cough, predisposing them to aspirate, and running the common risk of developing aspiration pneumonia due to status. *Id.* at 51. Finally, individuals in status for prolonged periods of time are at greater risk of lowered blood pressure. *Id.* at 219. Dr. Kastner agreed that status epilepticus can produce decreased blood pressure or decreased blood glucose levels and also secondary effects like loss of brain function as a consequence of hypoxia. Tr. 9/13/93 (Kastner) at 228.

2. Ebensburg Fails To Understand When An Individual Is In Status.

The serious risks associated with status attach to the two distinct forms of status. Tr. 12/13/93 (Coulter) at 14, 17. The most familiar expression of status is where the individual continuously seizes with grand mal or petit mal convulsive seizures for thirty straight minutes

^{2/} Dr. Kastner had testified that Dr. Alvarez "exaggerated" over the urgency of responding to status, implying that Dr. Alvarez was wrong in treating status as an emergency. In responding to these comments by Dr. Kastner, Dr. Coulter testified that status is an emergency "and anybody who says differently is simply wrong." Tr. 12/13/93 (Coulter) at 34.

without interruption. Id. at 14; U.S. Exh. 1107. However, Dr. Coulter stressed that there is another way an individual can have status epilepticus: an individual can suffer a relatively brief convulsive seizure (of perhaps a minute or two duration), then remain unconscious in a partial comatose state (while perhaps suffering other brief convulsive seizures) for a total of thirty continuous minutes. Id.; U.S. Exh. 1107. Dr. Coulter indicated that this type of status is more akin to "a coma punctuated by seizures." Id. Dr. Coulter stressed that this second type of status is "as grave as an emergency as the continuous convulsive activity that we normally think of as status." Id. at 14-15. Dr. Coulter testified that it is important to understand that "brain injury occurs even in the absence of continuous convulsive activity. Brain injury occurs even when a patient is paralyzed ... and we do not see the continuous muscular exertion of a seizure and yet the seizure rages on in the brain." Id. at 17.

Dr. Coulter testified that he found there to be a lot of "confusion" in some of defendants' testimony concerning this second type of status. Tr. 12/13/93 (Coulter) at 15. In Dr. Coulter's opinion, although Dr. Kastner recognized that there are two distinct forms of status, Dr. Kastner "did not give sufficient weight to the second type of ... coma punctuated by seizures." Id. at 14-15. In addition, in Dr. Coulter's opinion, Dr. Chamovitz, Ebensburg's consultant neurologist, "really doesn't understand the current definition of status" because Dr. Chamovitz limits his definition of status to continuous convulsive activity to the exclusion of the coma-seizures type of status. Id. at 16.^{3/} Dr.

^{3/} Dr. Chamovitz indicated that he does not have much direct knowledge of the facility's management of emergency medical care other than that he knows they have a system in place and that it "seems" to work. Tr. 9/15/93 (Chamovitz) at 218. For example, Dr. Chamovitz admitted that he did not know the ambulance response time for residents in status. Id. at 220. He added that he never thought it important to find out because he was "told that it worked." Id.

Chamovitz also unnecessarily requires a patient to be "cyanotic or blue" before labelling the condition as status. Tr. 12/13/93 (Coulter) at 16.^{4/} Dr. Coulter testified on rebuttal that being cyanotic or blue "clearly is not a necessary part of the definition of status epilepticus." Id. Indeed, a status emergency will have begun long before cyanosis or blueness appears and that "requiring that the patient be in such desperate straits that cyanosis occurs" is unacceptable. Id. at 16-17.^{5/} Dr. Coulter explained that "by the time that degree of cyanosis has occurred, the likelihood or the possibility of injury is already well along." Id. at 23. The whole point of recognizing and treating status epilepticus, is to "catch it early on" so that the seizure activity is interrupted so that things don't get to the point where the

^{4/} Dr. Chamovitz had testified that if a patient is "clonic, moving, jerking and salivating" or "foaming at the mouth" and the individual gets "bluer and bluer and bluer" for 20-30 minutes, then that is "status." Tr. 9/14/93 (Chamovitz) at 236; Tr. 12/13/93 (Coulter) at 16. Dr. Chamovitz indicated that only when that occurs are you "in trouble" and is there a "medical emergency." Tr. 9/14/93 (Chamovitz) at 236; Tr. 12/13/93 (Coulter) at 16. Dr. Kastner acknowledged that Dr. Chamovitz's statement that an individual is not in status until he gets 'bluer and bluer and bluer' was not the "best language to have used to describe status epilepticus." Tr. 12/13/93 (Kastner) at 198.

^{5/} Dr. Chamovitz had testified that a medical emergency only occurs when an individual has suffered for 30-40 minutes with "deep cyanosis, not a little bit of blueness around the lips; this is when your fingernails get blue and your ears get blue; that's real status." Tr. 9/14/93 (Chamovitz) at 237; Tr. 12/13/93 (Coulter) at 22. Dr. Chamovitz had also testified that if you are "blue for a long period of time, if you have decreased oxygen, but your heart is beating, you don't get brain damage until your heart stops." Tr. 9/14/93 (Chamovitz) at 237; Tr. 12/13/93 (Coulter) at 23. Dr. Coulter testified in response that "there's no evidence to support" Dr. Chamovitz's statements. Tr. 12/13/93 (Coulter) at 23. Dr. Coulter added that "you can get brain damage in the absence of convulsive activity if the muscles are paralyzed, and the heart is still beating, and yet the seizure activity is still raging on in the brain and can cause brain damage." Id. Dr. Coulter added that it "doesn't make sense to wait for cardiac arrest before worrying about whether it's a serious episode of status." Id. at 23. On surrebuttal, Dr. Chamovitz admitted that what he meant to say was that "the brain dies quicker, more quickly if the heart stops, because there is no oxygen that gets there." Tr. 12/13/93 (Chamovitz) at 206. Dr. Chamovitz testified that "I did not wish to imply that one has to have the heart stop before you have brain damage." Tr. 12/13/93 (Chamovitz) at 206.

individual has to be so horribly cyanotic that tissue hypoxia and brain injury have developed." Id.^{6/}

3. The Generally Accepted Standards For The Proper Management And Treatment Of Status Seizures Are Clear.

The need for providing proper emergency management of status seizures is generally accepted within the medical community specializing in the care of developmentally disabled people. Tr. 7/30/93 (Alvarez) at 55. In addition to the body of literature that indicates that this is well accepted, it is just common sense to treat a life-threatening situation like status right away. Id. at 56.

The Epilepsy Foundation of America ("EFA") recently published a treatment protocol or a "position statement" in the Journal of the American Medical Association ("JAMA") delineating the standards in the field regarding the treatment of status. U.S. Exh. 1107; Tr. 12/13/93 (Coulter) at 54. This position statement does not represent new standards but is merely a codification of long existing standards regarding the treatment of status. Tr. 12/13/93 (Coulter) at 54, 64.^{7/} Dr. Coulter testified that the EFA article in JAMA represents more than just a typical peer reviewed article; he stressed that "it represents the

^{6/} On surrebuttal, Dr. Chamovitz tried to modify his definition of status to lessen the importance of cyanosis or blueness. Tr. 12/13/93 (Chamovitz) at 204. In testifying about this issue, Dr. Chamovitz admitted that he had "probably misspoke." Id.

^{7/} The Epilepsy Foundation published its position statement for the benefit of general care physicians working in community hospital settings who may encounter patients in status. Tr. 12/13/93 (Coulter) at 18. The idea for a "position statement" grew from the concern of Dr. Coulter and other members of the Epilepsy Foundation that patients in status were not receiving proper treatment in all cases in community hospitals. Id. The Foundation was confident that neurologists knew how to treat status, but they were concerned that the average hospital physician and ambulance worker did not know the medical knowledge that had accumulated in the field about status over the past ten or fifteen years. Id. The treatment protocol was therefore published in the Journal of the American Medical Association so that general physicians would see it. Id. at 19.

consensus of the field" in the treatment of status. Id. at 20. The EFA article was circulated to over 90 expert reviewers, including Dr. Coulter. Id. at 21; U.S. Exh. 1107.^{8/}

Dr. Kastner admitted that the EFA position statement is a "generally recognized guideline for the management of status epilepticus" and is "very well-reasoned." Tr. 12/13/93 (Kastner) at 191, 195. Dr. Grossman agreed, stating that the EFA paper was "reasonable" and "reasonably clear." Tr. 12/13/93 (Grossman) at 134.

4. Ebensburg's Treatment Of Status Is Seriously Deficient In Three Respects.

As the case of Stephen C. illustrates, there are three serious deficiencies in the facility's management of status. Tr. 7/30/93 (Alvarez) at 57-60, 75. First, and most important, Ebensburg waits too long before treating its residents for status. Id. at 57-58. It takes too long for Ebensburg physicians to react. Id. at 58. On a number of occasions, physicians have waited hours after the onset of status to make treatment decisions. Id. at 60. Ebensburg has no policy or plan for the emergency management of status epilepticus. Id. at 56; Tr. 12/13/93 (Coulter) at 40. Second, Ebensburg treats status with IM and PO medications, resulting in status seizures that are never effectively controlled. Tr. 7/30/93 (Alvarez) at 60. Third, Ebensburg physicians treat some residents in status over the telephone without ever examining them personally. Id. In addition, physicians often do not write their decisions or opinions about their treatment of status in the resident's medical chart. Tr. 7/30/93 (Alvarez) at 60.

^{8/} Dr. Grossman and Dr. Kastner were not among the 90 experts selected to review the EFA article. Tr. 12/13/93 (Grossman) at 139; Tr. 12/13/93 (Kastner) at 196. In fact, Dr. Grossman is not even board certified in neurology and he has not provided hands-on care to any institutionalized individual since 1981. Tr. 12/13/93 (Grossman) at 138-139.

a. Ebensburg Waits Too Long To Treat Its Residents In Status.

Ebensburg does not treat residents as being in a status emergency until the 30 minute definitional level for status is reached in violation of generally accepted professional standards.^{9/} Experts for the United States and defendants agree that the field, in general, and the EFA treatment protocol, in particular, require that IV anticonvulsant medication should be administered beginning at ten minutes into an episode of status. Tr. 12/13/93 (Coulter) at 32; Tr. 12/13/93 (Grossman) at 135; U.S. Exh. 1107. Dr. Grossman added that if a seizure goes on for ten minutes, "one's anxiety level should be appropriately increased." Id. at 135-6.^{10/} All of the physicians testifying about neurology issues agree that the goal of therapy for status is rapid termination of clinical and electrical seizure activity because clinical and experimental evidence suggest that the longer an episode of status goes untreated, the more difficult it is to control with medication. Tr. 7/30/93 (Alvarez) at 50-51, 182; Tr. 12/13/93 (Coulter) at 17; Tr. 9/13/93 (Kastner) at 227; Tr. 12/13/93 (Kastner) at 196; Tr. 12/13/93 (Grossman) at 141; U.S. Exh. 1107.

^{9/} Experts for both the United States and the Commonwealth disagree with Dr. Kastner's conclusion that it is "not clear that a patient with a seizure of ten minutes or twenty minutes or thirty minutes is experiencing a medical emergency which is life-threatening." Tr. 9/13/93 (Kastner) at 119; Tr. 12/13/93 (Coulter) at 30; Tr. 12/13/93 (Grossman) at 137. Dr. Grossman noted that "we have to be very careful to recognize that the longer the seizure, the greater the possibility of subsequent neural damage." Tr. 12/13/93 (Grossman) at 137.

^{10/} Dr. Kastner had testified that "if someone has a seizure that's fifteen minutes, no one, I don't believe, would advocate the use of intravenous medication to disrupt that seizure." Tr. 9/13/93 (Kastner) at 120; Tr. 12/13/93 (Coulter) at 36. Dr. Coulter disagreed with Dr. Kastner's testimony, citing to the EFA position paper in which the Foundation recommended using IV medication prior to fifteen minutes. Tr. 12/13/93 (Coulter) at 36. Dr. Coulter concluded that Dr. Kastner is therefore wrong that "no one would recommend it;" in fact, he testified that "the field recommends it in its consensus document." Id.

The field recognizes that the thirty minute definitional time frame is not a marker for when medical intervention should begin. Tr. 12/13/93 (Coulter) at 30-32. Dr. Coulter testified that the "whole point of identifying and treating patients is to keep them from getting to" the point that they are actually in status. Id. at 31. Dr. Coulter stressed that even though the definitional time frame for status is thirty minutes, nonetheless, "we have to do something earlier, we have to begin the treatment and the interventions earlier, in order to protect the individual, and to protect the individual's neurological functioning as well as just health and safety." Id. at 31.^{11/} A facility without IV capabilities, like Ebensburg, should call an ambulance with paramedic abilities to ensure that IV medications can be started at about the ten minute mark. Id. at 37.

Experts for both the United States and defendants agree that the field requires Ebensburg to have a policy for the treatment of status. Tr. 7/30/93 (Alvarez) at 55; Tr. 7/30/93 (Coulter) at 39; Tr. 12/13/93 (Grossman) at 141-142; U.S. Exh. 1107. In violation of generally accepted practices, Ebensburg has no policy or plan for the emergency management of status. Tr. 12/13/93 (Coulter) at 40; Tr. 7/30/93 (Alvarez) at 55-56.^{12/} Ebensburg should develop a policy with the help of outside neurological expertise, the local ambulance team, and the local hospital. Tr. 12/13/93 (Coulter) at 39-40. A contingency plan for status would eliminate wasted time in gaining effective treatment for the residents of Ebensburg. Tr. 7/30/93 (Alvarez) at 154.

^{11/} On surrebuttal, Dr. Kastner admitted that he largely agreed with Dr. Coulter's testimony regarding managing status. Tr. 12/13/93 (Kastner) at 194. Dr. Kastner added that, overall, Dr. Coulter's comments were "very good and very appropriate." Id.

^{12/} Dr. Kastner did not know if Ebensburg had in place a policy for the emergency management of seizures. Tr. 9/14/93 (Kastner) at 70.

Ebensburg improperly relies on the past seizure history of an individual to determine whether or not it will treat a seizure as status.^{13/} (See discussion of Ann P. infra § XIII.A.5.) However, Dr. Coulter testified that "any seizure can go into status epilepticus and the fact that a patient has not developed status in the past is no guarantee that they won't develop status on this particular episode or sometime in the future." Tr. 12/13/93 (Coulter) at 33. By the time the seizure condition persists for ten minutes, it has reached the point where it requires emergency treatment. Tr. 12/13/93 (Coulter) at 55. The past seizure history of the individual is not necessarily the best indicator of whether or not this persistent seizure condition will turn into status because on any given occasion, the individual may not stick to the pattern possibly due to a medication error, or other internal medical reason. Id. at 55-56. A medical professional needs to take this into account and cannot just rely on the individual's past seizure history. Id. at 56-7.^{14/}

b. Ebensburg Treats Its Residents In Status With Intramuscular (IM) Medication In Violation Of Generally Accepted Standards.

Experts for both the United States and defendants agree that the field, in general, and the EFA position paper, in particular, require that IV medication -- not IM medication -- be

^{13/} Dr. Kastner testified that "you really can't predict how long a seizure is going to last and, in advance, call an ambulance, anticipating that you're going to be treating status epilepticus." Tr. 9/13/93 (Kastner) at 120. In commenting on that testimony, Dr. Coulter testified that while it is true that you can't predict with any degree of certainty that a patient is going to go into status, "you also can't predict they won't." Tr. 12/13/93 (Coulter) at 33.

^{14/} Simply missing a dose of a medication is a very common precipitant to status. Tr. 12/13/93 (Coulter) at 35. Dr. Coulter testified that "Dr. Chamovitz may have known the patient very well for a very long time" but if he did not know of a missed medication or a medication error, for example, he would now miss the indication that this patient was going to develop a very serious episode of status. Tr. 12/13/93 (Coulter) at 35. Dr. Coulter testified that "you can never be totally assured [no matter] how well you know that individual." Id. at 36.

used to gain control of an individual's seizures during a status emergency. Tr. 7/30/93 (Alvarez) at 55; Tr. 12/13/93 (Coulter) at 38; Tr. 12/13/93 (Grossman) at 136; U.S. Exh. 1107. The EFA position paper specifically states that "intramuscular therapy has no place treating status epilepticus or seizures in general. Insofar as possible, drugs should be administered by the IV route only." U.S. Exh. 1107 (emphasis added). Experts for both the United States and defendants agree that IM therapy has no place in the treatment of status. Tr. 7/30/93 (Alvarez) at 55; Tr. 12/13/93 (Coulter) at 37-38; Tr. 12/13/93 (Kastner) at 195.^{15/} This has been a "very consistent opinion in the field of neurology for some time." Tr. 12/13/93 (Coulter) at 38.^{16/}

Ebensburg does not provide its residents with IV medications during status emergencies. Tr. 7/30/93 (Alvarez) at 59, 66; U.S. Exh. 633 (Shertz Dep.) at 25. Because Ebensburg has no system that treats status in a few minutes, Dr. Alvarez characterized Ebensburg's way of treating status as "very dangerous." Tr. 7/30/93 (Alvarez) at 67, 168. To treat status, Ebensburg staff typically observe the resident in status, notify the physician after a time by phone, and then provide the resident ineffective IM or PO medication, while

^{15/} Even Dr. Chamovitz acknowledged that IM medication "doesn't do the job completely" during a status emergency. Tr. 9/15/93 (Chamovitz) at 210. Dr. Coulter testified that there is no support for Dr. Chamovitz' theory that there are benefits to the use of IM medication in status because it makes the eventual IV treatment work faster or more effectively. Tr. 12/13/93 (Coulter) at 38-39. Indeed, Dr. Coulter testified that "you don't really know how [IM medications are] going to affect any subsequent treatment, so if anything it's contraindicated. In that sense it doesn't necessarily make your job easier. It makes it harder." Tr. 12/13/93 (Coulter) at 39.

^{16/} IM medications are contraindicated for status because blood flow during status can be shifted away from the injection site, causing delays in absorption of the IM drug. Tr. 12/13/93 (Coulter) at 38.

the seizures continue.^{17/} At some point, often involving more ineffective IM or PO medications, the decision is made to call an ambulance. Tr. 7/30/93 (Alvarez) at 66; U.S. Exh. 633 (Shertz Dep.) at 24; U.S. Exh. 652. It takes an ambulance about nine to twelve minutes to arrive at Ebensburg once a call is placed. Tr. 9/13/93 (Kastner) at 222. (See detailed discussion of specific examples at Ebensburg, infra § XIII.A.5.) Thus, valuable time is lost while ineffective measures are taken, and the patient suffers harm while the seizures continue. Tr. 7/30/93 (Alvarez) at 142. In Dr. Alvarez's opinion, Ebensburg residents would be better off with no physician, and going instead directly to Mercy Hospital. Id. at 176. Ebensburg either must learn to properly and safely perform IV medications in a status emergency situation, or it must have a clear contingency plan in place that dictates that the individuals in status should be sent to the hospital emergency room right away without any attempts at intervention at Ebensburg. Id. at 142.

c. Ebensburg Physicians Are Inappropriately Treating Residents In Status Via The Telephone Rather Than Face-to-Face.

In spite of the fact that no patient is ever more than five minutes away from a physician on campus at Ebensburg, Ebensburg physicians inappropriately treat some residents in status over the telephone, relying only on the descriptions of a nurse, without ever examining the resident personally. Tr. 7/30/93 (Alvarez) at 58, 60, 200. (See detailed discussion of specific examples at Ebensburg, infra § XIII.A.5.) This is contrary to generally accepted standards which require a doctor to treat an individual in status face-to-face. Id. at 61. In properly managing the incipient stages of status epilepticus, it is

^{17/} The EFA treatment protocol called the use of IM medication to treat status "archaic." U.S. Exh. 1107.

important that the physician personally assess the situation because the physician is the person who is the most qualified to assess the patient and to determine whether or not the individual is in status epilepticus. Tr. 7/30/93 (Alvarez) at 54, 200.

When a doctor treats an individual in status via the telephone and not face-to-face, it represents a "failure in the provision of care." Tr. 7/30/93 (Alvarez) at 60, 200. It is a failure because status is a real medical emergency; it is a "life-threatening condition, a brain-threatening condition." Id. at 60. During status, there are many differential diagnoses that must be made which a nurse is not able to do. Id. at 60, 200.

5. Ebensburg Residents Have Been Harmed Due To The Facility's Poor Management Of Their Status Seizures.

In addition to the case of Stephen C. discussed earlier, Dr. Alvarez provided examples to the Court of the harm that Ebensburg residents suffer due to Ebensburg's poor emergency management of status seizures.^{18/}

- On September 20, 1991, Keith T. suffered 22 visible seizures from 4:25 p.m. to 5:49 p.m. without ever regaining consciousness between the seizures. U.S. Exh. 1109B. The seizures each lasted between 20 to 80 seconds and were characterized by "severe jerking and loss of consciousness." Id. Staff did not notify a doctor until 5:00 p.m., and Ebensburg then treated Keith with IM medication at 5:04 p.m. -- 39 minutes after the onset of Keith's status. Tr. 7/30/93 (Alvarez) at 68. Keith did not regain consciousness and, in fact, seized ten more times before he was given more IM medication at 5:40 p.m. Id.; U.S. Exh. 1109B. Keith continued to seize, and he was finally sent to Mercy Hospital, where he was treated for grand mal status. Tr. 7/30/93 (Alvarez) at 68; U.S. Exh. 1109B. It took Ebensburg's medical staff over an hour and forty-five minutes to call an ambulance from the

^{18/} Dr. Chamovitz had implied that the individuals Dr. Alvarez cited in his testimony were not in fact suffering from status episodes. Tr. 12/13/93 (Coulter) at 25-26. Based upon his review of the records, Dr. Coulter concluded that "it's really quite clear" that the individuals cited by Dr. Alvarez did in fact suffer episodes of status epilepticus. Tr. 12/13/93 (Coulter) at 26-28; U.S. Exh. 1109 A-D. For example, in the case of Stephen C., Dr. Coulter testified that "he had persistent seizures going on for several hours and did not recover consciousness in between them; and by anybody's definition, would constitute status." Id. at 28.

onset of Keith's status. Tr. 7/30/93 (Alvarez) at 68. Dr. Alvarez concluded that the medical care Keith received at Ebensburg was inadequate. Id.^{19/}

- Robert C. had frequent recurring seizures from November 19 through November 21, 1992, when he was finally admitted to Mercy Hospital. Tr. 7/30/93 (Alvarez) at 70-71; U.S. Exh. 321AA, 654. For this entire three day period, in spite of being repeatedly contacted about Robert's continuing seizures, no Ebensburg physician had face to face contact with Robert before 12:15 p.m. on November 21. Tr. 7/30/93 (Alvarez) at 71; U.S. Exh. 321AA.^{20/} On November 21, 1992, Robert was in status, suffering at least eight visible seizures, starting at 1:45 a.m., without ever regaining consciousness between the seizures. Tr. 7/30/93 (Alvarez) at 71; U.S. Exh. 321AA, 654, 1109C. Cyanosis started at about 10:00 a.m. Id. Ebensburg treated Robert's seizures with IM and PO medications for days, and these medications were not effective in treating his seizures. Tr. 7/30/93 (Alvarez) at 72; Tr. 9/15/93 (Chamovitz) at 228. The decision to send Robert to Mercy was not made until 3:00 p.m. on the 21st, again by phone. Tr. 7/30/93 (Alvarez) at 72. Robert died on November 26, 1992 at Mercy Hospital. Tr. 7/30/93 (Alvarez) at 69; U.S. Exh. 321AA. Robert died of respiratory arrest secondary to pneumonia. Id. at 72. Dr. Alvarez testified that the pneumonia could have resulted from aspiration, which is a natural complication of prolonged seizures. Id. at 72-73.^{21/}

- On October 13, 1992, Ann P. suffered 53 seizures, described as "abrupt loss of consciousness with muscle rigidity," between 9:45 a.m. and noon. Tr. 7/30/93 (Alvarez) at 74; U.S. Exh. 1109D. At Ebensburg, her seizures were treated with IM medication, which was ineffective. Id. at 74; U.S. Exh. 1109D. In fact, after the first IM injection, "seizures continued ... becoming more frequent." U.S. Exh. 1109D. Ann's status was managed by telephone. Tr. 7/30/93 (Alvarez) at 75. There are no notes at all from the doctors involved in her care. Id. at 74. Ann was eventually admitted to the hospital with a diagnosis of "status epilepticus." Id. at 75.^{22/}

^{19/} Dr. Kastner did not review Keith T.'s record. Def. Exh. HH.

^{20/} United States' Exhibit 321AA shows that on 11/20, Dr. Shertz was notified, and he gave orders to "observe" and call him again if Robert had another seizure; Dr. Shertz was again notified and ordered staff to "observe for now;" Dr. Shertz was again notified and ordered "continue to observe;" on 11/21, Dr. Shertz was notified and he "stated to observe"; later that day, Dr. Shertz was again notified and he ordered staff to "observe."

^{21/} Although Dr. Kastner reviewed Robert's death record, he could not remember the details of the hospitalization, or whether Robert had been seizing for days before his hospitalization, or whether Ebensburg physicians had had any face to face contact with Robert in the days before his hospitalization. Tr. 9/13/93 (Kastner) at 237.

^{22/} Ann's case illustrates the danger of relying on past history to make treatment decisions about status. About a month before her October status episode, Ann had suffered prolonged seizures that

(continued...)

● On January 31, 1993, Ronald A. suffered visible seizures at 10:10, 10:20, 10:54, 11:14, 11:25, 11:40, 11:52, 12:17, 12:33, 12:45, and 13:13. U.S. Exh. 909. After each seizure, Ronald's condition was "sleep (deep)." Id. At the onset of his first seizure at 10:10, Ronald was noted to be "sleeping." U.S. Exh. 908. He remained in "post-ictal sleep" until at least 13:25 when, for the first time, Ronald "responds slightly." Id. Even then, Ronald reverted back immediately to post-ictal sleep. Id. Thus, Ronald was in a seizure-coma state from at least 10:10 to 13:25 -- more than three hours. U.S. Exhs. 908, 909. Dr. Kastner agreed that the IM and PO medications provided to Ronald by Ebensburg were not effective in stopping his seizures that day. Tr. 9/13/93 (Kastner) at 227.

The medical care that Stephen C., Keith T., Robert C. and Ann P. received from Ebensburg are examples of Ebensburg's unacceptable treatment of status. Tr. 7/30/93 (Alvarez) at 73-75. In each case, Ebensburg waited too long to get necessary treatment for status; ineffective IM and/or PO medications were used in the interim; physicians failed to personally assess the individual to inform treatment decisions; and physicians failed to document reasons for treatment decisions in the individual's chart. Tr. 7/30/93 (Alvarez) at 57-75. Moreover, because their seizures are prolonged by Ebensburg's inadequate treatment of status, Ebensburg residents suffer because it becomes more difficult to treat status, resulting in the use of more medications and entailing greater risk of complications. Id. at 69.

²²/(...continued)

stopped without medication. Tr. 9/15/93 (Chamovitz) at 190-191. "It was then, I think a month or two later, she had another episode, and they waited, thinking that she wouldn't need any medication; and so from the past history, the experience was that she would be all right. It was different. This convulsion -- a series of convulsions lasted longer." Id. at 191.

B. Ebensburg Is Harming Its Residents With Epilepsy By Failing To Adequately Intervene In The Management Of Their Seizures.

1. Ebensburg Is Failing To Adequately Address Seizure Injuries.

Although the field requires an institution like Ebensburg to provide individualized plans to protect its residents prone to seizure injuries, Ebensburg systemically fails to provide such protection. Tr. 7/30/93 (Alvarez) at 78, 94.^{23/} The field requires Ebensburg to take both preventive measures as well as measures to protect the individual during the seizure. Id. at 77. The use of helmets is one option.^{24/}

Ebensburg fails to protect its residents prone to seizure injuries in two ways. First, Ebensburg acts too slowly in providing protective measures. Tr. 7/30/93 (Alvarez) at 92-93. Second, where protective measures have been provided, individuals often suffer repeated new serious injuries, many requiring sutures, due to ineffective or improper protections. Id. at 93. Dr. Alvarez testified that the consequence of Ebensburg's failures has been many, many preventable injuries. Id. at 79. Dr. Chamovitz admits that he has seen individuals at Ebensburg "who have scarring all over their face" from seizure injuries. Tr. 9/15/93

^{23/} The parties agree that individuals with epilepsy have a tendency to injure themselves during seizures due to falls or due to jerking or shaking motions. Tr. 7/30/93 (Alvarez) at 76; Tr. 9/15/93 (Chamovitz) at 222. Head and face injuries are common, and can be very detrimental to both health and appearance. Tr. 7/30/93 (Alvarez) at 77. Dr. Kastner did not study seizure injuries at Ebensburg during his assessment of the care provided there. Tr. 9/13/93 (Kastner) at 221.

^{24/} Dr. Kastner indicated that in some cases the use of a helmet is appropriate to protect people who have seizures from falling and striking their head. Tr. 9/13/93 (Kastner) at 221-222. Dr. Shertz testified that "I really think we have to use helmets" in preventing further injuries such as fractures to Ebensburg residents prone to fall due to seizures. U.S. Exh. 633 (Shertz Dep.) at 44-45. Dr. Chamovitz agreed: "I think there is a place for helmets." Tr. 9/15/93 (Chamovitz) at 187.

(Chamovitz) at 238. Examples of residents who have been harmed due to Ebensburg's failure to provide adequate protections from seizure injuries include:^{25/}

- Barbara K., who has a chronic seizure disorder and, over the years, has suffered many serious accidents and injuries during seizures. Tr. 7/30/93 (Alvarez) at 79, 84. For a detailed description of some of Barbara's seizure injuries since 1991, see U.S. Exh. 268A (attached). Ebensburg knew of Barbara's recurring seizure injury problem, but for years did not act to protect her. Tr. 7/30/93 (Alvarez) at 81. For example, a direct care worker at Ebensburg, Betty Ferut, testified in her deposition that Barbara frequently gets hurt during seizures. Tr. 7/30/93 (Alvarez) at 80; U.S. Exh. 611A. She testified that "she falls straight as a rock right on her face." Tr. 7/30/93 (Alvarez) at 80; U.S. Exh. 611A. Ms. Ferut added that she has participated in team meetings to discuss a helmet for Barbara, but the team concludes that Barbara would simply not tolerate wearing a helmet. Tr. 7/30/93 (Alvarez) at 80-81; U.S. Exh. 611A. If an individual, like Barbara, will not tolerate wearing a helmet, the psychologist must be brought in to develop and implement a helmet tolerance program to make the individual understand that the helmet is the best thing for her. Tr. 7/30/93 (Alvarez) at 207.

In addition to Ms. Ferut, other staff had recognized that Barbara needs protection. Tr. 7/30/93 (Alvarez) at 81. On October 21, 1992, Barbara fell on her chin during a seizure and split her skin open. Id. at 82; U.S. Exh. 392A. Following this injury, one staff recommended that Ebensburg devise "some kind of chin guard" for Barbara. Tr. 7/30/93 (Alvarez) at 82; U.S. Exh. 392A. Another staff member wrote: "I believe Barbara needs a helmet with a permanent chin guard that she cannot remove." Tr. 7/30/93 (Alvarez) at 82-3; U.S. Exh. 392A. Another staff member indicated that Barbara needs to "wear helmet with face guard." Tr. 7/30/93 (Alvarez) at 83; U.S. Exh. 392A. Still another staff member indicated that Barbara needs a "helmet with chin guard." Tr. 7/30/93 (Alvarez) at 83; U.S. Exh. 392A.

Ebensburg finally provided a helmet for Barbara, but the helmet was ineffective and Barbara continued to suffer seizure fall injuries. Tr. 7/30/93 (Alvarez) at 79. For example, on March 18, 1993, Barbara suffered a seizure injury in which she cut her chin even though she had her helmet on. Tr. 7/30/93 (Alvarez) at 85-6; U.S. Exh. 392C. Following that injury, a staff member indicated that Barbara needs a "different helmet to protect her chin." Tr. 7/30/93 (Alvarez) at 86; U.S. Exh. 392C. Another staff member indicated that Barbara needs a "better helmet for protection." Tr. 7/30/93 (Alvarez) at 86; U.S. Exh. 392C. Another staff member wrote that "Barbara needs a helmet where the chin strap is unable to move around because when she has a seizure and falls, the strap does not protect her face." Tr. 7/30/93 (Alvarez) at 86-7; U.S. Exh. 392C.

^{25/} Dr. Kastner did not review any of the medical records of the individuals discussed below. Def. Exh. HH.

- Ronald A. has a long history of serious injuries from seizures. Tr. 7/30/93 (Alvarez) at 87. Among many other injuries, Ronald has suffered a fractured nose, lacerations on his eyelids and other lacerations requiring sutures. Tr. 7/30/93 (Alvarez) at 87. For details, see U.S. Exh. 268B (attached), which is a chart summarizing a few of the seizure injuries Ronald has suffered since 1991. Due to its poor seizure injury management for Ronald, Ebensburg was cited by IOC surveyors in October 1991 for its failure to protect Ronald from his frequent seizure injuries. Tr. 7/30/93 (Alvarez) at 89; U.S. Exh. 66. Ebensburg finally provided a helmet for Ronald, but his helmet is inadequate because Ronald continues to suffer seizure injuries. Ronald suffered at least five injuries to his head and face in 1992 and one in early 1993. Tr. 7/30/93 (Alvarez) at 204, 216. The seizure injuries Ronald continues to suffer indicate that Ebensburg's injury management is inadequate. Tr. 7/30/93 (Alvarez) at 89.

- Michael M. has suffered many injuries due to seizures. Tr. 7/30/93 (Alvarez) at 92. However, there is no plan in place to prevent Michael's seizure injuries. Id. In addition to Michael M., Jackie B., Ronald S., and many others suffer similar problems at Ebensburg. Id. at 93.

State surveyors have repeatedly cited Ebensburg for its failure to protect residents prone to seizure injuries from harm. For instance, in January 1993, the IOC found that Glenn A. should be provided with a behavioral program for helmet tolerance in view of three uncontrolled seizures and a high incidence of injuries. Tr. 7/30/93 (Alvarez) at 91; U.S. Exh. 67.

2. Ebensburg Is Failing To Provide Adequate EEG Diagnostic Testing For Its Residents With Epilepsy.

Contrary to accepted professional standards, Ebensburg does not offer residents with epilepsy the advantage of EEG diagnostic technology that could help medical professionals make better decisions about when and what kind of medication to use to gain control of seizures. Tr. 7/30/93 (Alvarez) at 94, 100-101, 108-109. Ebensburg's poor utilization of accepted and appropriate diagnostic methods potentially affects all the residents with epilepsy. Id. at 109.

The fact that certain diagnostic techniques like the EEG have not been adequately used at Ebensburg has resulted in poor medical treatment and in many cases, excessive use of medication. Tr. 7/30/93 (Alvarez) at 94. Any Ebensburg resident who is on several medications and is having continuous seizures should have received the benefit of EEG testing. Id. at 108. Dr. Chamovitz agreed that the EEG is a "useful tool." Tr. 9/15/93 (Chamovitz) at 211.

EEGs are important in diagnosing seizures because clinical manifestations are very complex and it is often very difficult to determine whether a person is actually having an epileptic seizure or not. Tr. 7/30/93 (Alvarez) at 49. Some people have behaviors that look like epileptic seizures but they are not actually epileptic seizures. Id. at 49, 52.^{26/}

One of the most common pitfalls for medical professionals is to call an epileptic seizure a seizure when it is not. Tr. 7/30/93 (Alvarez) at 96.^{27/} If a physician does not recognize that certain events are not actually seizures, he or she may tend to increase the individual's anti-epileptic medication in order to attempt to gain better control of the

^{26/} An epileptic seizure can have many different clinical expressions. Tr. 7/30/93 (Alvarez) at 95. Sometimes those clinical expressions might appear very similar to non-seizure related behaviors. Id. For example, one clinical expression of seizures is rigidity; however, an individual may have spasticity from serious brain damage which is not seizure related. Id. Rigidity and spasticity appear clinically similar, and without further diagnostic testing, a doctor may mistakenly treat non-seizure spasticity with anti-seizure medication. Id. Similarly, individuals may be experiencing muscle tensing or reflex activity which may appear to be a seizure, but is really not. Id. Also, some individuals with mental retardation may stare blankly forward for prolonged periods of time and, based on clinical observation alone, this behavior could easily be mistaken for an absence type of seizure activity. Id.

^{27/} Dr. Alvarez testified that even "expert observers" can make mistakes in assessing what is an epileptic event and what is not. Tr. 7/30/93 (Alvarez) at 96. He added that certainly the rate of error increases when non-expert observers make assessments. Tr. 7/30/93 (Alvarez) at 96. He added that there is always the possibility that an event that is recorded in the medical records as an epileptic seizure is not necessarily an epileptic seizure just as there is always the possibility that something that is an epileptic seizure can be missed. Tr. 7/30/93 (Alvarez) at 96.

"seizures." Id. at 52. However, in this situation, the use of anticonvulsant drugs for these pseudo-seizure events is not medically indicated. Id. With treatment by drugs that are not indicated, the person's behavioral events will usually continue unabated. Id. at 96. In response to this, the professional will again usually increase the amount and/or number of anticonvulsant drugs in an attempt to gain some sort of control over the condition. Id. Dr. Chamovitz admitted that a medical professional could think a pseudo-seizure actually was a seizure and treat the event with anticonvulsive medications. Tr. 9/15/93 (Chamovitz) at 237. He further admitted that if the event is actually not a seizure, the anticonvulsant drugs will not have an effect because it is not a seizure. Id.

As a result, the individual can be provided medication that is not benefitting him and that can potentially harm him through side effects. Tr. 7/30/93 (Alvarez) at 96. Thus, it is important to ensure that what is treated as an epileptic seizure actually is an epileptic seizure. Tr. 7/30/93 (Alvarez) at 96-97. Dr. Chamovitz testified that the EEG can be a useful tool for a medical professional to use in distinguishing between a seizure and a pseudo seizure. Tr. 9/15/93 (Chamovitz) at 236-7. Dr. Chamovitz acknowledged that as a result, the EEG can aid a neurologist in the appropriate choice of medication to treat seizures. Tr. 9/15/93 (Chamovitz) at 211. Dr. Chamovitz added that an EEG reading can be "useful" for those individuals who experience events that look like seizures but in fact are not seizures, and vice versa. Tr. 9/15/93 (Chamovitz) at 236.

The current diagnostic system at Ebensburg depends too much on the observations of people who are not specifically trained in epilepsy and not enough on scientific generally accepted diagnostic techniques like the EEG. Tr. 7/30/93 (Alvarez) at 102. Without fully

utilizing the EEG, the Ebensburg doctors and the consultant neurologist are forced to rely on purely clinical descriptions from staff as to whether or not the behavior they witnessed was or was not a seizure. Dr. Chamovitz admitted that as an outside consulting neurologist, he necessarily has to rely on the observations and input of the direct care staff at Ebensburg for daily seizure and convulsion information about the residents he is reviewing. Tr. 9/15/93 (Chamovitz) at 206. Dr. Chamovitz testified that in differentiating between a pseudo-seizure and a real seizure, he relies on the staff "acting out" what the seizure was like. Tr. 9/15/93 (Chamovitz) at 209.

Dr. Chamovitz admitted however, that at Ebensburg some of the seizure information is not reliable because "you can't always be certain that a person recognizes a spell as a spell, a convulsion as a convulsion." Tr. 9/15/93 (Chamovitz) at 209; U.S. Exh. 606C. Dr. Chamovitz also testified that he thought the knowledge of the direct care staff in this respect certainly could be improved. Tr. 9/15/93 (Chamovitz) at 210. Dr. Chamovitz acknowledged that some people at Ebensburg are less reliable than others in discerning between real seizures and "fake spells." Tr. 7/30/93 (Alvarez) at 102.

Certainly a good clinical description of the behaviors is important but it is not sufficient. Tr. 7/30/93 (Alvarez) at 97. The use of the EEG allows medical professionals to more definitively determine whether or not an individual is having an actual seizure. Tr. 7/30/93 (Alvarez) at 97. EEGs are often combined with videotaping to provide the best method to document whether the person has had an epileptic seizure or not. Tr. 7/30/93 (Alvarez) at 97.

In not providing its residents with adequate EEG testing, Dr. Alvarez testified that Ebensburg is not meeting its own policies and the language of its mission statement. Tr. 7/30/93 (Alvarez) at 100.^{28/} Dr. Alvarez testified that every resident who has suspended his seizure activity and every resident who has a seizure that was normally controlled with medication should have the benefit of the EEG. Tr. 7/30/93 (Alvarez) at 102-103. Examples of individuals who would have benefitted from the use of the EEG in diagnosing their condition include:^{29/}

- Barbara K. has a history of having 20-30 seizures per year. Tr. 7/30/93 (Alvarez) at 103. In 1991, Dr. Chamovitz suggested that Barbara was acting a little differently for the past few months. Id. He indicated that she appeared to have rubbery legs. Id. He queried whether or not this behavior was a show for attention or whether or not it was minor seizure activity. Id. After Dr. Chamovitz's comments, there was no follow up by the staff. Id. An EEG might have been helpful to determine if this behavior was a seizure or just a behavioral problem.

Barbara's behavior recurred in September 1992. Tr. 7/30/93 (Alvarez) at 103. Dr. Chamovitz concluded that "inexperienced observers have improperly recorded these spells." Id. at 103-104; U.S. Exh. 606D. Barbara would have benefitted from the use of other diagnostic methods other than just pure observation by the staff. Tr. 7/30/93 (Alvarez) at 104. This is evident based on the fact that Dr. Chamovitz could not resolve the issue only on the basis of descriptions alone. Id.

Barbara was on a high number of anticonvulsant drugs -- four -- and yet she was still having frequent injuries. Tr. 7/30/93 (Alvarez) at 104. This demonstrates that there is some doubt about the effectiveness of all these drugs in effectively controlling her seizures. Id. With better diagnostic testing, different treatments, and perhaps fewer medications, could be undertaken. Id. No one will ever know if Barbara needs all these anticonvulsant drugs without adequate and appropriate diagnostic testing with the EEG. Id. at 104-105.

^{28/} Ebensburg Policy 128, Classification and Management, Seizure Disorders, and the Ebensburg Philosophy and Mission Statement expressly state that the facility is to provide its residents with appropriate testing for their seizures, that the testing is to be state of the art, and that it will meet the leading edge of the standards and expectations in the field of developmental disabilities. U.S. Exh. 11, 13A.

^{29/} Dr. Kastner did not review the medical records for any of the individuals discussed below. Def. Exh. HH.

- Nancy L. is severely spastic. Tr. 7/30/93 (Alvarez) at 105. Spasticity is a condition where all the individual's muscles are very tense. Id. Due to the severity of the brain damage, Barbara does not have much control of her muscles which have a tendency to overact quite often to different stimuli. Id. To an untrained observer, however, this action could appear to be an epileptic seizure even though it is not. Id. Nancy was on anticonvulsant medication and she was lethargic as a result. Id. Based on the descriptions of the "seizures" that appeared in her medical record, however, Dr. Alvarez testified that he would have had a difficult time concluding that the events described were in fact epileptic seizures. Id. at 106. He indicated that Nancy should have received the benefit of an EEG to help the staff make a proper diagnosis. Id. Nancy may be taking medications, with serious side effects, that are of no benefit to her and this would be great harm. Id. at 107.

- Sharon McK. suffered from a particular disorder that produced a sudden loss of muscle tone. Tr. 7/30/93 (Alvarez) at 107. It was unclear whether or not this activity was seizure related. Id. Some seizures which produce a sudden loss of muscle tone are called akinetic seizures. Id. at 107-108. This type of seizure produces a lot of falling injuries. Id. at 107-108. Akinetic seizures will improve with certain types of medication and will not improve with certain other types of medication. Id. at 108. If you are not sure which type of seizure the individual is experiencing, you may treat the individual with the wrong medication. Id. An EEG reading will aid in the correct diagnosis. Again, Sharon was treated with a certain type of anticonvulsant medication without the Ebensburg staff ever being sure which type of seizure she was suffering from (if in fact, she was suffering from seizures at all). Id. at 107. Sharon should have received the benefit of an EEG to help the staff make a proper diagnosis. The point of all this is to make the correct diagnosis so that the right medications can be prescribed if at all. Id. In this case, Sharon may have been given medications (with all the attendant risks of side effects) without the staff being sure that she was actually seizing. Id. at 108.

- Gerald G. was thought to have a focal type seizure but he was never provided with an EEG to determine if this was the case. Tr. 7/30/93 (Alvarez) at 108. As a result, he continued on four medications for prolonged periods of time and was subjected to medication side effects. Id. His medical records indicate that he suffered from dehydration which is a side effect of medication. Id.

3. Ebensburg Is Unduly Engaging In The Practice Of Anticonvulsant Polypharmacy.

The standard in the field is that medical professionals should try to use the least possible amount of medication. Tr. 7/30/93 (Alvarez) at 112. Polypharmacy is the use of several medications at once to treat one particular condition. Tr. 7/30/93 (Alvarez) at 109. Experts for both the United States and defendants agreed that polypharmacy is something the

medical staff should try to avoid in treating a developmentally disabled individual with epilepsy. Tr. 7/30/93 (Alvarez) at 110; Tr. 9/13/93 (Kastner) at 191; Tr. 9/14/93 (Chamovitz) at 244. Individuals should not be placed on several medications at once unless it is strictly necessary. Tr. 7/30/93 (Alvarez) at 110-111.

As far back as 1990, the Justice Department had notified Ebensburg that its practice of maintaining anticonvulsant polypharmacy was placing the long term health of its residents at risk. U.S. Exh. 638 (Sponsky Dep.) Exh. 50. And yet the deficient practices continue today.

The physicians at Ebensburg have engaged in anticonvulsant polypharmacy with some of the residents for long periods of time even though there are indications in the record that the residents are suffering from side effects. Tr. 7/30/93 (Alvarez) at 114. Dr. Kastner agreed that the percentage of individuals on anticonvulsant polypharmacy at Ebensburg was "a concern." Tr. 9/13/93 (Kastner) at 193, 195; U.S. Exh. 900. Dr. Kastner indicated that Ebensburg could do a little bit better in reducing the rates of polypharmacy. Tr. 9/13/93 (Kastner) at 195. Dr. Chamovitz also indicated that the use of anticonvulsants in combination at Ebensburg is a concern to him. U.S. Exh. 606 (Chamovitz Dep.) at 145-146.^{30/}

Individuals can be harmed by the use of polypharmacy. Tr. 7/30/93 (Alvarez) at 110. Dr. Alvarez pointed out that "antiepileptic medications are good to control and prevent

^{30/} Dr. Kastner indicated that it would be valuable for Ebensburg to augment its monitoring activities with respect to polypharmacy practices across the facility. Tr. 9/13/93 (Kastner) at 219. Dr. Kastner indicated that "systematic analysis of outcome data may be helpful in monitoring treatment or demonstrating treatment effectiveness of anticonvulsant medication and should be performed to monitor practice in this area." Tr. 9/13/93 (Kastner) at 221.

seizures; but at the same time we know that antiepileptic medication has side effects."

Id.^{31/} Side effects can be harmful to the patient. Id. Dr. Kastner agreed that an anticonvulsant polypharmacy regimen carries with it side effects that may include cognitive dulling and side effects potentially affecting every organ system depending on the particular medication used. Tr. 9/13/93 (Kastner) at 191. Dr. Kastner also admitted that it is well known that when anticonvulsant medications are used in combination, there are also interactions between the drugs that cause side effects. Tr. 9/13/93 (Kastner) at 110. The side effects tend to increase as you increase the numbers of medications. Tr. 9/13/93 (Kastner) at 110, 191. Thus, a doctor should have a very good reason for putting an individual on any medication and certainly on multiple medications due to the medication side effects. Tr. 7/30/93 (Alvarez) at 110.

A major problem with medication side effects is that they are very subtle and are not easily detected. Tr. 7/30/93 (Alvarez) at 111.^{32/} This is especially true for individuals with mental retardation who are non-verbal and who cannot convey how they feel. Id. For example, individuals with developmental disabilities may not be able to report tiredness or unsteadiness or poor motor coordination or declining health. Id.

Sometimes it may be necessary to use two or three anticonvulsant medications, but it is generally not accepted practice in the field to use four anticonvulsant drugs simultaneously

^{31/} Some medications can produce drowsiness and induce sleep, some produce decreases in cognitive functioning, some can produce changes in the way the liver functions, and, in fact, some medications can be toxic for the liver or red or white blood cells. Tr. 7/30/93 (Alvarez) at 110.

^{32/} In fact, the side effects may not be evident until the medication is decreased or stopped. Tr. 7/30/93 (Alvarez) at 111.

to treat an individual's epilepsy. Tr. 7/30/93 (Alvarez) at 112.^{33/} As Dr. Alvarez indicated "it is something you should avoid at any cost." Id. He indicated that in exceptional circumstances, four anticonvulsant drugs may be used for a short period of time, but that four drugs should not be used over the course of years. Id. at 112-113, 149, 151.^{34/} A fourth drug may be added for a short period of time, i.e., a month to two months, while you are trying to wean an individual off another anticonvulsant drug or if you want to try a new drug. Id. at 112-113, 149, 151. A fourth drug should only be used by a very experienced neurologist; this is not something that a primary care physician should undertake if he does not have much training in neurology. Id. at 151. In either case, the physician must have a good medical plan of action. Id. at 113.

Examples of Ebensburg residents who have been subjected to anticonvulsant polypharmacy for prolonged periods of time include:^{35/}

- Mark G., who has suffered only a small number of seizures in recent years. Tr. 7/30/93 (Alvarez) at 114.^{36/} However, Mark has been kept on four anticonvulsant medications over the course of years. Id. at 114, 115. The medications have produced clear side effects as evidenced in his record. Id. at 114. He has exhibited lethargy on many occasions including a number of times in February 1992. There was an awareness among the staff that Mark was lethargic from the medication, and yet nothing was done to attempt to decrease his medications. Id. at 115. The Ebensburg physicians continued Mark on four

^{33/} Dr. Shertz agreed that his general philosophy is to use the fewest anticonvulsant drugs as possible in treating someone with a neurologic problem, but he admitted that there are Ebensburg residents on four anticonvulsant drugs. U.S. Exh. 633 (Shertz Dep.) at 30-31.

^{34/} Dr. Chamovitz agreed that the use of four anticonvulsant drugs is not a "desirable practice." Tr. 9/14/93 (Chamovitz) at 241.

^{35/} Dr. Kastner did not review the medical records of any of the individuals discussed below. Def. Exh. HH.

^{36/} For example, in 1989, Mark suffered only three seizures, in 1990 no seizures were reported, in 1991 he had two seizures, and in 1992 he suffered only three seizures. Tr. 7/30/93 (Alvarez) at 114.

medications in spite of the fact that the outside consult neurologist suggested that Mark's medications be reduced. Id.^{37/} The consultant neurologist recognized that Mark was suffering from a small number of seizures. Id. at 116; U.S. Exh. 351A. In fact, the consult neurologist noted that Mark was receiving four medications even though he had only five total seizures in the last three years. U.S. Exh. 351A. Before October 1992, Mark had not been seen by the consult neurologist since 1982 -- ten years. U.S. Exh. 351A. The Ebensburg primary care doctor finally ordered a neurological consult for Mark on September 30, 1992, only two weeks after the United States' medical doctor, Dr. Sulkes, toured the facility, and only a few weeks before the United States' neurologist, Dr. Alvarez, was to tour the facility.

- Dennis B. was kept on four anticonvulsant medications even though he had very few seizures. Tr. 7/30/93 (Alvarez) at 116. On November 9, 1990, the consult neurologist suggested that the Ebensburg doctors decrease Dennis' medications, but his recommendation was never adopted or implemented at Ebensburg. Id. In fact, the Ebensburg primary care physician disagreed with the consult neurologist and decided to take full control of the case so as to keep Dennis on four anticonvulsant medications. Id. The Ebensburg doctor refused to accept the opinion of the neurologist that the patient was overmedicated. Id. This is another case of unnecessary polypharmacy that could produce harm to the patient. Id. On October 22, 1992, Dr. Chamovitz continued to express his concerns about Dennis being on four drugs. Id. at 116-7; U.S. Exh. 307A. Dr. Chamovitz wrote: "one has to be concerned that he is receiving four kinds of medication." U.S. Exh. 307A. He further noted that he and the primary care doctor would discuss "which direction we should take in an effort to effectively reduce his medication." U.S. Exh. 307A. The expert consult neurologist had not seen Dennis in about a year and a half. U.S. Exh. 307A. Dennis had continued on four anticonvulsant drugs for this entire two-year period in spite of the known written concerns of the consult neurologist. Tr. 7/30/93 (Alvarez) at 117.

- Darlene M. is receiving three anticonvulsant medications and yet the total number of her seizures is very small. Tr. 7/30/93 (Alvarez) at 117. Darlene is probably overmedicated. Id. at 118. The high amounts of medication she is receiving would tend to impair anyone's coordination. Id. Darlene has fallen regularly, but she is not having seizures. Id. Nonetheless, it was never considered that the falls may have been due to the side effects of the high amounts of medication in her system. Id. at 117-118. The neurologist was practically not involved in her care. Id. at 117. There were many problems in Darlene's neurological care: she was falling without seizing and yet she had not had the benefit of a consultation with the neurologist in a long time; there was no attempt to decrease her medications; and she was not provided with appropriate diagnostic techniques like an EEG to determine whether or not her events were in fact seizures and whether or not she should be kept on the medications. Id. at 118.

^{37/} On October 1, 1992, the consultant neurologist suggested that the Ebensburg doctors reduce Mark's medications: "I should like for the staff to consider trying to reduce and discontinue some of Mark's anticonvulsant medication." Tr. 7/30/93 (Alvarez) at 115-6, U.S. Exh. 351A.

- Louis L. had been kept on four anticonvulsant drugs. Tr. 7/30/93 (Alvarez) at 118. Even though the consult neurologist had suggested decreasing Louis' medications, the Ebensburg primary physician had taken over control of his neurological care and did not reduce his drugs until finally Louis became toxic. Id. After his medications were finally decreased, the tangible positive effects of the change were noted by the staff in his record: "he is alert. The quality of [his] life is good." Id. at 118-119. Before his medications were decreased, he was described by the staff as "drowsy." Id. at 119. In Dr. Alvarez' opinion, the Ebensburg doctors are very reluctant to change any residents' medication. Id. at 118.

4. Ebensburg Is Failing To Properly Manage The Side Effects Of Anticonvulsant Medication Administered To Its Residents.

It is generally accepted in the field of developmental neurology that an institutional medical staff treating a developmentally disabled individual on an anticonvulsant drug regimen is expected to properly manage the medications such that the negative side effects of the drugs are minimized. Tr. 7/30/93 (Alvarez) at 119-20.

In the management of seizures in an individual with epilepsy, there is a need for a team approach because anticonvulsant medication produces side effects and the entire team is needed to monitor the individual's progress on the drug. Tr. 7/30/93 (Alvarez) at 52.^{38/}

Overall, Ebensburg considers side effects like lethargy to be a complication a person with epilepsy should have to learn to live with. Tr. 7/30/93 (Alvarez) at 132. This is simply not the case. Tr. 7/30/93 (Alvarez) at 132. Dr. Alvarez testified that "there is no reason to keep th[ese] patient[s] lethargic." Tr. 7/30/93 (Alvarez) at 132. Lethargy in itself can induce seizures in many people with epilepsy. Tr. 7/30/93 (Alvarez) at 132. Dr. Alvarez testified that it is a "very tricky and dangerous area when you try to control seizures

^{38/} For example, the individual might be falling more often or might be very sedated or might not be able to swallow or drink as well as before. Tr. 7/30/93 (Alvarez) at 52. Dr. Chamovitz testified "There is no question that sedation and quietness and lethargy ... can be caused by some medications." Tr. 9/14/93 (Chamovitz) at 252. As a result, you need awareness among all the people that are involved with the patients to alert the physicians that something is wrong. Tr. 7/30/93 (Alvarez) at 52.

with high doses of medication" because you produce lethargy. Tr. 7/30/93 (Alvarez) at 132. A medical professional should not simply disregard the lethargy as beyond his control. Tr. 7/30/93 (Alvarez) at 132. This leads to an escalating cycle of more seizures and more anticonvulsants to control them. Tr. 7/30/93 (Alvarez) at 132. As a result, many Ebensburg residents end up being hospitalized for overmedication toxicity.

There is no awareness among the Ebensburg staff of any overmedication problem among the residents and there is no demonstrated sense of urgency to act to control these side effects. Tr. 7/30/93 (Alvarez) at 133. There is also a high degree of tolerance for some of these side effects, and as Dr. Alvarez testified, "this shouldn't happen." Tr. 7/30/93 (Alvarez) at 133. The facility's inappropriate evaluation and management of anticonvulsant medication side effects potentially affects all the residents with epilepsy at Ebensburg. Tr. 7/30/93 (Alvarez) at 133.

There was a general lack of awareness among the professional staff at Ebensburg of the negative side effects of the anticonvulsant medications provided to its residents. Tr. 7/30/93 (Alvarez) at 120. Examples include:^{39/}

- In January 1991, Jeffrey K. was being given five thousand milligrams of Depakote for his seizures. Tr. 7/30/93 (Alvarez) at 120. Dr. Alvarez labelled this as an "inordinately high" amount of this medication. *Id.* at 124.^{40/}

On January 10, 1991, Dr. Chamovitz wrote in one of his consults for Jeffrey that five thousand milligrams is "an unusually large amount" of Depakote for a person Jeffrey's size. Tr. 7/30/93 (Alvarez) at 121; U.S. Exh. 393A. Dr. Chamovitz showed concern about this, and yet the primary care physicians did not, and they chose not to follow his advice. Tr. 7/30/93 (Alvarez) at 121. The use of this extremely high amount of medication did not

^{39/} Dr. Kastner did not review the medical records of any of the individuals discussed below. Def. Exh. HH.

^{40/} Dr. Alvarez testified that he rarely goes over three thousand milligrams and never goes over three thousand five hundred. Tr. 7/30/93 (Alvarez) at 121.

result in any better control of Jeffrey's seizures and, in fact, the seizures increased. Id. Dr. Chamovitz again raised a concern in a December 19, 1991 consult. Tr. 7/30/93 (Alvarez) at 121; U.S. Exh. 393B. He wrote that in using this high amount of Depakote, "there has not been better control of his convulsions; and actually so far, there seems to have been an increase in his convulsions." U.S. Exh. 393B.

On February 27, 1992, Jeffrey was admitted to Mercy Hospital for a seizure disorder. Tr. 7/30/93 (Alvarez) at 122; U.S. Exh. 393C. Dr. Chamovitz admitted that Jeffrey had to be admitted to the hospital because he had high blood levels which made him sedated and lethargic. Tr. 9/15/93 (Chamovitz) at 203. Dr. Chamovitz acknowledged: "The medication was not doing him any good, and he was having side effects." Tr. 9/15/93 (Chamovitz) at 203. At Mercy, the hospital staff realized that the blood level of this medication was too high so they stopped this medication completely. Tr. 7/30/93 (Alvarez) at 122; U.S. Exh. 393C. After the Depakote was stopped, Jeffrey improved. Tr. 7/30/93 (Alvarez) at 123. He returned to Ebensburg from the hospital on Tegretol; the Ebensburg nursing notes indicated that he ate well for supper later that week, and that the next week he was "alert, active, seems his usual self." Id. Dr. Chamovitz acknowledged that once the hospital had stopped the Depakote, "lo and behold, as Dr. Alvarez points out, he stopped having spells." Tr. 9/15/93 (Chamovitz) at 203. Dr. Chamovitz agreed that "It was not a good medicine for him, and the level didn't make any difference." Id. He added that "We just guessed wrong." Id. After Jeffrey's return from the hospital, i.e., after his removal from the high levels of Depakote, Dr. Chamovitz noted in a June 12, 1992 consult that there had been "a dramatic change" in Jeffrey's convulsions and clinical state. Tr. 7/30/93 (Alvarez) at 125; U.S. Exh. 393D. Dr. Chamovitz concluded that "Jeffrey has had only two convulsions recorded since he has been on this present dose of medication." U.S. Exh. 393D. Dr. Chamovitz concluded that "One has to be very pleased with Jeffrey at this time." U.S. Exh. 393D. In fact, Jeffrey only suffered two seizures in the three months after the change by the hospital. Tr. 7/30/93 (Alvarez) at 125.

Jeffrey was harmed due to overmedication; Ebensburg's inability to perceive side effects; Ebensburg's inability to recognize that its medications were increasing the number of seizures; repeated rejection of advice of Ebensburg's consultant neurologist; and lack of diagnostic techniques such as the EEG. Tr. 7/30/93 (Alvarez) at 123-125.

- Neal S. was on anticonvulsant medications and was noted to be extremely lethargic for six weeks in early 1992. Tr. 7/30/93 (Alvarez) at 125. When a resident is lethargic for six weeks, that is a clear red flag that something is wrong. Id. However, no one at Ebensburg did anything to help Neal. Id. at 126. Dr. Alvarez stressed that it was "wrong" to continue someone on medication while he is lethargic for six full weeks. Id. As a result of his lethargy, Neal had suffered a drastic regression in programming. Id. at 125. A regression in programming is not a subtle side effect from a medication; it is a drastic side effect that directly affected Neal's quality of life in a negative way. Id.

Neal repeatedly suffered from blood toxicity levels above the therapeutic range. Id. at 126. For example, on March 25, 1992, his blood level of Dilantin was 26 which is high, well above the level limit of 20. Id. In addition, on April 21, 1992, his blood level of

Dilantin was 30, again well over the normal high level. Id. These two toxic blood level readings occurred during the period when Neal was lethargic. Id.

Besides lethargy, other consequences of Neal's overmedication included loss of appetite, excessive sleeping, and several seizures. Tr. 7/30/93 (Alvarez) at 126. These problems continued until Neal was admitted to Mercy Hospital on April 28, 1992. Id. at 127. The hospital admission report indicated that Neal suffered from lethargy and stupor, and he was unresponsive to painful or verbal stimuli. Id.; U.S. Exh. 468.

Even though Neal suffered from these and a myriad of other medical problems, he was never well evaluated by the Ebensburg primary care physician. Tr. 7/30/93 (Alvarez) at 127. There was no mention in Neal's medical record by an Ebensburg physician that he was lethargic or had a bad appetite. Tr. 7/30/93 (Alvarez) at 128. All of these problems were discovered upon his admission to Mercy Hospital.

- Sean M. was taking high doses of Dilantin and his blood level was recorded in the toxic range on May 21, 1992. Tr. 7/30/93 (Alvarez) at 129. However, there were no recorded evaluations of this episode by any Ebensburg doctor. Id. Fifteen days later, he is described in the notes as acting strange, walking around, falling and bouncing into walls and furniture. Id. This behavior is consistent with some of the side effects of Dilantin which produces a clinical state as if you were drunk. Id.; Tr. 9/15/93 (Chamovitz) at 192. Four days later, Sean was reported with another blood level reading in the toxic range. Tr. 7/30/93 (Alvarez) at 129.

- Rosemary W. was recorded with a Dilantin level of 33.5 which is well above the top therapeutic level of 20. Tr. 7/30/93 (Alvarez) at 130. She was described as unsteady and lethargic in the medical chart notes. Id. However, there were no physicians' notes in the record addressing this particular problem. Id.

- Charles S. was hospitalized for Dilantin toxicity. Tr. 7/30/93 (Alvarez) at 130; U.S. Exh. 462A. Charles had been given three anticonvulsant medications for a long time and there was indication in the 1992 annual review that he had been sedated. Tr. 7/30/93 (Alvarez) at 131. However, the medical staff was apparently never fully aware of the fact that Charles was being chronically sedated. Id. On July 16, 1992, a nurse described him as not alert enough to take medications. Id. If the individual has a history of being sedated and he is not alert enough to take medication on a given day, he must be provided with a blood level right away. Id. At the very least, the doctor should go and see the individual, but there is no evidence in the Ebensburg records that a doctor saw Charles. Id.

- Luberta H. was admitted to Mercy Hospital on December 4, 1992 for Dilantin toxicity. Tr. 7/30/93 (Alvarez) at 132-133; U.S. Exh. 372A. She had been placed on too high a level of anticonvulsant medication. Tr. 7/30/93 (Alvarez) at 133. At the time of her admission, her blood level reading was 47 which is well over the accepted high level of 20. Id. This is twice as high as it should be. Id. At that time, she was also exhibiting a high blood level reading of another anticonvulsant drug, Phenobarbital. Id.

● Ronald A. was taking anticonvulsant medications and was sedated for a long time. Tr. 7/30/93 (Alvarez) at 129. The Ebensburg physicians took too long to respond to his condition. Id. at 130.

These are not the only examples that Dr. Alvarez found at Ebensburg where residents unduly suffered from the negative side effects of anticonvulsant medications. Tr. 7/30/93 (Alvarez) at 133.

5. Ebensburg Is Failing To Fully Involve An Expert Neurologist In The Neurological Care Of Its Epileptic Residents.

Ebensburg does not fully utilize the input and services available to them from their consultant neurologist. Tr. 7/30/93 (Alvarez) at 135. In difficult cases, where the neurologist takes more of an active responsibility for the neurological care of the individuals, the person will suffer less injuries and less side effects. Tr. 7/30/93 (Alvarez) at 163.

a. The Neurologist's Advice Is Ignored.

In many cases, the Ebensburg primary care physicians disregard the advice of the consultant neurologist to the detriment of the residents' neurological care. Tr. 7/30/93 (Alvarez) at 135.^{41/} Dr. Alvarez testified that the fact that the Ebensburg physicians "disregarded this advice produced harm in the patients." Tr. 7/30/93 (Alvarez) at 135.^{42/}

^{41/} For example, other than the review of his written progress notes or his written consults, Dr. Chamovitz is not made part of any formalized drug review system that is currently in place at Ebensburg. U.S. Exh. 633 (Shertz Dep.) at 20-21. Dr. Chamovitz admitted that he does not participate in the drug reviews, but he indicated that it would be helpful to sit with the team because the more information he has, the better. U.S. Exh. 606 (Chamovitz Dep.) at 76-77. In addition, during the hospitalization of an Ebensburg resident, Dr. Chamovitz normally does not have any input in the medical care of the resident or the hospitalization process. U.S. Exh. 633 (Shertz Dep.) at 22.

^{42/} Dr. Alvarez testified that the neurologist should be more involved in the direct care of the residents instead of merely offering suggestions or advice that can be ignored by the primary care doctors. Tr. 7/30/93 (Alvarez) at 141. For the difficult cases, the neurologist should be the one to write the order to increase or decrease the individual's medication. Tr. 7/30/93 (Alvarez) at 141.

Dr. Chamovitz acknowledged that in the past, the Ebensburg physicians have decided not to follow his recommendations. Tr. 9/15/93 (Chamovitz) at 215. Dr. Chamovitz agreed with Dr. Alvarez in criticizing the Ebensburg primary care physicians for not always taking his advice. Tr. 9/14/93 (Chamovitz) at 256. The facility's poor utilization of its consult neurologist potentially affects all the residents at Ebensburg with epilepsy. Tr. 7/30/93 (Alvarez) at 139.^{43/} Examples of Ebensburg's improper utilization of its consulting neurologist's advice include:

- The Ebensburg physicians and the interdisciplinary team excluded the consultant neurologist from any direct input into Andrew Lo.'s neurological care making themselves exclusively responsible for it. Tr. 7/30/93 (Alvarez) at 137. Nonetheless, Andrew was taking four anticonvulsant medications and he was suffering complications and injuries. Id. Andrew was also never provided with an EEG reading. Id. at 136. At one point, Andrew developed left arm paralysis. Id. at 137. A few months later, he could not move the right arm. Id. This is the type of condition that is a red flag that should signal to any primary care physician that a neurologist with some expertise should be involved. Id. However, the consult neurologist was never called in for advice or consultation at this time in Andrew's care. Id. Andrew became sick and was hospitalized on June 14, 1992. Id. An MRI at Mercy Hospital revealed that Andrew had an infection in the cervical bones located in the spine. Id. The infection was producing an abscess that was producing compression on the spinal cord. Id. at 138. Dr. Alvarez found it incredible that the neurologist's expertise and advice were not heeded given the severity of the infection, the paralysis of the extremities, the high number of medications Andrew was taking, and the fact that he had been sedated on many prior occasions. Id. at 138. It turned out that Andrew was in fact overmedicated and the staff could not proceed with treatment. Id. The paralysis potentially could have been a bigger problem than it turned out to be for Andrew. Id.

- Dennis B. was receiving four antiepileptic medications and yet the consult neurologist was not involved in his care for seventeen months. Tr. 7/30/93 (Alvarez) at 139. When he finally did become involved, he decreased one of Dennis' medications. Id.

- Mark G. was on many different anticonvulsant medications with noted side effects. Tr. 7/30/93 (Alvarez) at 139. Even though the neurologist was requesting Mark's medications

^{43/} Specifically, Dr. Alvarez thought the amount of neurological services provided to Jeffrey K., Mark G., and David B. were inadequate. Tr. 7/30/93 (Alvarez) at 136.

be decreased, this was not implemented for quite some time. Id. In the meantime, Mark suffered from negative side effects of the medication. Id.

b. The Neurologist Does Not Have Control Over the Individuals That Need Expert Input.

Another deficiency is the lack of control given to the consult neurologist over who he sees on a given visit. Dr. Chamovitz admitted that the Ebensburg physicians dictate who he will provide neurological consult services to on a given visit. Tr. 9/15/93 (Chamovitz) at 213. Dr. Shertz admitted that the outside consultant neurologist does not control which Ebensburg residents he would like to see on a given visit to the facility. U.S. Exh. 633 (Shertz Dep.) at 7-8. Whether or not the outside consultant sees a given Ebensburg resident is solely within the discretion of the Ebensburg primary care physician. U.S. Exh. 633 (Shertz Dep.) at 15.^{44/} Many times, the outside neurologist, Dr. Chamovitz, has indicated in writing that he would like to see a certain patient within a "few months" (or other short time frame); however, the Ebensburg primary care physicians will often not respect this request and will not grant Dr. Chamovitz the right to see the resident. U.S. Exh. 633 (Shertz Dep.) at 15-16. Dr. Chamovitz admitted that he sees an occasional patient that he wished he had seen earlier. U.S. Exh. 606 (Chamovitz Dep.) at 100-101.

^{44/} Before Dr. Chamovitz arrives, a list of the residents he is to see is prepared by the Ebensburg primary care physicians. U.S. Exh. 633 (Shertz Dep.) at 7; Tr. 9/14/93 (Chamovitz) at 229. Dr. Chamovitz is not able to add to the list any residents he would like to see given the strictures of the present system. U.S. Exh. 633 (Shertz Dep.) at 8. Even if Dr. Chamovitz asks to see a patient for a follow-up visit, the patient's primary physician has the right to determine that the follow-up is not necessary. U.S. Exh. 606 (Chamovitz Dep.) at 29. The referring physician has the final say as to when Dr. Chamovitz sees a patient. U.S. Exh. 606 (Chamovitz Dep.) at 30-31.

c. The Number Of Consult Neurology Hours Is Inadequate.

The parties agree that there are not enough neurologist consult hours afforded to the residents of Ebensburg given the large number of individuals with neurological problems there. Tr. 7/30/93 (Alvarez) at 135; Tr. 9/14/93 (Chamovitz) at 229, 249. Dr. Chamovitz only provides neurological services to Ebensburg two days a month. Tr. 9/15/93 (Chamovitz) at 205.^{45/}

Dr. Chamovitz testified that he would like to spend more than two days a month at the facility, preferably one day a week. Tr. 9/15/93 (Chamovitz) at 206; Tr. 7/30/93 (Alvarez) at 144; U.S. Exh. 606F. He testified that "I can do [the job] better if I were there once a week." Tr. 9/14/93 (Chamovitz) at 249. He indicated that more time at the facility would be "better." Tr. 7/30/93 (Alvarez) at 144; U.S. Exh. 606F. He added that more time at the facility would afford him the ability to see the residents more consistently and to interact with the direct care staff more closely. Tr. 9/15/93 (Chamovitz) at 206; Tr. 7/30/93 (Alvarez) at 144; U.S. Exh. 606F. Dr. Alvarez commented that he agreed with Dr. Chamovitz's statements. Tr. 7/30/93 (Alvarez) at 144. Dr. Chamovitz testified that the residents would benefit because the primary care physicians would have more access to and

^{45/} Dr. Chamovitz added that "being there only two days a month does not give me the time to do the job that I am contracted to do all of the time. I have to spend so much time on those patients who are really in trouble, that you don't have the time to see everybody else." Tr. 9/14/93 (Chamovitz) at 249-50. Dr. Chamovitz admitted that most of his consults last only about 15 minutes. U.S. Exh. 606 (Chamovitz Dep.) at 68.

would have improved communications with the neurologist. Tr. 9/15/93 (Chamovitz) at 206; Tr. 7/30/93 (Alvarez) at 144-5.^{46/}

d. Time Constraints Preclude The Neurologist From Seeing All The Individuals Who Are Candidates For Neurological Care.

According to his contract, Dr. Chamovitz is expected to see every Ebensburg resident with epilepsy at least once a year. Tr. 7/30/93 (Alvarez) at 145. However, a September 1992 Ebensburg list of individuals with epilepsy revealed that Dr. Chamovitz has not in fact seen every resident with epilepsy every year. Tr. 7/30/93 (Alvarez) at 145; U.S. Exh. 149. There were several individuals with epilepsy at Ebensburg who the consult neurologist had not seen for years. Tr. 7/30/93 (Alvarez) at 145; U.S. Exh. 149.^{47/} Dr. Chamovitz testified that it is true that there are some individuals with epilepsy who he has not seen during a given year. Tr. 9/15/93 (Chamovitz) at 223-4. Not only did Dr. Chamovitz not meet the obligations of his contract, but more importantly, the residents of Ebensburg with epilepsy were denied the valuable input of a consult neurologist into their medical and neurological care for a period of years in many cases. Tr. 7/30/93 (Alvarez) at 145.^{48/}

^{46/} Dr. Chamovitz went on to testify that it would be better to have a full-time neurologist at Ebensburg. Tr. 9/15/93 (Chamovitz) at 205-6. Dr. Chamovitz admitted that he does not attend interdisciplinary team meetings. Tr. 9/15/93 (Chamovitz) at 217-8. He acknowledged that it would be helpful to sit down with the team and discuss issues, but Chamovitz admitted "time is a constraint." Tr. 9/15/93 (Chamovitz) at 218. Dr. Chamovitz testified that he might attend the team meetings if he worked there full-time. Tr. 9/15/93 (Chamovitz) at 218. He added that if he were full-time, he "would become a more integral part of the place." Tr. 9/15/93 (Chamovitz) at 218.

^{47/} As of September 1992, Dr. Chamovitz had not seen over 75 out of 245 individuals with epilepsy - about a third - in the past one year period. U.S. Exh. 149. A few of the individuals he had not provided neurological consult services to since the 1970s; many more he had not seen since the 1980s. Id.

^{48/} Only since this lawsuit was initiated, and scrutiny has been heightened, has Ebensburg required every resident who has epilepsy or is on anticonvulsant medications to be seen by the outside

(continued...)

The Ebensburg residents would benefit from more of a combined neuro-psychiatric approach to individual care at Ebensburg. Tr. 7/30/93 (Alvarez) at 140. Dr. Alvarez advocated that Ebensburg reorganize the whole way they provide medical and neurological services, and put it into a more integrated concept. Tr. 7/30/93 (Alvarez) at 140. He testified that about 50-60 percent of the individuals at Ebensburg have neuro-psychiatric problems. Tr. 7/30/93 (Alvarez) at 143. In the neuro-psychiatric approach, the neurologist, psychiatrist and psychologist would work together and be very much involved with certain residents. Tr. 7/30/93 (Alvarez) at 140-1.

6. Ebensburg Is Not Adequately Documenting Medical And Neurological Care For Its Residents In Violation Of Generally Accepted Standards.

The quality of the medical recordkeeping at Ebensburg does not meet generally accepted professional standards. Tr. 7/30/93 (Alvarez) at 146.

Dr. Alvarez indicated that in assessing conditions at Ebensburg, it was important to review the medical records because they provided him with insight into how the physicians communicated with other physicians and other members of the team; it provided him with an insight into how the physicians developed diagnoses and suggested treatments; it showed him whether or not a certain treatment was or was not successful; it also was the only way he could review documented cases where medication side effects presented themselves clinically. Tr. 7/30/93 (Alvarez) at 47-8.

⁴⁸/(...continued)

neurologist. U.S. Exh. 633 (Shertz Dep.) at 8. In fact, Dr. Shertz testified that he was not looking to have the outside neurologist see everyone on anticonvulsants on any given time interval, such as every year, because he felt the Ebensburg doctors were more than capable of handling neurologic problems on their own without outside help. U.S. Exh. 633 (Shertz Dep.) at 84.

He testified that the medical notes were incomplete. Tr. 7/30/93 (Alvarez) at 146. For example, when reviewing Stephen C.'s record on the date he was hospitalized for uncontrolled seizures, Dr. Alvarez could not find physicians' notes describing the patient's condition, so he had to rely on the nurses' documentation. Tr. 7/30/93 (Alvarez) at 64. He added that sometimes there were no notes for days. Tr. 7/30/93 (Alvarez) at 146. Even in cases where the physicians were actively giving the residents medications, the medical notes did not reflect much of the physician's thought processes. Tr. 7/30/93 (Alvarez) at 146.

As far back as 1990, the Justice Department had notified defendants that Ebensburg erratically documented and described seizure activity, and that this impeded efforts to reduce seizure activity. U.S. Exh. 638 (Sponsky Dep.) Exh. 50.

Dr. Chamovitz testified that physicians notes in the Ebensburg medical charts are sometimes lacking especially when there is a medication change. Tr. 9/15/93 (Chamovitz) at 222. He added that "progress notes sometimes aren't as complete as they might be." Tr. 9/15/93 (Chamovitz) at 222. Dr. Chamovitz acknowledged that the physician will not always describe why there was a change in medications. U.S. Exh. 606 (Chamovitz Dep.) at 158-159. Dr. Chamovitz testified that charting consistency and reliability could be better at Ebensburg. Tr. 9/15/93 (Chamovitz) at 222.

XIV. EBENSBURG FAILS TO PROVIDE RESIDENTS WITH ADEQUATE PHYSICAL THERAPY AND PHYSICAL MANAGEMENT SERVICES WHICH HAS RESULTED IN HARM.

Based upon her week of observations at Ebensburg during November 1992, interviews with staff, and review of records, Ms. McAllister determined that, overall, physical management practices at Ebensburg are "grossly inadequate." Tr. 7/28/93 (McAllister) at 161-162, line 6. Ms. McAllister found that at all levels -- from physical therapy staffing, assessments, positioning, lifting and transferring techniques, to wheelchairs -- Ebensburg's practices were substandard (and in some cases, totally non-existent), resulting in serious harm to the individuals with physical disabilities who live there. Tr. 7/28/93 (McAllister) at 119, 120, 163-165, 206-207, 210-212, 214, 216, 219-233, 225-226, 230. In fact, based upon her review of a number of similar facilities during the past several years, Ms. McAllister has not encountered a facility that is as far behind in the implementation of physical management services for individuals with significant physical disabilities as is Ebensburg. Tr. 7/29/93 (McAllister) at 26.

A. The Defendants Have Been On Notice Of Deficiencies In Services For Physically Handicapped Ebensburg Residents Since At Least 1987.

As far back as 1987, the Commonwealth was aware that Ebensburg residents were not receiving "essential" physical therapy services, placing them at undue risk of contractures, bodily deformity, and other serious threats to physical health. U.S. Exh. 638 (Sponsky Dep.) Exh. 49 at 3, 4, 6. In its letter to the defendants outlining deficiencies identified during a CRIPA investigation of Ebensburg, the United States Department of Justice specifically advised the Commonwealth, inter alia, that the number of physical therapists and

physical therapy aides was inadequate, the evaluation process to determine who was in need of physical therapy was deficient, and wheelchairs were ill-fitted or broken, thereby causing new physical problems or exacerbating old ones. Id. at 4. Again, in 1990, following tours by the Justice Department to determine what corrections, if any, had been made at Ebensburg, the United States put the Commonwealth on notice of continuing serious problems in the area of physical therapy. U.S. Exh. 638 (Sponsky Dep.) Exh. 50. The defendants were advised that the use of adaptive equipment at Ebensburg for residents with physical disabilities was contrary to professional standards. Id. at 4. In particular, the United States advised the defendants that Ebensburg residents were suffering injuries as a result of broken or ill-fitting wheelchairs and the lack of support afforded by wheelchairs was resulting in physical deterioration. Id. Moreover, the Commonwealth was advised that resident care was inadequate due to insufficient communication between the physical therapists and occupational therapists. Id. at 5. Ebensburg has never consulted with or brought in any independent experts in the field to evaluate Ebensburg's overall practices and to provide suggestions to Ebensburg in the areas of physical therapy and physical management. Tr. 10/15/93 (Bellomo) at 13.

Mr. Arnall, who is one of three contract physical therapists at Ebensburg, is the only person who testified for the Commonwealth at trial about physical therapy services.^{1/} Mr. Arnall admitted that any opinions he offered during the trial about the adequacy of physical therapy services at Ebensburg were, therefore, judgments about his own practices and the

^{1/} Other Ebensburg staff and administrators testified about problems in physical therapy services at the facility through depositions which have been entered into evidence as admissions by a party opponent.

practices of his wife and a company employee. Tr. 9/17/93 (Arnall) at 18-19, 111. He admitted that he and his wife-partner at CAMCO are responsible for ensuring the adequacy of services that CAMCO provides at Ebensburg. Tr. 9/17/93 (Arnall) at 107-108. They have not developed a quality assurance system to measure the adequacy of care, however, despite the fact that this has been one of their contract objectives with Ebensburg Center since at least July 1, 1991. U.S. Exhs. 948, 950; Tr. 9/17/93 (Arnall) at 110-112. Mr. Arnall testified that he has not developed such a quality assurance system because it would be "self-serving" and it is inappropriate for the individuals performing an activity "to adjudicate the quality and appropriateness thereof." Tr. 9/17/93 (Arnall) at 108. He defended the adequacy of his services at Ebensburg for purposes of this litigation without the benefit of having conducted any such overall assessment and based upon a limited review of issues after his deposition during the two weeks before his testimony. Tr. 9/17/93 (Arnall) at 147, 152.

B. Background On Ebensburg Residents With Physical Disabilities.

At least 127 Ebensburg residents rely on wheelchairs for mobility.^{2/} In addition, there are eight Ebensburg residents who live in carts. Tr. 7/28/93 (McAllister) at 97. Other Ebensburg residents have physical limitations, such as unsteady gaits or walking on their toes. Tr. 7/28/93 (McAllister) at 97. Although there are residents with physical disabilities in each of the five living units at Ebensburg, the majority live in Keystone, where approximately 94 people resided as of the time of Ms. McAllister's tour. Tr. 7/28/93

^{2/} Ebensburg provided a list to Ms. McAllister of 117 residents with wheelchairs which was incomplete. Tr. 7/28/93 (McAllister) at 97. Counsel for the defendants indicated during cross examination that the corrected number of Ebensburg residents who use wheelchairs is actually 127. Tr. 7/29/93 (McAllister) at 51.

(McAllister) at 97-98. Approximately one-third of Keystone residents are immobile, i.e. they do not have any active movement. Tr. 7/28/93 (McAllister) at 98. Another one-third of Keystone residents have significant limitations, i.e. they may be able to roll over or sit independently but they have limited functional skills. Tr. 7/28/93 (McAllister) at 98. The remaining Keystone residents have minimal to moderate limitations, i.e., they have physical limitations but some functional skills. Tr. 7/28/93 (McAllister) at 98-99.

C. Intervention Is Necessary To Prevent Deformity Patterns.

The individuals who live at Ebensburg who have significant deformity patterns (e.g., contractures, twisted limbs, curved spines) were not born with them. Tr. 7/28/93 (McAllister) at 107. Instead, deformity patterns generally develop over time. Id. Deformity patterns originate with brain damage or malformation that causes abnormal messages to be sent to the muscles. Id. at 107. Deformities result when there are no attempts to counteract the resulting abnormal muscle development through appropriate intervention. Id. at 107, 109, 147-148. Deformity patterns can make it difficult for a person to breathe, eat, interact with other people, and perform skills. Id. at 110. Since the 1960's, the field of physical therapy has recognized that deformity patterns can actually be prevented with appropriate intervention at an early stage. Tr. 7/28/93 (McAllister) at 157. Mr. Hauenstein agrees that if individuals are properly and consistently positioned and provided with an active physical therapy regimen, it is possible to prevent the effects of scoliosis. U.S. Exh. 619 (Hauenstein Dep.) at 67.^{3/}

^{3/} Scoliosis, a common condition among Ebensburg residents, is an imbalance in the muscles surrounding the spine causing the muscles to pull harder on one side of the body.

(continued...)

Ms. McAllister introduced Tim P. and Christine G. to the Court during her slide presentation as examples of people who live at Ebensburg who have significant physical disabilities and deformity patterns from scoliosis who do not receive adequate services to meet their needs. Tim P. is thirty-three years old and lives in Keystone. He has lived at Ebensburg since a month before he turned age three. Tr. 7/28/93 (McAllister) at 103; U.S. Exh. 973. At the time of Tim's admission to Ebensburg, he was able to walk on his toes with assistance and could babble. Tr. 10/15/93 (O'Brien) at 77-78; U.S. Exh. 973. Tim is currently immobile and lives in a cart in Keystone. Tr. 7/28/93 (McAllister) at 103. His scoliosis has developed to the point where his hip is actually up underneath his rib cage. Tr. 7/28/93 (McAllister) at 103; U.S. Exh. 670. Tim does not receive any physical therapy services. Tr. 7/28/93 (McAllister) at 105. As a result of spending his day being "pancaked" (turned from his stomach to his back), Tim's chest has been flattened and his muscles are very tight through his upper chest region. Tr. 7/28/93 (McAllister) at 104. Because of this, it is difficult for Tim to breathe and he has become a shallow breather. Id. In March 1993, Tim was hospitalized for pneumonia. U.S. Exh 144. As of the time of Dr. Sheppard's tour

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Tr. 7/28/93 (McAllister) at 107-108. Where an individual does not have the muscle strength or therapeutic interventions to counteract the force of gravity, the muscles pull into a deformity pattern where the body becomes curved to one side or the other. Id. at 109. Absent appropriate therapeutic intervention (through surgery and/or therapeutic positioning), this deformity pattern can continue to the point where the hip actually pushes up underneath the rib cage and the person can become "fixed" in this position if there is no subsequent intervention. Tr. 7/28/93 (McAllister) at 109; Tr. 7/29/93 at 33, 36. This phenomena occurred in such Ebensburg residents as Tim P., Frank H., and Joe T. Tr. 7/28/93 (McAllister) at 110, 111, 112. When the hip is lodged up underneath the rib cage, it presses against the internal organs and can make it difficult for the diaphragm to function. Tr. 7/28/93 (McAllister) at 110-111; U.S. Exh. 619 (Hauenstein Dep.) at 66.

in July 1993, Tim's condition had deteriorated to the point that he was being fed by a gastrostomy tube. Tr. 10/18/93 (Sheppard) at 96; Tr. 7/28/93 (McAllister) at 104. See also § IX.B.1 for a discussion of Tim's significantly low body weight.

Christine G. is twenty-nine years old and has been at Ebensburg since age nine. U.S. Exh. 363. She currently lives in Keystone, is confined to a wheelchair, and is an example of someone who has significant limitations as a result of her physical disabilities. Tr. 7/28/93 (McAllister) at 105 (U.S. Exh. 671 is a picture of Christine). Christine was able to sit independently at four months of age, she stood at age one, and she was able to walk at sixteen months. Tr. 7/28/93 (McAllister) at 106. Mr. Arnall agrees that Christine has the capability to walk. Tr. 9/17/93 (Arnall) at 32. As of January 1993, however, Christine did not receive any physical therapy services. Id. There is no physical therapist or physical therapy aide on her interdisciplinary team and neither a physical therapist or physical therapy aide attended Christine's 1993 annual review. Tr. 7/28/93 (McAllister) at 106; U.S. Exh. 363. Christine's position in her current wheelchair forces her to bend at her abdomen, as opposed to her hips. Tr. 7/28/93 (McAllister) at 105; U.S. Exh. 671. This position places a great deal of pressure on her tailbone and she has had skin irritations in that area as well as on her knees. Tr. 7/28/93 (McAllister) at 105-106. Her wheelchair seat belt is also placed across her stomach, which places a lot of pressure on her abdominal cavity. Tr. 7/28/93 (McAllister) at 105. In December of 1992, Christine was placed on a gastrostomy tube during a two month hospitalization for pneumonia. Tr. 7/28/93 (McAllister) at 106; U.S. Exh. 363. A year earlier, Christine was able to eat a chopped diet with pureed meat. Tr. 7/28/93 (McAllister) at 106.

D. Physical Therapy Staffing At Ebensburg Is Inadequate.

Ebensburg does not have any full-time physical therapists on staff. 7/28/93 (McAllister) at 229. The only physical therapists involved at Ebensburg are part-time consultants. Id. In Ms. McAllister's opinion, the amount of time that the physical therapy consultants spend at Ebensburg is insufficient to meet the needs of Ebensburg residents. Tr. 7/28/93 (McAllister) at 230. Ms. McAllister bases her opinion both on the very limited amount of time that the physical therapists spend at Ebensburg, as well as her "gross concerns" about the adequacy of assessments, programs, positioning, and gross motor programs provided to residents and the inadequate transferring, lifting, and handling skills of staff. Id. at 230.

As of December 16, 1992, there were three part-time consultants at Ebensburg who are part of a corporation called CAMCO. Tr. 9/17/93 (Arnall) at 18. The three CAMCO consultants are: Michael Arnall, Yolanda Arnall, and Antoinette Repak. U.S. Exh. 977. Mr. Arnall has been a consulting physical therapist at Ebensburg through CAMCO since 1989. Tr. 9/17/93 (Arnall) at 147. Mr. Arnall has never been employed as a staff physical therapist in a residential facility serving individuals with mental retardation. Tr. 9/17/93 (Arnall) at 9. The only consultative services that he has provided in the area of physical therapy services in a mental retardation facility other than Ebensburg is the period of time that he worked in a facility in Italy while he was on a fellowship more than 10 years ago. Tr. 9/17/93 (Arnall) at 9. His practice at CAMCO provides services to individuals in schools, which he admits is a different population than the adults at Ebensburg. 4/ He has

4/ Although Mr. Arnall also testified that CAMCO provides services to two group homes,
(continued...)

not made any statewide or national presentations on topics related to individuals with the type of physical disabilities at Ebensburg. Tr. 9/17/93 (Arnall) at 12. The only presentation that Mr. Arnall can ever remember making that is even remotely relevant to the population at Ebensburg was one presentation sometime during the past several years on electro-diagnostic treatment which he presented to some of the staff at Ebensburg. Tr. 9/17/93 (Arnall) at 11-12. Mr. Arnall has never published any articles on topics related to the types of disabilities found in the Ebensburg population. Tr. 9/17/93 (Arnall) at 12). He was unable to name any specific book, manual or article that he considered to be authoritative in the field of physical therapy or physical management of individuals with mental retardation. Tr. 9/17/93 (Arnall) at 12-13. He was not familiar with several books that specifically relate to the population at Ebensburg with multiple and complex disabilities. Tr. 9/17/93 (Arnall) at 13-14. His practice, in general, has been limited to Pennsylvania. Tr. 9/17/93 (Arnall) at 14-15. He has not been trained in issues related to mealtimes. Tr. 9/17/93 (Arnall) at 17-18.

CAMCO consultants do not provide services at Ebensburg on a daily basis. Tr. 9/17/93 (Arnall) at 131. Between January through August 1993, CAMCO provided 395 hours of service at Ebensburg. Tr. 10/13/93 (Arnall) at 105. This averages to 50 hours per month, 12.5 hours per week, or 2.5 hours per day. As of his deposition several weeks before he testified, Mr. Arnall was unable to estimate at all the amount of time he spent at Ebensburg. Tr. 9/17/93 (Arnall) at 132. He did not know the number of hours, the number of days per week, or even whether he was at Ebensburg on a weekly basis. Id. In fact, the

4/(...continued)

on cross examination he admitted that neither he nor his company had provided any physical therapy services to group homes. Tr. 10/13/93 (Arnall) at 96.

amount of time that Mr. Arnall has personally spent at Ebensburg is minimal. In the first eight months of 1993, he only spent a total of 42.5 hours at Ebensburg. Tr. 9/17/93 (Arnall) at 137; U.S. Exh. 971. Most of the hours that Mr. Arnall spent at Ebensburg during 1993 were after June 1993, when he began providing training to staff in how to lift residents. U.S. Exh. 971. Up until the point that Ebensburg began training staff at the end of June 1993, Mr. Arnall had only spent a total of 9.5 hours at Ebensburg during 1993. Id. Mr. Arnall also spent a negligible amount of time at Ebensburg during 1992 and 1991. During 1992, he was only at Ebensburg one time for a total of 2 hours, and in 1991, he was at Ebensburg 3 times for a total of 9 hours. Tr. 9/17/93 (Arnall) at 137; U.S. Exh. 971. In fiscal year 1989-1990, Mr. O'Brien recommended revising the CAMCO contract by reducing it almost 50% because CAMCO did not have enough staff to provide physical therapy services at Ebensburg. Tr. 10/19/93 (O'Brien) at 84-85.

Between July 1991 and December 15, 1992, there was an additional part-time physical therapist, Spencer Hauenstein, who spent part of one day each week at Ebensburg. U.S. Exh. 619 (Hauenstein Dep.) at 10, 11. Typically, Mr. Hauenstein was only present at Ebensburg between 9:00 a.m. and 2:30 p.m. U.S. Exh. 619 (Hauenstein Dep.) at 13. About one-third of the time, he only worked between 9:00 a.m. and 11:30 a.m. U.S. Exh. 619 (Hauenstein Dep.) at 13. Mr. Hauenstein spent approximately 70% of his time at Keystone. U.S. Exh. 619 (Hauenstein Dep.) at 49. During his employ at Ebensburg, Mr. Hauenstein had no contact with the CAMCO physical therapists. U.S. Exh. 619 (Hauenstein Dep.) at 11, 52. Prior to retiring, he did not work with a replacement physical therapist in preparation for a transition at Keystone. U.S. Exh. 619 (Hauenstein Dep.) at 71. With his

retirement, Mr. Hauenstein did not feel that there was a sufficient number of physical therapists and physical therapy aides remaining at Keystone to meet the needs of residents. U.S. Exh. 619 (Hauenstein Dep.) at 105. Mr. Bonfanti, who is the Unit Manager at Keystone, thought that there was an inadequate amount of physical therapy consultation time for the individuals who live at Keystone even before Mr. Hauenstein left. U.S. Exh. 604 (Bonfanti Dep.) at 33. In particular, Mr. Bonfanti states with regard to the population at Keystone:

as they're getting older, they're requiring even more care. I think they need more physical therapy, there's no question in my mind. We do have a lot of cases of osteoporosis and I think we need more hands on there as far as expertise in that area.

U.S. Exh. 604 (Bonfanti Dep.) at 33, lines 19-24.

There are also no occupational therapists assigned to Keystone and Mr. Bonfanti believes there should be. U.S. Exh. 604 (Bonfanti Dep.) at 34. Mr. Bonfanti has made his desires known about the need for physical and occupational therapists at Keystone to Mr. Devine, Mr. O'Brien, and Mr. Bellomo. U.S. Exh. 604 (Bonfanti Dep.) at 37. According to Mr. Bonfanti, "it's very obvious what the needs are there." U.S. Exh. 604 (Bonfanti Dep.) at 37, lines 16-17. As of December 1992, he had been discussing the need for additional physical and occupational therapy time at Keystone with the Ebensburg administration for a year. U.S. Exh. 604 (Bonfanti Dep.) at 38. Despite these discussions, there were no commitments about increasing the physical or occupational therapy time. U.S. Exh. 604 (Bonfanti Dep.) at 37. Although Mr. Bellomo can increase, at will, the amount of physical therapy contract time at Ebensburg, he did not increase the amount of physical

therapy contract time when Mr. Hauenstein left. Tr. 10/14/93 (Bellomo) at 48-49; U.S. Exh. 603 (Bellomo Dep.) at 107.^{5/}

There are six physical therapy aides at Ebensburg. None of them have taken the two year training program required of a physical therapy assistant. Tr. 7/28/93 (McAllister) at 230. As of his deposition on August 31, 1993, Mr. Arnall did not know how many physical therapy aides worked at Ebensburg, or even whether there were more or less than ten physical therapy aides. Tr. 9/17/93 (Arnall) at 157-158. There are no physical therapy assistants at Ebensburg. The aides only work during the first shift on weekdays, leaving Ebensburg without support personnel at other times. Tr. 7/28/93 (McAllister) at 231; U.S. Exh. 619 (Hauenstein Dep.) at 105. Mr. Hauenstein believes that with more physical therapy aides, residents would receive more frequent treatments and more individualized attention, thus benefitting the residents and enhancing their welfare. U.S. Exh. 619 (Hauenstein Dep.) at 106.

E. The Limited Physical Therapy Related Services At Ebensburg Are Inadequate.

There are only three types of physical therapy related programs that are provided at Ebensburg, all of which are provided by physical therapy aides. Tr. 7/28/93 (McAllister) at 209. These are: (1) range of motion exercise; (2) percussion; and (3) programs to assist with ambulation. Id. at 209.

Even these few services are very limited. The average session by a physical therapy aide is 15 to 20 minutes. U.S. Exh. 619 (Hauenstein Dep.) at 58; U.S. Exh. 977. Physical

^{5/} Mr. Bellomo erroneously refers to CAMCO consultants as "Yolanda Arnold Associates" throughout his depositions. See U.S. Exh. 601 (Bellomo Dep.) at 96.

therapy aides provide services to some people only two or three times a week. U.S. Exh. 619 (Hauenstein Dep.) at 58; U.S. Exh. 977. Range of motion exercises that are provided at Ebensburg are intended to maintain rather than to expand range of motion. Tr. 7/28/93 (McAllister) at 209-210. The LOTA's provide range of motion in addition to the physical therapy aides. At best, individuals at Keystone only receive five to ten minutes of range of motion by LOTA's. U.S. Exh. 610 (Fagan Dep.) at 54. There are also very few ambulation programs at Ebensburg. Tr. 7/28/93 (McAllister) at 210. Many more residents who would benefit from gait training and ambulation programs do not receive them. Id. Only five Ebensburg residents receive percussion. Tr. 9/14/93 (Kastner) at 6.6/

Mr. Arnall did not have any idea whether he had provided any physical therapy services at Ebensburg during 1993. Tr. 9/17/93 (Arnall) at 140. He did not know the name of any individual whom he had evaluated, developed a program for, and then overseen the program at Ebensburg. Tr. 9/17/93 (Arnall) at 140. He does not know when a CAMCO consultant last wrote a treatment plan or physical therapy program for someone in Keystone. Tr. 9/17/93 (Arnall) at 141-142. He does not know how many people at Ebensburg receive physical therapy services. Tr. 9/17/93 (Arnall) at 142. Mr. Arnall incorrectly testified on direct examination that 62 individuals in Keystone are receiving physical therapy services when, in fact, as he admitted on cross-examination, each one of the programs that these individuals receive are provided by physical therapy aides who, according to regulations promulgated by the Pennsylvania State Board of Physical Therapy, are strictly prohibited

6/ Mr. Arnall did not know how many individuals receive percussion at Ebensburg; for that matter, he did not know the name of any resident who received percussion. Tr. 9/17/93 (Arnall) at 154-155.

from providing physical therapy services. Tr. 9/17/93 (Arnall) at 34, 145; U.S. Exh. 952. Physical therapists are not on site at Ebensburg to provide continual supervision of the aides. Tr. 10/13/93 (Arnall) at 87. State regulations require supportive personnel (anyone other than a physical therapist assistant who aids and assists a physical therapist) to function under the "direct on-premise supervision of a physical therapist." U.S. Exh. 952; 49 Pa. Code Ch. 40.32. "Direct on-premise supervision" is defined by regulation as:

[t]he physical presence of a physical therapist in the facility or location where the physical therapist assistant or the supportive personnel is providing patient care services, so that the physical therapist is immediately available to provide supervision, direction and control.

U.S. Exh. 952; 49 Pa. Code Ch. 40.1. State regulations governing the provision of physical therapy services also specifically prohibit a physical therapist from permitting supportive personnel to "assume responsibility for patient care or document physical therapy treatment." U.S. Exh. 952; 49 Pa. Code Ch. 40.32(c). Mr. Arnall did not know the name of a single Ebensburg resident for whom he has written a progress note which consisted of more than just initialing a physical therapy aide's note. Tr. 9/17/93 (Arnall) at 140-141. The physical therapists do not even review and countersign every progress note that an aide writes, although they are required to do so. Tr. 10/13/93 (Arnall) at 92. For example, although a physical therapy aide entered a quarterly progress note in Frank H.'s record about his percussion treatment, no physical therapist had reviewed and countersigned those notes between December 1992 and June 1993. Tr. 10/13/93 (Arnall) at 93; U.S. Exh. 975. Mr. Arnall does not view this as a "failure to countersign the notes" because "they probably are going to be signed." Tr. 10/13/93 (Arnall) at 94. He agrees, however, that the purpose of

reviewing and countersigning the physical therapy aide notes is to evaluate the progress and status of the resident to determine if any changes need to be made. Tr. 10/13/93 (Arnall) at 94. As of April 27, 1993, Ron E.'s progress notes regarding his percussion had not been reviewed and signed by a physical therapist since December 18, 1992 -- four months earlier. Tr. 10/13/93 (Arnall) at 94; U.S. Exh. 343. Mr. Arnall agrees that "[w]e may not take care of the notes as rapidly as we would like to." Tr. 10/13/93 (Arnall) at 111. He explains that CAMCO has to "triage" what has to be done at Ebensburg: "[W]e get backed up once in a while, and we have many things to do, and we have to determine which are the most important ones to do first." Tr. 10/13/93 (Arnall) at 111, lines 21-24.

The physical therapists also do not provide the training to physical therapy aides required by their Ebensburg contract objectives since at least July 1, 1991. Tr. 9/17/93 (Arnall) at 115. CAMCO has not developed a quarterly training program for the physical therapy staff and submitted reports to Ebensburg on this training, as required by its contract objectives with Ebensburg. Tr. 9/17/93 (Arnall) at 115.

Mr. Arnall claims that the reason physical therapists are not involved with Ebensburg residents with significant physical disabilities is because the physical therapists have been directed not to provide physical therapy by an orthopedist. Tr. 9/17/93 (Arnall) at 25. In fact, of the eight orthopedic recommendations that Mr. Arnall is relying on as the reason why he and the other physical therapists are not providing physical therapy, only one has a specific recommendation for no physical therapy. U.S. Exh. 1005. For example, Mr. Arnall testified that the orthopedist recommended no physical therapy for Joe T. Tr. 10/13/93 (Arnall) at 17. Mr. Arnall is wrong. The orthopedist specifically states in his

recommendation that Joe "needs physical therapy because he is severely contracted, especially in the lower extremities, and hopefully that [physical therapy] will help him as well." U.S. Exh. 1005 (12/10/81 orthopedic consult for Joe T.).

The orthopedist does not see Ebensburg residents at regular intervals, only on an "as needed basis." Tr. 10/13/93 (Arnall) at 19. Some Ebensburg residents with significant physical disabilities have not been seen by the orthopedist for the past seven to twelve years. Tr. 10/13/93 (Arnall) at 19-20; U.S. Exh. 1005. The last orthopedic evaluation that Tim P. had, for example, was in December 1981. Tr. 10/13/93 (Arnall) at 32, 35; U.S. Exh. 1005.^{7/} At that time, Tim was twenty-one years old.^{8/} Mr. Arnall agrees that people in their twenty's are within the age group where skeletal maturity may not have occurred. Tr. 9/17/93 (Arnall) at 36. At the time of his 1981 orthopedic evaluation, Tim was able to sit in a wheelchair. Tr. 10/13/93 (Arnall) at 32; U.S. Exh. 1002. The orthopedist describes Tim's condition as "a mild scoliosis that appears to be not a clinical problem at this time." U.S. Exh. 1002. The orthopedist specifically recommends that Tim should go to physical therapy for stretching exercises. Tr. 10/13/93 (Arnall) at 32; U.S. Exh. 1002. The orthopedist also recommends evaluation and training to teach Tim "to use his upper

^{7/} Following Mr. Arnall's testimony on September 17, 1993 and before his cross examination in October 1993, Tim P. had an orthopedic evaluation on September 29, 1993. Mr. Arnall admits that Tim had had no orthopedic evaluation in the twelve year interim between his December 1981 evaluation and this most recent one. Tr. 10/13/93 (Arnall) at 35.

^{8/} Counsel for the United States incorrectly identified Tim's age as 24 at the time of the orthopedic evaluation. Tr. 10/13/93 (Arnall) at 32. Both Mr. Arnall and Ms. McAllister testified that Tim is currently 33, therefore he was 21, not 24, in 1981. Tr. 7/28/93 (McAllister) at 103; Tr. 9/17/93 (Arnall) at 28.

extremities for purposeful movements, perhaps positioning the hands in a way they can be useful for him." U.S. Exh. 1002. Twelve years later, Tim is confined to a cart with a scoliosis of his trunk that is so severe, his hip is actually up underneath his rib cage. Tr. 7/28/93 (McAllister) at 103. He can only move his hands "a little bit." Id. See also discussion supra at 5, herein, on Tim and his level of deformity pattern.

F. Ebensburg's Services To People With Physical Disabilities Do Not Comport With Accepted Standards And Principles.

Appropriate services for people with physical disabilities must begin with a comprehensive assessment to identify their individualized needs. Tr. 7/28/93 (McAllister) at 118. This assessment is the basis for developing adequate, individualized therapeutic interventions to prevent the development or progression of disabilities and to attempt reversal of any existing disabilities. Id. at 145. Because mentally retarded individuals with physical disabilities often are dependent upon staff for all aspects of their care, therapeutic interventions, by their very nature, must be broader than physical therapy in a traditional sense. Id. at 147. The therapeutic interventions must form an overall plan for guiding all staff actions in providing therapeutic care to the individual with a physical disability. Id. at 146-147. This overall plan is known as "physical management." Id. A physical management plan includes direct physical therapy when needed. Id. at 146. It also must include, however, other aspects of 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. Id. at 146. Staff responsible for implementing the physical management plan must be adequately trained. Tr. 7/28/93 (McAllister) at 145, 147. The

efficacy of the plan must be monitored and modifications to the plan made when warranted. Id. at 145. Mr. Arnall is in full agreement with Ms. McAllister's definition and conception of physical management. Tr. 10/13/93 (Arnall) at 97.

A physical therapist is a licensed professional who is responsible for conducting the comprehensive assessment, designing an appropriate physical management plan, training staff in how to implement ancillary programs within the physical management plan, monitoring the efficacy of interventions, and making revisions when necessary. Tr. 7/28/93 (McAllister) at 145. In order to provide effective services that are responsive to an individual's needs, the physical therapist must work as part of an interdisciplinary process. Tr. 7/28/93 (McAllister) at 144-145. Physical therapists have a duty under the standards of practice and code of ethics promulgated by the American Physical Therapy Association to meet the needs of their clients by staying abreast of developments in their field of specialization. Tr. 7/28/93 (McAllister) at 156-157; U.S. Exh. 29.

None of the components of providing adequate services to residents with physical disabilities exist at Ebensburg. Tr. 7/28/93 (McAllister) at 119-120, 161-165, 207. Moreover, physical therapy involvement in the planning and overall care of Ebensburg residents is virtually non-existent. Id. at 123, 143-144.

1. Ebensburg Fails To Conduct Adequate Physical Therapy Assessments In Keeping With Accepted Professional Standards In The Field.

The Standards of Practice for Physical Therapy and Code of Ethics for the American Physical Therapy Association set forth basic standards for physical therapy assessments. Tr. 7/28/93 (McAllister) at 125; U.S. Exh. 29. Physical therapy assessments at Ebensburg do not meet these standards. Id. There are essential components of these standards that are

missing in Ebensburg assessments, including history and diagnosis, information about problems, complications and precautions, and physical and functional status. Tr. 7/28/93 (McAllister) at 125. Based upon her review of well over one hundred recent physical therapy assessments at Ebensburg, Ms. McAllister concluded that they were:

grossly inadequate in content, grossly inadequate in the analysis of the information, that the frequency that they were used was inadequate, and that the expectations that the physical therapist had when they were doing the assessments were inadequate.

Tr. 7/28/93 (McAllister) at 119, 23-25; 120, lines 1-2.

a. Ebensburg Physical Therapy Assessments Are Inadequate In Content And Analysis Of Residents' Needs.

In terms of content, the one page Ebensburg physical therapy assessments do not evaluate such important aspects of residents' physical status as their postures in different positions, reflexes, functional skills, and motor skills. Tr. 7/28/93 (McAllister) at 120; U.S. Exh. 34. Mr. Arnall agrees that to determine whether an individual is appropriate for some of the positions that Ms. McAllister demonstrated through her slides (e.g., an upper weight bearing position), it is necessary to conduct an individualized assessment. Tr. 10/13/93 (Arnall) at 51. He admits, however, that the physical therapists at Ebensburg rarely conduct an evaluation of a resident to determine whether they can be placed in this position. Tr. 10/13/93 (Arnall) at 54. The physical therapy assessment form in use at Ebensburg also does not contain information about the client's diagnosis and pertinent historical information. Tr. 7/28/93 (McAllister) at 120. Further, the assessment does not contain any information for the physical therapist to evaluate components of the resident's current physical management, such as positioning, transfers, and lifts. Id. The physical therapist conducting

the assessment does not have the resident's record while doing the assessment. U.S. Exh. 619 (Hauenstein Dep.) at 28. The physical therapy assessment also does not contain information needed to serve as the basis of a physical management plan. (McAllister) at 120, 123. Mr. Arnall admits that he can not remember ever having recommended specific positioning or precautions as a part of a physical therapy assessment of an Ebensburg resident. Tr. 9/17/93 (Arnall) at 178-179.

Tim P.'s physical therapy assessment is representative of the types of deficiencies that Ms. McAllister found to be "consistent across all the assessments." Tr. 7/28/93 (McAllister) at 123; U.S. Exh. 433 (a). Tim's assessment does not contain any information about his shoulder subluxation, neck hyperextension, wind swept legs, labored breathing, flat chest, the type of reflex or spasticity patterns he exhibits in different positions, the difference in tone throughout different parts of his body, and how to help maintain him in better alignment. Tr. 7/28/93 (McAllister) at 121, 122; U.S. Exh. 433(a). His physical therapy assessment also does not include goals, any expectations for change, or any physical management plan, including the types of positions he should be in throughout his day and movement opportunities. Id. at 123. The missing information in Ebensburg's physical therapy assessments is not contained in other parts of residents' records. Tr. 7/29/93 (McAllister) at 47.

Mr. Arnall has not taken primary responsibility for any physical therapy evaluation in the past year. Tr. 9/17/93 (Arnall) at 140. He did not conduct a physical therapy evaluation on any of the residents about whom he testified. Tr. 9/17/93 (Arnall) at 148. Instead, he "merely checked what has been done by others." Tr. 9/17/93 (Arnall) at 148, line 12. Yet,

he "didn't actually check the evaluations for each and every person [about whom he testified]." Tr. 9/17/93 (Arnall) at 149, lines 1-2. For most, he just observed their wheelchair position. Tr. 9/17/93 (Arnall) at 150. Mr. Arnall has not had any significant involvement with the residents about whom he testified. Tr. 9/17/93 (Arnall) at 152-153.

b. The Physical Therapy Assessments At Ebensburg Are Not Conducted With The Frequency Dictated By Commonly Accepted Professional Standards.

Individuals at Ebensburg with significant physical disabilities who do not receive any services prescribed by a physical therapist only receive a physical therapy assessment once every three years. Tr. 7/28/93 (McAllister) at 126, 127; U.S. Exh. 619 (Hauenstein Dep.) at 20. Although these individuals receive an annual review, it is very cursory. *Id.* at 127. For example, Cathy M.'s physical therapy annual reviews for 1990, 1991, and 1992 consist of nothing more than the notation "reviewed; no PT recommended." U.S. Exh. 979.^{9/} Without a more frequent, meaningful assessment of Ebensburg residents with significant physical disabilities, there is no measure of whether new interventions need to be developed or existing interventions need to be changed. Tr. 7/28/93 (McAllister) at 127. In particular, there is no measure of whether deformity patterns are becoming worse and, if so, the interventions that are needed to prevent continuing deterioration. *Id.* There is also no measure of whether interventions have been or could be helpful in improving overall health and level of functioning for the resident. *Id.* A large contributing factor to Ebensburg's failure to conduct more meaningful assessments with greater frequency is that the physical

^{9/} Cathy M. is pictured in United States' Exhibits 740 and 751 in a poor position in her wheelchair. Her hips are not well stabilized, she is leaning over to the side, and her legs are elevated and twisted so that her knee caps are facing out to one side. Tr. 7/28/93 (McAllister) at 186, 193.

therapists at Ebensburg universally do not have any expectations that residents' underlying disabilities and physical health deformity patterns could be improved. Id. at 127-128. In addition, the physical therapists do not have any goals or long term view about what they are trying to achieve with each individual. Id. at 128. Ebensburg's failure to adequately evaluate individuals with significant physical disabilities more frequently than once every three years is contrary to commonly accepted standards in the field of physical therapy which require a comprehensive assessment every year. Tr. 7/28/93 (McAllister) at 127; Tr. 7/29/93 (McAllister) at 44.

2. Ebensburg Does Not Develop Adequate Physical Management Plans For Residents With Physical Disabilities.

a. Physical Therapists At Ebensburg Do Not Develop Physical Management Plans.

Physical management programs at Ebensburg are also "grossly inadequate." Tr. 7/28/93 (McAllister) at 162. The physical therapists do not develop physical management plans. Tr. 7/28/93 (McAllister) at 123. At best, they recommend procedures to be carried out by physical therapy aides. Tr. 10/13/93 (Arnall) at 103-104. Ethel M.'s range of motion program is an example of such a procedure. Tr. 10/13/93 (Arnall) at 104; U.S. Exh. 976. It is a one page document that was developed more than six years ago, on June 9, 1987. The author is not identified on the procedure nor are the names of the staff who are supposed to implement it. The "method" section of the form, which is supposed to detail how the range of motion is to be carried out by an aide, contains lines for filling in the blanks. None of the blanks are filled in. U.S. Exh. 976.

b. Interdisciplinary Teams Do Not Develop Adequate Physical Management Plans.

In addition to the physical therapists at Ebensburg failing to generate physical management plans, the interdisciplinary teams also do not develop an integrated and comprehensive plan to address residents' physical management needs, particularly those residents with significant physical disabilities. Tr. 7/28/93 (McAllister) at 142-144. To begin with, the interdisciplinary teams do not have the understanding or expectations of what a physical management plan is and what it should strive to achieve. *Id.* at 142. In addition, the teams lack the benefit of physical therapy input in the development of residents' annual plans. *Id.* at 143. They do not have the basic information base from which to work because of deficient physical therapy assessments. *Id.* at 142. By defendants' own admission, occupational therapy assessments of residents with physical disabilities at Ebensburg are also inadequate. Ms. Graham, the Director of Occupational Therapy Services at Ebensburg, does not feel that the occupational therapy assessments she conducts on Keystone residents, which form the basis for occupational therapy services, are adequate to "pick up on their physical limitations that OT could address." U.S. Exh. 617 (Graham Dep.) at 74. Moreover, physical and occupational therapists do not participate in the annual reviews. *Id.* at 143. During 1992, the only occupational therapist at Ebensburg also did not attend an annual review for any resident who had an occupational therapy program for positioning, feeding, or oral motor facilitation. U.S. Exh. 618 (Graham Dep.) at 59. As a QMRP for 24 individuals and the nurse supervisor on Keystone, Ms. Malloy is involved in several annual reviews each month for individuals who live at Keystone. U.S. Exh. 622 (Malloy Dep.) at 61. Neither a physical therapist nor an occupational therapist is ever present at the annual reviews that Ms.

Malloy attends at Keystone. U.S. Exh. 622 (Malloy Dep.) at 62. At least since July 1991, Ebensburg has imposed a contract objective, acknowledged and signed by CAMCO, that CAMCO consultants must attend annual reviews of individuals who have physical therapy programs, as well as those who have a stated need that must be addressed. U.S. Exhs. 948, 950. Mr. Arnall, who doesn't know whether he has ever sat in on an annual review of any Ebensburg resident, dismissed this objective, stating that "it's not realistic for us to be in each of these meetings, given our current schedule." Tr. 9/17/93 (Arnall) at 118, 120, lines 2-3; U.S. Exh. 948. He acknowledges, however, that important decisions about a person's physical disability must be made through interdisciplinary evaluation and review. Mr. Arnall further acknowledges that the annual review is the time when all relevant professionals get together at Ebensburg to meet with the resident and plan the goals, expectations, and services that Ebensburg will provide for the year. Tr. 9/17/93 (Arnall) at 191, lines 19-24.

c. Physical Therapists Are Not Involved In The Interdisciplinary Process.

A physical therapist or physical therapy aide is often not even part of the interdisciplinary team. Tr. 7/28/93 (McAllister) at 143. Consequently, the lack of communication between team members and the lack of an integrated, coordinated approach to physical management continues throughout the year. Tr. 7/28/93 (McAllister) at 143-144. Ms. McAllister was particularly concerned about this lack of coordination because a physical therapist can not operate in isolation in providing services to a developmentally disabled individual with significant physical disabilities. *Id.* at 144-145. Given that an individual's physical disability can affect a number of functions, such as communication, eating, and

health status, it is critical that the physical therapist be part of an interdisciplinary process which looks at the individual's total needs. Id. at 145.

Mr. Arnall, who is not a member of any resident's interdisciplinary team, admits that the physical therapists do not have direct involvement with the occupational therapy department at Ebensburg. Tr. 9/17/93 (Arnall) at 117-118; 195-196. Mr. Hauenstein concurred. Although he knew that there were Keystone residents who received services from both physical therapy and occupational therapy aides, he did not have any communication with occupational therapy staff in terms of coordinating their therapy. U.S. Exh. 619 (Hauenstein Dep.) at 53. To Mr. Hauenstein, physical and occupational therapy were "two pretty much separate programs." U.S. Exh. 619 (Hauenstein Dep.) at 53. Mr. Arnall has no contact with the Dysphagia Team and neither he nor the other CAMCO physical therapists are involved at all with positioning during mealtimes. Tr. 10/13/93 (Arnall) at 95-96. Mr. Hauenstein also did not have any interaction with Ebensburg residents during mealtimes and was not involved in developing any feeding plans or supervising staff during feeding. U.S. Exh. 619 (Hauenstein Dep.) at 50, 113. The physical therapists at Ebensburg also have no direct involvement with the nursing department. Tr. 9/17/93 (Arnall) at 196. Other than one contact with a QMRP at Ebensburg, Mr. Arnall can not recall any other issue that he has ever discussed with a QMRP. Tr. 9/17/93 (Arnall) at 156. In fact, he testified that his "face to face involvement with the QMRP's is not frequent." Tr. 9/17/93 (Arnall) at 156-157. Mr. Hauenstein also did not know the QMRP's for the clients for whom he was responsible. Tr. 7/28/93 (McAllister) at 143-144.

There are a number of examples of the physical therapists' lack of involvement with Ebensburg clients with significant physical disabilities. For example, no physical therapist, physical therapy aide, or physician attended Sylvia B.'s August 1992 annual review. U.S. Exh. 293 at 00347164, 00347169. In the prior twelve months, she had had a hip operation and an open area on her hip that bled at one point, required medical attention, and prevented her from being able to go to her day program. Id. at 00347288, 00347289. Her life management plan completed before her August 1992 annual review notes that "wheelchair does not appear to meet Sylvia's needs. She is no longer continent, no longer can propel herself in chair" and is "no longer able to sit on toilet." Id. at 00347500. It further notes that she needs a physical therapy evaluation to acquire a more appropriate wheelchair, needs an evaluation of the foot rest on her wheelchair, needs to increase her range of motion through physical therapy, and needs improved body positioning and comfort. Id. Neither a physical therapist nor a physical therapy aide attended Ron E.'s annual review in either 1992 or 1993, despite the fact that he receives percussion by a physical therapy aide and also has had a serious skin breakdown that lasted for more than a year. Tr. 10/13/93 (Arnall) at 25-28; U.S. Exh. 343. At his 1992 annual review, Ron's interdisciplinary team identified the need for a physical therapist to evaluate his lower extremities to facilitate their separation. U.S. Exh. 343 at 00082563.

3. Ebensburg Does Not Provide Adequate Physical Management Services.

a. Physical Management Is Necessary To Prevent Significant Health Risks.

Physical management is key in the prevention of deformity patterns in the first instance and in arresting further deterioration and reversing deformity patterns that have

occurred. Tr. 7/28/93 (McAllister) at 147-148. It is accepted professional practice among physical therapists who have specialized in developmental disabilities to use physical management to attain these goals. Id. at 155. Physical therapists have been practicing the prevention of deformities through physical management for the past thirty years. Id. at 157. Physical therapists have also recognized the concept of reversing existing deformities through therapeutic positioning, handling, and equipment for the past twenty years. Id. During the past decade, the concept of using physical management for the prevention and reversal of deformities has been common information available to physical therapists who specialize in developmental disabilities. Tr. 7/28/93 (McAllister) at 157-161. Dr. Sulkes agrees that it is possible for individuals who have become contractured in form to have their deformities slowed or perhaps reversed through proper physical management. Tr. 7/27/93 (Sulkes) at 145.

There are a number of books that set forth the principles of physical management, including a training manual written by Ms. McAllister. Id. at 158-160; U.S. Exh. 71.^{10/} Mr. Arnall agrees that there is useful information in Ms. McAllister's publication. Tr. 9/17/93 (Arnall) at 192. Mr. Arnall also believes that the book entitled Physical Management of Multiple Handicaps by Beverly Fraser, et al., is "a definitive work in the

^{10/} These include: Dynamic Positioning Treatment by Eileen Cox; Physical Management of Multiple Handicaps by Beverly Fraser et al.; Transfers, Lifting Children and Adolescents by Lavon Yeager; Positioning the Client with Central Nervous System Deficits by Adrienne Bergen; Positioning for Function by Adrienne Bergen; Seating and Mobility by Elaine Treffler et al.; Seating and Moving Through the Decades, an anthology of the principles during the past ten years of seating and moving individuals; and Challenges in Physical Management: How to Assist Individuals with Severe Physical Challenges by Susanne McAllister et al. Id. at 158-160; U.S. Exh 71.

area, an important work," a "leading one in the field." Tr. 9/17/93 (Arnall) at 53, 103. As of his August 31, 1993 deposition, however, Mr. Arnall did not know, and could not even venture any guess, as to what parts of the book he had read, the subject matter of the parts, or when he had last reviewed the book. Tr. 9/17/93 (Arnall) at 192. Information about physical management practices has also been generally available to physical therapists through continuing education conferences and courses presented by experts and specialists in the field as well as through such groups as the American Physical Therapy Association, Rehab Engineering Services of North America ("RESNA"), a specialty organization of vendors, engineers, and therapists, and through neuro-developmental treatment ("NDT") groups. Tr. 7/28/93 (McAllister) at 160-161. During the past decade, basic principles of physical management have also been incorporated as requirements in court ordered decrees mandating necessary corrective measures in this area in mental retardation facilities. Id. at 157-158.

Mr. Arnall believes that all living things demonstrate changes of some sort. Tr. 9/17/93 (Arnall) at 189. He also believes that if an individual has a significant physical disability it is possible in some cases to change the effects of that disability, even where the individual has reached maturation, if the person has not reached his or her potential in terms of activities of daily living or ambulation. Tr. 9/17/93 (Arnall) at 189-190. He agrees that in some situations it is possible to reverse a functional scoliosis. Tr. 9/17/93 (Arnall) at 190. Mr. Arnall further agrees that "certainly," efforts should be made to try and effect changes in a person with physical disabilities if change is possible. Tr. 9/17/93 (Arnall) at 190.

Individuals with significant disabilities who do not receive physical management are at risk of developing serious medical problems. Tr. 7/27/93 (Sulkes) at 147-152. Without appropriate physical management, deformity patterns will progressively worsen, along with a possible decrease in skills, strength, mobility, and eventually health complications and physiological changes. Tr. 7/28/93 (McAllister) at 148. As a person becomes immobile, complications such as skin breakdown, contractures, and internal physiological changes occur. Id. at 148-149; U.S. Exh. 71, Appendix II (Hazards of Immobility). When individuals are not repositioned and left in a position for a long period of time, contractures develop and portions of the body become fixed in a certain position. Tr. 7/28/93 (McAllister) at 151-152. This is similar to what occurs when a cast is placed on a broken limb and there is a limitation in flexibility and strength when the cast is removed. Id. at 151. Deformity patterns or contortions on the outside of the body reflect distortions or displacement of internal organs. Id. at 149. The distortion of internal organs can affect digestion, aspiration, breathing, and heart rate. Id. at 149-150. It can lead to such significant health problems as gastroesophageal reflux, aspiration, and osteoporosis. Id. Mr. Arnall agrees that physical deformities impact on internal organs and physiological functions. Tr. 10/13/93 (Arnall) at 44.

Frank H. is an example of an Ebensburg resident whose deformity patterns have developed due to inadequate intervention and have created significant health problems. Ms. McAllister worked with Frank during her tour of Ebensburg and provided the Court with a videotape of her work with Frank during her direct testimony. U.S. Exh. 261; see also United States' Exhibit 679 for a picture of Frank. Frank has severe scoliosis, where his

pelvis is up under his rib cage. Tr. 7/28/93 (McAllister) at 111. His intrathoracic structures are distorted and he has restrictive lung capacity due to his scoliosis. Id. at 112. As a result, he has to rely on abdominal breathing. Id. at 139. He has limited flexibility in many of his joints and skin breakdown is starting to occur in the crease inside of his elbow where his arm is tightly bent. Id. at 139-140. His scoliosis has also affected his skin integrity in the side where his body is curved. Throughout 1992, the progress notes in his record reflect that his skin integrity in this area was "fair to poor." Id. at 112. During this time, Frank did not receive any physical therapy services. Id. at 112. In addition, Frank has developed the following deformity patterns: his neck is in hyperextension, his arms are in flexion, he has severe deformities of his wrist, and his legs are wind swept. Id. at 111; U.S. Exh. 679. Frank H. is confined to a cart. In Ms. McAllister's professional opinion, Frank H. does not have to live in a cart. Tr. 7/28/93 (McAllister) at 141. Frank H. has had multiple hospitalizations for aspiration pneumonia and has a history of gastrointestinal bleeding from the lower esophagus. Tr. 7/28/93 (McAllister) at 112; Tr. 7/29/93 (McGowan) at 113. He has also had problems with constipation and has had urinary tract infections, both of which can be caused by dehydration. Tr. 7/28/93 (McAllister) at 112.

Ron P. has severe scoliosis of his trunk. Tr. 7/28/93 (McAllister) at 114; U.S. Exh. 682. His neck is in hyperextension and his legs are wind swept. Tr. 7/28/93 (McAllister) at 114. Because he has spent so much time over the years on his stomach and his back, his chest has become flattened, his chest muscles are tightened making it difficult for his chest to expand, and it is very difficult from him to breathe. Id. at 114-115. His difficulty in breathing is exacerbated when he is positioned on his back. Id. at 114. This is because

gravity places pressure on his jaw and the oral motor areas. When his jaw falls back, it begins to occlude the airway and makes it difficult for air to enter. Id. at 114. When Ms. McAllister observed Ron positioned on his back, he had a great deal of mucous production, difficulty breathing, and exhibited snoring respirations. Id. at 114. At the time that Ms. McAllister saw Ron in November 1992, he had just returned to Ebensburg following a hospitalization for aspiration pneumonia. Id. at 115. He has been hospitalized twelve times since 1990 for pneumonia, bowel paralysis, and respiratory insufficiency. Tr. 7/28/93 (McGowan) at 116. Ron has had multiple episodes of aspiration pneumonia and has to be fed through a gastrostomy tube. Tr. 7/28/93 (McAllister) at 115.

Physical management can improve health and physiological function. Tr. 7/28/93 (McAllister) at 148, 163. It also assists people with significant physical disabilities to function as independently as possible. Id. Mr. Arnall agrees that positioning can have therapeutic effects such as increasing tone, increasing the mineralization of bone, encouraging mid-line upper extremity activity, encouraging head control, and encouraging relaxation. Tr. 10/13/93 (Arnall) at 43. Two key elements of physical management to attain these outcomes are therapeutic positioning and gross motor programs to facilitate a movement experience. Tr. 7/28/93 (McAllister) at 162. These therapeutic interventions do not exist at Ebensburg. Id. at 163, 164-165, 206-207.

Dr. Sulkes agrees that immobility creates significant medical problems and that Ebensburg residents have been compromised because of immobility, lack of activity, or inappropriate positioning. Tr. 7/27/93 (Sulkes) at 145. Dr. Sulkes stressed that people who are immobile and who are poorly positioned can develop problems with virtually every organ

system. Tr. 7/27/93 (Sulkes) at 144. People who are not positioned properly to help them bear weight will suffer a degeneration of their bones. Tr. 7/27/93 (Sulkes) at 144. Their muscles will atrophy and they will become contractured. Tr. 7/27/93 (Sulkes) at 144. The essence of good motor therapy for people with cerebral palsy at any age is to appropriately position them to avoid contractures, to help the individual take advantage of normal physiology. Tr. 7/27/93 (Sulkes) at 144. If a person is positioned improperly, their lungs can not work as well. Tr. 7/27/93 (Sulkes) at 144. If one is lying in a position where the lungs can not expand fully, the oxygen exchange and carbon dioxide exchange do not work normally. Id. This places an extra strain on the heart. Id. In addition, the intestines will not move things along as well. Id. Constipation is a pervasive problem with people with developmental disabilities because they are immobile. Tr. 7/27/93 (Sulkes) at 144-5. Unless people with significant physical disabilities are moved around and positioned appropriately, their intestines do not contract normally and the stool pools in the intestines and causes blockages. Tr. 7/27/93 (Sulkes) at 145. Similarly, urine pools in the kidneys. Tr. 7/27/93 (Sulkes) at 145. Dr. Sulkes added, "I'd say name an organ system and inappropriate positioning and immobility take a toll." Tr. 7/27/93 (Sulkes) at 145.

b. Ebensburg Residents Do Not Receive Therapeutic Positioning.

i. Therapeutic Positioning Is Necessary For Residents With Physical Disabilities To Prevent Health Risks.

There is agreement among physical therapists who specialize in developmental disabilities that proper alignment of the body and therapeutic positioning are essential in providing appropriate physical management. Tr. 7/28/93 (McAllister) at 156. Proper alignment means that the parts of the body are lined up as straight as possible and the nose,

navel, knees, and toes are all pointing in the same direction. Tr. 7/28/93 (McAllister) at 178; U.S. Exh. 71 at 96(a) "Job Aid 11: Principles of Positioning." Therapeutic positioning maintains a person in the best alignment possible. By placing someone in therapeutic positioning it helps to reverse or prevent deformities from occurring and to improve or maintain physiological function of body systems. Tr. 7/28/93 (McAllister) at 163. Therapeutic positioning also increases flexibility and strength and, by so doing, helps an individual to achieve the level of skill acquisition and functional independence that he or she is capable of achieving. *Id.* at 163. Therapeutic positioning facilitates teaching basic skills to people with significant physical disabilities because proper positioning can facilitate one's ability to learn basic and essential skills, such as eye and hand coordination, activating a switch to control things in the environment, and using a communication system. *Id.* at 165, 201; U.S. Exhs. 766, 767 (pictures of clients with whom Ms. McAllister worked using a switch and communication board). Therapeutic positioning is much more than "adaptive" positioning, which involves placing the individual in a comfortable position that simply adapts to his or her deformity pattern but has no therapeutic benefits. *Id.* at 162-163.

The importance of therapeutic positioning is recognized in the literature. The authors of Physical Management of Multiple Handicaps, which Mr. Arnall recognizes as a definitive work in the area, an important work, a "leading one in the field," are a physical therapist,

an orthopedic surgeon, and an occupational therapist. Tr. 9/17/93 (Arnall) at 53, 103.^{11/}

The authors state:

Positioning is a major part of the therapeutic program for persons with severe multiple handicaps. Proper positioning improves quality of life. It minimizes the influence of pathological forces on body posture and thus helps to maintain physical status and promote skeletal alignment. Positioning often sets the stage for performance and function. Positioning that provides a stable basis of support from which to work facilitates movement patterns and active functioning. For many individuals with multiple handicaps, positioning is the key to increased independence and improved self-esteem.

In Adrienne Bergen's book, Positioning for Function, which Mr. Arnall recognizes as a "scholarly book" (Tr. 9/17/93 (Arnall) at 54), the author states that as a result of positioning "[a]ll clients should show some increase in 'function.'" Tr. 10/13/93 (Arnall) at 36. She describes "function" as follows:

This function may range from improved respiration to the ability to access assistive devices such as augmentive communication systems or environmental controls.

Id. Mr. Arnall agrees with the principles set forth in both of these treatises as a general rule. Tr. 9/17/93 (Arnall) at 194; Tr. 10/13/93 (Arnall) at 36-37. In particular, he concurs that all individuals should demonstrate some increase in function from positioning. Tr. 10/13/93 (Arnall) at 36-37. He also agrees that all individuals at Ebensburg need to undergo positioning. Tr. 9/17/93 (Arnall) at 194.

^{11/} The orthopedic surgeon is Dr. Hensinger, who is a professor of surgery at the University of Michigan Medical School and Chief of Orthopedics at University Hospital. Tr. 10/13/93 (Arnall) at 9. He is a widely published and lectured surgeon who has received international acclaim and has served in several national orthopedic societies. Id.

ii. What Little Positioning Is Done At Ebensburg Is Not Therapeutic.

Ebensburg residents do not receive any therapeutic positioning. Tr. 7/28/93 (McAllister) at 163. The only positioning devices that are available at Ebensburg are wheelchairs, carts, sidelyers, mats, and air mattresses. Tr. 9/17/93 (Arnall) at 18. Residents do not have any plans setting forth the type of therapeutic positioning programs that they should be in throughout the day. Tr. 7/28/93 (McAllister) at 142, 233. During her week long observation, Ms. McAllister did not see anyone at Ebensburg who was in an appropriate therapeutic position. Id. at 206. When residents are in carts or placed on mats at Ebensburg, there is no attempt to even place them in proper alignment. Instead, the pelvis and legs are twisted, arms are tucked underneath the body, and heads are in hyperextension. Tr. 7/28/93 (McAllister) at 170, 171, 178, 179, 180; U.S. Exh. 705 (George N.), 706 (Andrea S.), 707 (Andrea S.), 708 (Linda K.), 697 (Ron P.), 698 (Barry D.), 713, 714 (Patti W.). Mr. Arnall admits that neither he nor any of the other physical therapists at Ebensburg have developed any written plans for the individuals who live in carts to ensure that they are in the best possible alignment throughout the day. Tr. 10/13/93 (Arnall) at 5. He also agrees that the pictures taken by Ms. McAllister during her tour of Ebensburg that depict the various positions in which she observed residents are "not necessarily . . . perfect positionings." Tr. 9/17/93 (Arnall) at 76, lines 14-15.^{12/} The physical therapists at Ebensburg are not necessarily involved in positioning, even when a resident has a serious skin breakdown. Tr. 10/13/93 (Arnall) at 24. In Ron E.'s case, the orthopedist specifically

^{12/} Instead, Mr. Arnall characterizes the positions as "resting positions." Tr. 9/17/93 (Arnall) at 76.

recommended that "[a]t this point care should be taken in the positioning of the patient so that we do not have skin breakdown." Tr. 10/13/93 (Arnall) at 21; U.S. Exh. 1005. Beginning November 1990, shortly after the orthopedist made this recommendation, Ron began having a skin breakdown that continued to worsen through at least January 1992. Tr. 10/13/93 (Arnall) at 21-24; U.S. Exh. 343. Between May 1991 and January 1992, the skin breakdown prevented Ron from being positioned at all on his side. Id. Although he testified at length about Ron, Mr. Arnall was not aware of Ron having had this prolonged skin breakdown. Tr. 10/13/93 (Arnall) at 21. Sylvia B. had an open area on her coccyx which began in February 1991 and continued intermittently through September 1991. U.S. Exh. 293. Her 90 day nursing summary notes that "[o]pen area on coccyx is a direct result of being non-ambulatory and requiring more frequent position changes." Id. at 00347279. The open area required medical treatment, at one point was bleeding, and necessitated her being kept back from day programs. Id. at 00347279-00347289. Neither her July 1991 physical therapy assessment or review one year later even mentions the skin breakdown or anything about positioning. Id. at 00347237. Mr. Bonfanti, the Unit Manager at Keystone, admits that there is a need for more physical therapy input and assistance in positioning individuals in Keystone on an ongoing daily basis. U.S. Exh. 604 (Bonfanti Dep.) at 78.

Where an individual is immobile and is not able to reposition himself or herself, it is critical that staff provide therapeutic positioning throughout the day, seven days a week. Tr. 7/28/93 (McAllister) at 156.^{13/} This simply does not occur at Ebensburg. Tr. 7/28/93

^{13/} United States' Exhibit 71 at Section IV, 138 (Weekday Schedule) presents examples of therapeutic positioning throughout the day and how it can be incorporated into day programs for residents.

(McAllister) at 163. At best, positioning at Ebensburg consists of turning someone in their cart, or placing them on a bean bag or mat in the same inappropriate position that they were in while in their wheelchair or cart. Tr. 7/28/93 (McAllister) at 152-153. This positioning is not therapeutic and does not provide any alignment or support. Tr. 7/28/93 (McAllister) at 152. The only positioning plan for Tim P., for example, is to turn him from his stomach to his back. Id. at 103; Tr. 9/17/93 (Arnall) 196-197; U.S. Exh. 973. Even this is only done between the hours of 10:00 a.m. and 8:00 p.m. U.S. Exh. 973.^{14/} Tim is not maintained in proper alignment while in his cart. Tr. 7/28/93 (McAllister) at 103. Tim's positioning plan, which was written by a nurse, has remained unchanged since March 14, 1987, when it was developed. Tr. 9/17/93 (Arnall) at 196-197; U.S. Exh. 973. Mr. Arnall admits that someone like Tim is not born with the kind of deformity pattern and level of disability that Tim currently has. Tr. 9/17/93 (Arnall) at 197, lines 17-19. In fact, at age 3, when Tim was admitted to Ebensburg, the admitting physician notes that he was able to walk on his toes with assistance. U.S. Exh. 973. Tim's parents noted on their application for his admission to Ebensburg that Tim could take a few steps with help. Tr. 10/15/93 (O'Brien) at 77-78. Mr. Arnall agrees that "if at this time some intervention had been made to try to prevent him from becoming scoliotic, it may have helped." Tr. 9/17/93 (Arnall) at 199, lines 7-8.

The physical therapists at Ebensburg have not established any goals for Tim. Tr. 10/13/93 (Arnall) at 5. Mr. Arnall and the other physical therapists who contract with

^{14/} Mr. Hauenstein agrees that, at a minimum, staff should reposition individuals who can not reposition themselves every two hours. U.S. Exh. 619 (Hauenstein Dep.) at 100.

Ebensburg believe that "obviously . . . [they] cannot provide anything for him." Tr. 9/17/93 (Arnall) at 197, lines 15-16. This attitude towards Tim and other Ebensburg residents is contrary to established literature in the field, including the treatise Physical Management of Multiple Handicaps. In this book, the authors set forth a number of therapeutic positions for people who have a C-shaped scoliosis and other fixed body deformities. Physical Management of Multiple Handicaps at 167-187.

Ron E., who lives in Keystone, has a severe curve in his lower back because the extensor muscles in his back are much stronger than the flexor muscles in his stomach. Tr. 7/28/93 (McAllister) at 115-116. This results in a deformity pattern where his head and legs are bowed backwards. U.S. Exh. 687. Ron E.'s orthopedic notes indicate that during a two year period of time while Ron was under Ebensburg's care, his scoliosis increased from approximately forty-five degrees to one hundred ten degrees. Id. His deformity pattern is currently so severe that he sometimes assumes a bowed position where his head reaches his feet. Tr. 7/28/93 at 116. Ron's deformity pattern is similar to the deformity pattern exhibited by Kent, a client with whom Ms. McAllister worked in the early 1980's. Id. at 115, 117. When Ms. McAllister first started working with Kent, he lived in a cart, similar to the cart in which Ron currently lives. Id. at 116, 118; U.S. Exh. 686. By placing Kent in various therapeutic positioning devices, his trunk was straightened and his hip flexion increased to the point where he was able to be placed in a customized powered wheelchair. Tr. 7/28/93 (McAllister) at 117; U.S. Exh. 688. Within a year and a half, he went from being immobile and confined to a cart to independent mobility. Tr. 7/28/93 (McAllister) at 117-118.

Therapeutic positions include sidelying, prone on forearms, and quadraped on forearms. Tr. 7/28/93 (McAllister) at 168, 173, 176. The individuals in these positions in the slides that Ms. McAllister presented during her testimony are individuals with whom she has worked and who have the same level of disabilities as individuals at Ebensburg. Id. at 178.

iii. Sidelying Is Inadequate At Ebensburg.

Sidelying is placing an individual on a board on his or her side with a strap to support the entire trunk surface to maintain good trunk alignment. Id. at 168; U.S. Exh. 703, 711). It is a therapeutic position for straightening out scoliosis and placing a person in better alignment. Tr. 7/28/93 (McAllister) at 168. By placing a person in a sidelying position, it counteracts reflex patterns of extension (curved backward) and flexion (curved forward). Id. As of the time of Ms. McAllister's tour, there were only two individuals at Ebensburg who had a sidelying program, Raymond W. and Karen S.^{15/} Id. at 171. Raymond's sidelying program only occurs two days a week for one hour; Karen's program is four days a week for one hour. U.S. Exh. 610 (Fagan Dep.) at 87-88, 96. Sidelying is limited to a maximum of four days a week at Ebensburg because the LOTA's work a five day work week and on the fifth day they are responsible for cleaning equipment and note writing. U.S. Exh. 610 (Fagan Dep.) at 88-89. The progress of individuals in a sidelying program is only noted

^{15/} A third person, George S. was supposed to be on a sidelying program but it had been changed to a supine program. U.S. 610 (Fagan Dep.) at 89. As of the time of Ms. McAllister's tour, George had been resisting even being put in a supine position since at least June 1992 but no one had reevaluated him. U.S. Exh. 610 (Fagan Dep.) at 90. Ebensburg developed a sidelying program for Tony R. following Ms. McAllister's tour. U.S. Exh. 617 (Graham Dep.) at 143.

once every three months. U.S. Exh. 610 (Fagan Dep.) at 95. Ms. Fagan, a LOTA at Ebensburg responsible for carrying out the sidelying programs, believes that one hour a day is not sufficient to accomplish therapeutic results. U.S. Exh 610 (Fagan Dep.) at 95-96. Ms. Graham, Ebensburg's Director of Occupational Therapy, admits that sidelying at Ebensburg could be improved. U.S. Exh. 617 (Graham Dep.) at 132.

Rather than being therapeutic in nature, the sidelying apparatus at Ebensburg actually poses a risk of harm. Id. For example, the combination of a non-elevated sidelyer, along with narrow straps, places potentially harmful pressure on various parts of the body, rather than supporting and stretching out the body. Id. at 171-172. In Raymond's case, the placement of straps across his knees causes his legs to come together in an abduction pattern, creating a risk of hip dislocation. Id. at 172; U.S. Exh. 709. Raymond has subluxed hips, which means they are already partially out of the socket. Raymond's position in sidelying thus exacerbates this condition. Id. In Karen's case, the straps cut into her body and fail to support her in a therapeutic position. Tr. 7/28/93 (McAllister) at 172, 173; U.S. Exh. 710. Ms. Graham agrees with Ms. McAllister that the straps used at Ebensburg for sidelying are too narrow and that wide straps would provide more support, greater comfort, and better alignment. U.S. Exh. 617 at 151. Mr. Arnall also agrees that sidelying straps "should not be so narrow that it goes against whatever purposes you have, and it shouldn't be so narrow it's discomforting for the patient." Tr. 9/17/93 (Arnall) at 51.

The physical therapists do not have any involvement with sidelying at Ebensburg. Tr. 9/17/93 (Arnall) at 155. Mr. Arnall does not know the number of residents who have sidelying programs and, as of his deposition the night before his testimony, could not even

provide a rough estimate of the number of individuals who have sidelying programs. Tr. 9/17/93 (Arnall) at 155-156. Mr. Hauenstein also did not have any involvement with sidelying programs at Ebensburg. Hauenstein at 101-102. He agrees, however, that sidelying has health benefits, is a good position for teaching skills, and could play a therapeutic role in terms of improving the overall alignment of the spine. U.S. Exh. 619 (Hauenstein Dep.) at 103.

iv. Prone On Forearms Is Not Used At Ebensburg.

Prone on forearms is a position where an individual is on a wedge on his her stomach with weight bearing through the upper extremities. Tr. 7/28/93 (McAllister) at 173; U.S. Exh. 693, 694, 695, 696. This position has a number of health-related benefits for individuals with significant physical disabilities, including: increased muscle strength and coordination; decreased spasticity; counteracting the effects of osteoporosis by strengthening bones; and improved eating abilities through increased range, flexibility and strength of the oral motor structures. Ms. McAllister worked with Lisa, a woman in Florida, who had significant disabilities similar to a number of individuals at Ebensburg who live in carts. Tr. 7/28/93 (McAllister) at 175-176. When she was placed in a prone on forearms positions, staff found that it gave her much greater independence and control over her life. For example, she was able to lift up her head and began to gain greater control over the ability to move her head and upper trunk. Id.; U.S. Exh. 696. Prior to being placed in this position, Lisa had spent all of her time lying on her stomach and back, as is the case for some Ebensburg residents. Tr. 7/28/93 (McAllister) at 176. No one at Ebensburg is in a prone on forearms position or anything similar to it. Id. at 175.

v. Quadrapped On Forearms Is Not Used At Ebensburg.

Quadrapped on forearms is a position in which the individual is on his or her stomach and is weight-bearing through the upper and lower extremities. Tr. 7/28/93 (McAllister) at 176; U.S. Exh. 700, 701, 702. This position has many of the same benefits of prone on forearms, with the added benefit of therapeutic value to the lower extremities. Tr. 7/28/93 (McAllister) at 176. For example, it is a position which helps to prevent hips from subluxing or dislocating because of increased muscle tone and strength. Id. Ms. McAllister has used this position to increase hip flexion to the point that individuals previously unable to sit upright can now sit in a wheelchair. Id. at 177. It is also a position which assists with the digestive process and clearing congested lungs. Id. at 176-177. No one at Ebensburg is in a quadrapped on forearms position or anything similar to it. Id. at 177.

c. Ebensburg Residents With Physical Disabilities Do Not Receive Adequate Gross Motor Programs.

Ebensburg residents with significant physical disabilities do not receive adequate gross motor programs to facilitate a movement experience. Tr. 7/28/93 (McAllister) at 164-165. During her week long observation, Ms. McAllister did not see anyone at Ebensburg who was in an appropriate gross motor program. Id. at 207. Mr. Arnall admits that he is not involved with nor does he have any familiarity with gross motor programs at Ebensburg. At most, he may have walked by and seen what he thinks may have been a gross motor program, but he has never made the effort to actually attend and observe a gross motor program in progress. Tr. 9/17/93 (Arnall) at 178. He has no idea of the duration of gross motor programs at Ebensburg and has never recommended a gross motor program for any individual at Ebensburg. Tr. 9/17/93 (Arnall) at 178.

It is important for individuals at Ebensburg with physical disabilities to experience movement. Tr. 7/28/93 (McAllister) at 162. For individuals who are immobile, passive movement is important. Id. at 162. This can be provided through a wheelchair swing, an air mattress, or some other device that provides the sensation of movement. Id. at 164, 204; U.S. Exh. 776. Mr. Arnall agrees that the opportunity to experience movement throughout the day should be provided to individuals if there is a functional or physiological reason for it. Tr. 9/17/93 (Arnall) at 177. For individuals who have some movement skills, movement programs entail teaching gross motor skills, such as crawling, head control, protective extension, or sitting balance, to improve gross motor functions. Id. at 162, 164, 202; U.S. Exhs. 768, 769, 779 (demonstrating various gross motor activities). Development of these skills enables a person to function as independently as possible rather than relying on staff for all of their needs. Id. at 164-165.

d. Ebensburg Residents Have Suffered Significant Health Problems And Lost Physical Capabilities Due To A Lack Of Adequate Physical Management Services.

As discussed above, Ebensburg residents have developed significant deformity patterns that have caused serious health problems due to Ebensburg's failure to provide adequate services to meet their needs. See, e.g., discussion regarding Tim P., Christine G., Frank H., Joe T., Ron P., Ron E. Other residents have similarly regressed and lost function because of Ebensburg's failure to provide adequate physical management. Tr. 7/28/93 (McAllister) at 210-211. For example, Joe T. has lost thirty degrees of shoulder flexion and fifteen degrees of elbow extension. Id. at 114. Ron E.'s orthopedic notes indicate that his scoliosis increased during a two year period of time from approximately forty-five degrees to

one hundred ten degrees. Id. at 211. George N. experienced a twenty degree decrease in his right shoulder abduction and a thirty degree decrease in his right wrist flexion. Id. Karen S. experienced a decrease of ten degrees in her right shoulder and twelve degrees in her left shoulder. Id. at 212. Linda B. has lost five to ten degrees of range of motion. Id. Harold B. has lost twenty degrees of shoulder flexion and ten degrees of range of motion in his right elbow. Id.

Other Ebensburg residents have lost physical skills or eating skills that they once had due to a lack of adequate physical management. Tr. 7/28/93 (McAllister) at 211. For example, Ron P. could orally eat at one time and now he is being fed through a gastrostomy tube. Id. at 115. Tim P. could walk on his toes with assistance at the time he entered Ebensburg at age three. U.S. Exh. 973. At age 21, he could sit in a wheelchair. In August 1992, he was fed orally. He now is immobile, is confined to a cart, and is fed through a gastrostomy tube.

Ebensburg residents' ability to attain skills and to participate in activities has also been limited by failure to provide appropriate positioning and physical management. For example, Frank H.'s interdisciplinary team notes that he displays emotions, responds to his name, recognizes staff, and "appears to have a high level of awareness." U.S. Exh. 975 (4/23/93 annual review at 2). He is being denied the opportunity to develop the ability to identify objects through a head pointer, however, because his position in his cart does not allow this. U.S. Exh. 975 (4/23/93 annual review at 3). He had a skills training program that began in August 1992 to identify a picture by pointing to it with a head pointer. Because of his positioning, however, he was unable to accomplish this skill. Id. Moreover,

although he needs glasses and his team feels that they would be beneficial to Frank, he is unable to wear them because his "head positioning in his reclining chair was not conducive to wearing the glasses successfully." Id. Ron E.'s interdisciplinary team specifically noted during his annual review that his "ability to attend out of unit recreational activities was severely limited by the fact that he is in an orthopedic cart." U.S. Exh. 343 at 5. Sylvia B. has not been able to attend day programs because of her skin breakdowns. U.S. Exh. 239.

e. Ebensburg Professional And Paraprofessional Staff Believe That Residents Would Benefit From Physical Management.

Ms. McAllister saw a change in the attitude of Ebensburg staff during the course of her tour and felt that they were very interested in learning more about physical management. Tr. 7/29/93 (McAllister) at 25.^{16/} As she worked with Ebensburg clients, discussed them with staff, and demonstrated better alignment, staff began to appreciate that things could be different for these clients. Tr. 7/28/93 (McAllister) at 129.

Ebensburg staff were particularly impressed with Ms. McAllister's demonstrations about proper alignment and positioning with individuals who live in Keystone. For example, Richard Bonfanti, Unit Manager at Keystone, thought her demonstrations were "quite amazing." U.S. Ex. 604 (Bonfanti Dep.) at 92. "Susanne made a definite impression on those who watched her." U.S. Ex. 604 (Bonfanti Dep.) at 94, lines 1-2. Mr. Bonfanti was "very impressed," in particular, with the fact that she was able to realign individuals by straightening them out, thereby revealing "possibly eight inches of that person's body that no one ever saw before." U.S. Ex. 604 (Bonfanti Dep.) at 92, lines 20-21. Based upon what

^{16/} Based upon her contact with the physical therapists, Ms. McAllister did not believe that they were interested in change and new ideas. Tr. 7/29/93 (McAllister) at 25.

he saw during Ms. McAllister's demonstrations, Mr. Bonfanti is not satisfied that everything is currently being done that can be done in terms of positioning individuals at Keystone.

U.S. Ex. 604 (Bonfanti Dep.) at 94. He sees benefits accruing to the individuals at Keystone from the facility doing more in terms of positioning; he foresees improvement in their health and appetites, decompressing their stomachs, weight gain, and an overall healthier appearance. U.S. Ex. 604 (Bonfanti Dep.) at 94-95. He "certainly" believes that some of the physical deformities of Ebensburg residents could be corrected and reversed based upon his contact with Ms. McAllister. U.S. Exh. 604 (Bonfanti Dep.) at 92. Mr. Bonfanti sees "nothing but good things" coming from the types of positioning techniques that Ms. McAllister believes should be implemented at Ebensburg. U.S. Ex. 604 (Bonfanti Dep.) at 95.

Ms. Malloy, the nurse supervisor at Keystone, who also observed the positioning demonstration by Ms. McAllister during her November 1993 tours, was equally impressed with the possibility of using therapeutic interventions not currently being used with Keystone residents. In Ms. Malloy's words, Ms. McAllister was "amazing," "her techniques; she is really good at what she does." U.S. Exh. 622 (Malloy Dep.) at 103-104. Ms. Malloy thought that as a result of Ms. McAllister's repositioning Ethel M., she was placed in a healthier position. U.S. Exh. 622 (Malloy Dep.) at 102. After observing demonstrations by Ms. McAllister with Tim P. and Joe T., Ms. Malloy learned that "they could be relaxed, that their legs could be straightened," and that Tim P., in particular, "was so calm." U.S. Exh. 622 (Malloy Dep.) at 102, 103, lines 5-6. Ms. Malloy has never had any in-service

training in positioning in the 30 years that she has been at Ebensburg. U.S. Exh. 622 (Malloy Dep.) at 109.

Mr. Bonfanti discussed Ms. McAllister's demonstrations with one of the occupational therapy aides assigned to Keystone, Sue Fagan, who was as impressed, if not more impressed, than he was. U.S. Ex. 604 (Bonfanti Dep.) at 93. Ms. Fagan states that Ms. McAllister "was fabulous with what she was doing." U.S. Exh. 610 (Fagan Dep.) at 36, lines 14-15. She was "quite impressed" with Ms. McAllister's demonstration with Tim P. U.S. Exh. 610 (Fagan Dep.) at 36, line 25. She was particularly impressed with the fact that Ms. McAllister was able to relax Tim to the point that he "was straight in his cart as compared to having curvatures." U.S. Exh. 610 (Fagan Dep.) at 37, lines 4-5. She believes that deformities could potentially be reversed if more time could be spent on positioning at Ebensburg. U.S. Exh. 610 (Fagan Dep.) at 95-96. Ms. Fagan thinks that if individuals at Ebensburg were positioned better, their health would be improved:

If they're positioned properly, especially during feeding, you're not going to see them choking, no aspiration, just breathing --- I mean, just all in all general health I could see where there would be a difference. Their [skin] breakdowns.

U.S. Exh. 610 (Fagan Dep.) at 108, 109, lines 3-7. Based upon Ms. McAllister's demonstrations, Ms. Fagan determined that she needed more training. U.S. Exh. 610 (Fagan Dep.) at 35. She expressed a desire, in particular, to seek some training from Ms. McAllister. U.S. Ex. 604 (Bonfanti Dep.) at 93.

Lois Graham, the Director of Occupational Therapy at Ebensburg, concluded that Ebensburg could do more than what it was doing in terms of positioning and needed to look more closely at each individual client in terms of their positioning throughout the day as a

result of her contact with Ms. McAllister and reading Ms. McAllister's manual on Challenges in Physical Management. U.S. Exh. 617 (Graham Dep.) at 71, 151-152. Ms. Graham feels that Ebensburg residents would benefit if they received better positioning. U.S. Exh. 617 (Graham Dep.) at 71. She also believes that residents' health would be improved by more appropriate positioning. U.S. Exh. 617 (Graham Dep.) at 71. Ms. Graham testified during her deposition in January 1993, however, that in order for any changes to occur at Ebensburg, she felt it would be up to her. U.S. Exh. 617 (Graham Dep.) at 154-155. She was not comfortable with that responsibility given her large workload and the fact that she was the only occupational therapist at Ebensburg. U.S. Exh. 617 (Graham Dep.) at 155. Moreover, Ms. Graham does not think that she, alone, could accomplish these changes, because it is difficult to change things at Ebensburg and "more people need to realize the needs." U.S. Exh. 617 (Graham Dep.) at 156. She does not think that Ebensburg's management understands the problems that she sees at Ebensburg because they need "more contact with what's going on day-to-day in the lives of people at Ebensburg." U.S. Exh. 617 (Graham Dep.) at 157. She additionally believes that there is "definitely" a need for Ebensburg to bring in consultants with specific expertise in oral motor, positioning, wheelchair adaptations, and splinting. U.S. Exh. 617 (Graham Dep.) at 155. Ebensburg has not consulted with or brought in any independent experts to provide suggestions to Ebensburg in the areas of physical therapy and physical management. Tr. 10/15/93 (Bellomo) at 13. Ms. Graham also concluded that she needed training as a result of her contact with Ms. McAllister. She made a request to Mr. Bellomo to attend the Ninth Annual Seating Symposium in February 1993, along with Sue Fagan, to get some more ideas

on functional seating and positioning. Graham I at 69-70. Ms. Graham was not permitted to attend the training although Mr. Cicotello, the Director of Training at Ebensburg, admitted that she "certainly" would have "benefited" from attending it. Tr. 10/15/93 (Bellomo) at 9; U.S. Exh. 1024 (Cicotello Dep. excerpts at 117). Ms. Graham is no longer at Ebensburg. Tr. 10/13/93 (Arnall) at 8, 50; Tr. 10/15/93 (Bellomo) at 7.

Mr. O'Brien also admits that Ebensburg needs to do more work on positioning individuals and training staff with respect to positioning. U.S. Exh. 624 (O'Brien Dep.) at 40. Mr. O'Brien has concerns with respect to positioning of the Keystone population. He is concerned about whether Ebensburg is doing as much as possible for these individuals and also whether they are comfortable. U.S. Exh. 624 (O'Brien Dep.) at 41-42.

4. The Wheelchairs At Ebensburg Are Inadequate.

a. Wheelchairs Are Inappropriate And Residents Are Not Positioned Properly In Them.

Both Ms. McAllister and Mr. Arnall agree that the purpose of a wheelchair should be to provide the best possible support and best possible alignment, along with comfort. Tr. 7/28/93 (McAllister) at 180; Tr. 7/29/93 (McAllister) at 13-14; Tr. 10/13/93 (Arnall) at 58. Proper alignment promotes individuals' health, safety, independent functioning, and skill acquisition. Id. Proper alignment is dependent upon an appropriate wheelchair for the individual's body as well as positioning the individual correctly in the wheelchair. A proper position of the pelvis, in a slight anterior pelvic tilt and snug against the back of the wheelchair, is essential to provide stability for the trunk and the head to keep the body in alignment. Tr. 7/28/93 (McAllister) at 181. A properly located seat belt, just below the hip bones, is critical to keep the pelvis in the appropriate position. Id. at 182. When a person is

slouched in his or her wheelchair (sitting in posterior pelvic tilt) and remains in this position for long periods of time, kyphotic posturing can result. Id. at 184. This is an abnormally increased backward curvature of the spine that causes a hump-like appearance of the upper back. U.S. Exh. 71, Appendix VI, Glossary, at 6. When individuals are uncomfortable in their wheelchair, they tend to squirm and shift, which puts them in improper alignment. Mr. Hauenstein, who spent most of his time in Keystone, was clear that Keystone residents "let you know if they are uncomfortable. They protest, slide out and they're in a worse position than when they started." U.S. Exh. 619 (Hauenstein Dep.) at 94. Mr. O'Brien admits that individuals in wheelchairs at Ebensburg are not comfortable all the time. U.S. Exh. 624 (O'Brien Dep.) at 40-41. Mr. Arnall agrees that how comfortable a person is in their wheelchair is a critical factor in ensuring that person's compliance in sitting in the desired position. Tr. 10/13/93 (Arnall) at 43.

During her entire week-long observation at Ebensburg, Ms. McAllister did not see anyone at Ebensburg who was in an appropriate wheelchair. Tr. 7/28/93 (McAllister) at 206. In addition, Ms. McAllister never saw a staff person attempting to properly position a resident in a wheelchair. Id. at 188-189. Ms. McAllister presented multiple slides illustrating examples of the following types of problems with wheelchairs and residents'

alignment in wheelchairs:^{17/}

- sitting in posterior pelvic tilt
- collapsed trunks
- head below headrest
- feet dangling in foot troughs
- leaning to one side
- feet and legs twisted
- inadequately supported arms, feet, knees, legs, head, and trunks
- seat belts across the abdomen and thighs.

Tr. 7/28/93 (McAllister) at 184-193.

Ms. McAllister also observed Ebensburg residents, such as Michael F., in wheelchairs with sling backs and sling seats. Tr. 7/28/93 (McAllister) at 187. Ms. McAllister was particularly concerned about the use of these chairs because they provide no support and are inappropriate for someone with a severe scoliosis, such as Michael. Id. Physical therapists across the country working with a developmentally disabled person with very poor trunk control and the type of deformity pattern exhibited by Michael F. would not recommend a wheelchair with a sling back and sling seat. Tr. 7/28/93 (McAllister) at 57. In Michael's case, the sling back and sling seat cause him to sink further and further into his deformity pattern and contribute to his health problems. Tr. 7/28/93 (McAllister) at 187-188. Michael has a hiatal hernia, poor gastric motility, gastroesophageal reflux, a poor appetite and has lost twenty pounds in the last year. Tr. 7/28/93 (McAllister) at 187. Ms. McAllister believes that these health problems are related to the fact that Michael's

^{17/} Ebensburg residents depicted in these slides, include: Robert H. (U.S. Exhs. 734, 750); Patrick G. (U.S. Exh. 735); William B. (U.S. Exh. 737); Kathy M. (U.S. Exhs. 740, 751); Janice G. (U.S. Exh. 741); Michael F. (U.S. Exhs. 746, 747); David V. (U.S. Exhs. 742, 743); Christine G. (U.S. Exh. 738); Delillah H. (U.S. Exh. 739); James M. (U.S. Exh. 744); Harvey B. (U.S. Exh. 736); George S. (U.S. Exhs. 748, 749); Raymond W. (U.S. Exh. 752).

wheelchair does not provide proper support and he "collapses" down on his side. Tr. 7/28/93 (McAllister) at 187. The side on which he collapses is the side of the body on which the stomach is located. Tr. 7/28/93 (McAllister) at 188. Ms. McAllister saw Michael F. in his wheelchair in the same or similar position pictured in U.S. Exh. 746 and 747, where he is collapsed on one side, at several times during her week long observation at Ebensburg during November 1992. Tr. 7/28/93 (McAllister) at 73. Ten months earlier, during March 1992, Mr. Bellomo was aware that Michael F.'s position in this chair was of "particular concern" to outside surveyors. U.S. Exh. 162.

A sample of additional deficiencies in wheelchairs and wheelchair positioning that Ms. McAllister observed at various locations during the course of her tour include other individuals in wheelchairs with sling backs and seats (Robert F., Kenneth B., MarK S., Tom T., and Luberta H.); seat belts improperly positioned around residents' chests (Denise D., Sylvia B.) and abdomens (Linda K., Christine G., Lydia B.); inadequate neck and head support (Denise D., Andrea S., Linda K., Christine G., Beth S., Sylvia B.); and inadequate arm and feet support (William B., Robert F., Kenneth B., Denise D., Linda K., Christine G., Sylvia B., Luberta H.). Tr. 7/28/93 (McAllister) at 213; U.S. Exh. 782. The problems with wheelchairs and wheelchair positioning for the twenty-five residents highlighted by Ms. McAllister during her testimony are exemplary only. This is not an exhaustive list of residents or Ms. McAllister's concerns about wheelchairs and wheelchair positioning at Ebensburg. Tr. 7/28/93 (McAllister) at 213.

Mr. Arnall commented about the adequacy of wheelchair positions of five Ebensburg residents pictured in Ms. McAllister's slides. He agreed that each of the five residents were

either in an inadequate wheelchair or in an inappropriate position.^{18/} Mr. Arnall's comments are as follows:

- Robert H. (U.S. Exh. 734): "Ms. McAllister is correct that this is not a good chair for this individual." Tr. 9/17/93 (Arnall) at 81, lines 20-21.
- Chris G. (U.S. Exh. 738): "Ms. McAllister criticizes the posture that this individual is in and I would agree that she is in poor posture." Tr. 9/17/93 (Arnall) at 82, lines 18-20.
- Cathy M. (U.S. Exh. 740): "This is Cathy M. She is pictured in a poor position in an adaptive chair." Tr. 9/17/93 at 83, lines 23-24.
- David V. (U.S. Exh. 742,743): David is "pictured in a temporary chair, and it is not an adequate one for him." Tr. 9/17/93 (Arnall) at 84, lines 6-7.
- U.S. Exh. 733: "He is not in a good position. Ms. McAllister indicates that this client is not in good position, and she is absolutely correct." Tr. 9/17/93 (Arnall) at 82, lines 7-9.

b. Ebensburg Does Not Develop, Modify, And Monitor The Condition Of Wheelchairs Appropriately.

Mr. Arnall admits that it is "not uncommon" that the interdisciplinary team discusses and expresses concern about the adequacy of wheelchairs during the annual review process and yet there is no physical therapist present at the annual review. Tr. 10/13/93 (Arnall) at 80. For example:

A physical therapist is not a member of David V.'s interdisciplinary team and was also not present during David V's January 5, 1993 annual review, despite the fact that the

^{18/} Mr. Arnall also discusses Dellilah H. (U.S. Exh. 739), James M. (U.S. Exh. 744), and Michael F. (U.S. Exhs. 746, 747) but does not specifically comment about the appropriateness of their particular position. During cross examination, Mr. Arnall admitted that Michael F.'s sling back and sling seat wheelchair "is not the best from the standpoint of a course or book on wheelchairs, but it is a negotiated position." Tr. 10/13/93 (Arnall) at 86, lines 10-12.

interdisciplinary team had requested the physical therapist on several earlier occasions to review the adequacy of his wheelchair. Tr. 9/17/93 (Arnall) at 185; U.S. Exh. 974. Just several weeks before the annual review, a referral had been sent to the physical therapist because David injured his foot, which protrudes out from his wheelchair, as staff were wheeling him through a door. United States' Exhibit 742 is a picture of David in his wheelchair. David's QMRP describes David's "most irregular" position in his wheelchair as:

his back is twisted almost 90 degrees to the chair back, and his feet hang over the right side of his chair.

U.S. Exh. 974 at 00541131. David's "wheelchair and his position in it were the central issues" at his annual review. Id. The team was advised that the physical therapy department "is backed up with requests. As such the team was told that it would be a long time before anything can be done." Id. The team considered a new wheelchair but "was reminded that '...such things take time...' and was further reminded that in one recent case two years were required to secure a new chair" for another resident. Id. At the meeting, David's mother "voiced a request that the physical therapist be made to sit in [David's] chair, as it was postulated that if the therapist had to do so, the process may be greatly speeded up." Id.

19/

Although Frank H. also receives percussion by a physical therapy aide, no physical therapist serves on his interdisciplinary team, even though the team membership was updated

19/ This annual review took place two months after the pictures of David V. (U.S. Exhs. 742, 743) were taken, which Mr. Arnall dismissed as a "temporary chair." Tr. 9/17/93 (Arnall) at 84.

as recently as May 1993. Tr. 9/17/93 (Arnall) at 121, 122; U.S. Exh. 975. No physical therapist attended Frank's annual review in either 1992 or 1993. Tr. 9/17/93 (Arnall) at 121, 122. At both Frank's 1992 and 1993 annual review, the team agreed that a physical therapist needed to re-evaluate his cart to determine whether it was the most appropriate mode of mobility available to him. Tr. 9/17/93 (Arnall) at 122; U.S. Exh. 975. Mr. Arnall did not know whether a physical therapist had responded to the requests and could find no indication in the progress notes of Frank H.'s record that a physical therapist responded. Tr. 9/17/93 (Arnall) at 123-125.20/ He admits that the physical therapists do not always write a progress note reflecting their thought process about the appropriateness of wheelchairs in response to a specific concern. Tr. 9/17/93 (Arnall) at 129.

On both June 16, 1992 and August 13, 1992, staff identified the need to reevaluate Cathy M.'s wheelchair as part of her living area assessment. U.S. Exh. 423 at 00338974, 00339252, 00339012.21/ Despite this identified need, neither a physical therapist or physical therapy aide attended her annual review on August 25, 1992. Tr. 10/13/93 (Arnall) at 78-79. During Cathy M.'s annual review in August 1992, her interdisciplinary team

20/ Although Mr. Arnall testified in September 1993 that if a response was written, it would be contained in the progress notes, during redirect testimony one month later, Mr Arnall was able to produce a "speed message" which is not contained in Frank's record and which consisted of a two sentence response from a physical therapist to the team's 1993 request for assistance with Frank. Tr. 9/17/93 (Arnall) at 130; Tr. 10/13/93 (Arnall) at 113, 117.

21/ Cathy M. is pictured in United States' Exhibits 740 and 751 in a poor position in her wheelchair. Her hips are not well stabilized, she is leaning over to the side, and her legs are elevated and twisted so that her knee caps are facing out to one side. Tr. 7/28/93 (McAllister) at 186, 193.

determined that she needed not only a reevaluation of her wheelchair but physical therapy as well. Tr. 10/13/93 (Arnall) at 78; U.S. Exh. 423.

Although Mr. Arnall agrees that Michael F.'s sling back and sling seat wheelchair is "not the best" but claims that "it is the only one that he will agree to," no physical therapist or physical therapy aide was present at Michael's March 1993 annual review to discuss this situation. Tr. 10/13/93 (Arnall) at 84-86. Mr. Arnall's reason for why no representative from physical therapy attended Michael F.'s review is that "[t]hese are not just social occasions that everybody attends." Tr. 10/13/93 (Arnall) at 84. Mr. Arnall added that "[i]t's very costly to have these meetings [annual reviews] and it actually interferes with the best development of the meeting if too many people are there." Tr. 10/13/93 (Arnall) at 84-85.

Robert B.'s team also identified the need for physical therapy to evaluate his wheelchair during his March 1992 annual review and no physical therapist was present at the review. Tr. 10/13/93 (Arnall) at 83; U.S. Exh. 300.

The evaluation process at Ebensburg for developing and modifying wheelchairs is inadequate. Tr. 7/28/93 (McAllister) at 196. Ebensburg does not evaluate residents to determine the specific properties that are needed in the wheelchair to accommodate the resident's particular needs. Id. at 196. A simulator or positioning chair is not used to evaluate the precise measurements and properties of the wheelchair for each resident. Id. at 195-196; U.S. Exh. 732. Despite the fact that the simulator has been in use for the past fifteen years, is commercially available, and has replaced the trial and error method used at Ebensburg, as of the time of Ms. McAllister's tour, the physical therapists had never heard

of one. Tr. 7/28/93 (McAllister) at 195; Seating and Mobility (Treffler, Hobson, et al.) at 73. Mr. Arnall agrees that a simulator is an "excellent" tool and one that has "proven to be very useful." Tr. 10/13/93 (Arnall) at 60-61.

The condition of wheelchairs is not monitored with sufficient frequency at Ebensburg to ensure that they are in good working order and not in a state of disrepair. Tr. 7/28/93 (McAllister) at 214. During her tour, Ms. McAllister observed Tom T.'s sling back wheelchair literally falling apart at the back. U.S. Exh. 782. Ebensburg residents have been injured as a result of unaddressed problems with their wheelchairs. Tr. 7/28/93 (McAllister) at 214. Recent injuries include scratches sustained by Vernon R. from sharp jagged edges of a damaged and unrepaired footrest on his wheelchair; abrasions sustained by Duane P. from his ripped wheelchair tray that had exposed staples; and "numerous" black and blue marks found on both legs of Barb C. assumed by Ebensburg staff to be the result of bolts on the footrest of her wheelchair. U.S. Exh. 86, 781. The defendants did not refute or challenge U.S. Exh. 781 which summarizes these and a number of other injuries attributable to individuals' wheelchairs.

5. Ebensburg Staff Do Not Handle, Lift, And Transfer Ebensburg Residents Safely And In Accordance With Accepted Standards.

It is critical that staff move and transfer residents with physical disabilities consistently and safely. Tr. 7/28/93 (McAllister) at 162. Ebensburg staff are not following either of these principles. Id. at 216, 219-223. Staff do not comply with Ebensburg's own policy on lifting and transferring residents and there is a great deal of inconsistency in the type of transfer techniques that staff use. Tr. 7/28/93 (McAllister) at 216; U.S. Exh. 82. Contrary to Ebensburg's policy, Ms. McAllister never saw a staff person lock the wheelchair

brakes before conducting a transfer. Id. at 221. Moreover, aspects of Ebensburg's lifting and transfer policy do not comport with accepted professional standards. Id. at 216-218. For example, Ebensburg's policy advocates a transfer where both staff lift the person under the arm pits. Id. This creates pressure in the axilla area that can cause damage under the arm pit or in the shoulder joint. Id. The possibility for damage is particularly high in a population such as that at Ebensburg where joint integrity is already weakened due to the nature of individuals' physical disabilities. Tr. 7/29/93 (McAllister) at 48. The physical therapists who provide consultative services to Ebensburg do not advocate a lift under the arm pits. Tr. 7/28/93 (McAllister) at 218. They were not involved, however, in developing Ebensburg's lifting and transfer policy and did not seem to be aware of the policy. Id. at 218. In fact, Mr. Arnall, who has recently been responsible for training Ebensburg staff in lifting and transfers, had never seen the facility's policy on this topic until it was shown to him at his deposition on August 31, 1993. Tr. 9/17/93 (Arnall) at 163. He agrees that residents with osteoporosis are at risk of serious injury, including fractures of the humerus, if they are lifted by their arms rather than the thorax being the point of lift. Tr. 9/17/93 (Arnall) at 170.

Based upon her observation of numerous lifts and transfers of Ebensburg residents, Ms. McAllister observed the following types of unsafe practices to be pervasive at Ebensburg:

- Staff lift residents under their armpits. Tr. 7/28/93 (McAllister) at 220, 221. Mr. Arnall agrees that this is not a recommended technique. Tr. 9/17/93 (Arnall) at 170.
- Staff lift residents under the knees posing a risk of serious knee damage. Tr. 7/28/93 (McAllister) at 220, 225. Mr. Arnall agrees that this is not a recommended technique. Tr. 9/17/93 (Arnall) at 170.

- Staff do not have control of the head and trunk. Tr. 7/28/93 (McAllister) at 220, 221, 222. Mr. Arnall agrees that head and trunk control are important. Tr. 9/17/93 (Arnall) at 171. Mr. Hauenstein also agrees that it is important to support the head, shoulders, pelvis, and upper legs. U.S. Exh. 619 (Hauenstein Dep.) at 77.

- Staff do not provide any support to the head, leaving it dangling or suspended. Tr. 7/28/93 (McAllister) at 220, 221, 222. Mr. Arnall agrees that the head should not be unsupported or dangling. Tr. 9/17/93 (Arnall) at 171.

- Staff do not attempt to position the resident properly in a wheelchair or on the mat after the transfer and use the resident's limb for turning. Tr. 7/28/93 (McAllister) at 221, 222. Mr. Arnall agrees that residents should be repositioned in their wheelchairs. Tr. 9/17/93 (Arnall) at 176.

- Staff do not lock wheelchair brakes prior to transferring a resident. Tr. 7/28/93 (McAllister) at 221, 222. Mr. Arnall and Mr. Hauenstein both agree that it is important to lock the brakes on a wheelchair before moving a client into or out of the wheelchair. 9/17/93 (Arnall) at 172; U.S. Exh. 619 (Hauenstein Dep.) at 79.

- Staff use momentum rather than controlled techniques, resulting in "flopping," "heaving," "dropping," or "throwing" residents into wheelchairs or onto mats. Tr. 7/28/93 (McAllister) at 220, 221, 222, 223. Mr. Tackett confirmed that when he worked in Keystone, he observed staff just "plopping" residents into their wheelchairs. Tr. 8/3/93 (Tackett) at 9. Both Mr. Arnall and Mr. Hauenstein agree that it is important for the staff person to be in control throughout the process of transferring, as opposed to using momentum. Tr. 9/17/93 (Arnall) at 175; U.S. Exh. 619 (Hauenstein Dep.) at 76, line 6.

- Staff pick up residents from the middle of the bed rather than the side of the bed. Tr. 7/28/93 (McAllister) at 222. Mr. Arnall agrees that it is better to position the client at the edge of a cart or bed rather than the middle before attempting a lift. Tr. 9/17/93 (Arnall) at 175.

- Staff do not arrange the environment prior to moving the resident resulting in letting go of the resident and rearranging the wheelchair during the middle of a transfer. Tr. 7/28/93 (McAllister) at 221. Mr. Arnall agrees that one of the cardinal rules in lifting is controlling the environment. Tr. 9/17/93 (Arnall) at 172. He agrees that if the environment is correctly prepared, there should be no need to let go of a client with one hand during the transfer unless there is an emergency and the environment becomes out of control. Tr. 9/17/93 (Arnall) at 171.

- Staff use poor body mechanics. Tr. 7/28/93 (McAllister) at 220, 221, 222.

Ms. McAllister narrated a videotape demonstrating Ebensburg staff using these improper techniques with Ebensburg residents during her tour. The videotape was taken under her observation and at her direction by an FBI photographer. Tr. 7/28/93 (McAllister) at 219-223; U.S. Exh. 261 (Part II). The scenes depicted in the videotape are illustrative of the types of deficiencies that she observed throughout her week long tour of Ebensburg. Tr. 7/28/93 (McAllister) at 72. In addition, Ms. McAllister witnessed other unsafe transfers, including a resident's head hitting a footrest, a resident landing on his head in a transfer down to a mat, and staff's clothing getting caught on unlocked wheelchairs. Tr. 7/28/93 (McAllister) at 224. In another instance, Ms. McAllister witnessed a resident who was transferred into the wrong wheelchair. Id. at 225. The staff did not realize it was the wrong wheelchair until they attempted to attach the straps and they did not fit. Id. Ms. McAllister observed paraprofessional staff as well as direct care staff using unsafe lifting and transfer techniques. In one excerpt on her videotape, the two LOTA's assigned to Keystone, Sue Fagan and Jane Schneider, are lifting Karen S. from her wheelchair into a sidelyer by grabbing her under her armpits and knees and failing to support her head and upper trunk. Id. at 220. Ms. Fagan admitted that the last training she received in lifting was several years ago. U.S. Exh. 610 (Fagan Dep.) at 105.

This is no dispute that each of the unsafe practices in lifting and transfers that Ms. McAllister described in her testimony and videotape narrative are contrary to accepted professional practice. Mr. Arnall offered no testimony during his direct examination about staff performance in lifting and transferring Ebensburg residents. On cross examination he specifically agreed, however, that each and every one of the deficient practices described by

Ms. McAllister during her testimony is not recommended. Tr. 9/17/93 (Arnall) at 170-175.

a. Ebensburg Residents Have Suffered Harm As A Result Of Improper Handling, Lifting, And Transferring By Staff.

Based upon her review of occurrence reports, Ms. McAllister identified thirty-five examples of situations where Ebensburg residents with physical disabilities have been injured while being handled, lifted, or transferred. Tr. 7/28/93 (McAllister) at 225-226; U.S. Exh. 85, 791 (attached). This is not an exhaustive list of injuries but merely a sampling of injuries during the past several years, primarily during 1992 and 1993. Tr. 7/28/93 (McAllister) at 227. The defendants did not refute or challenge any of these examples. Mr. Arnall has not reviewed any occurrence reports involving injuries due to lifts and transfers. Tr. 9/17/93 (Arnall) at 163, 175. He agrees, however, that if clients are not lifted appropriately, they are at risk for fracture or soft tissue injury or injury of another body part. Tr. 9/17/93 (Arnall) at 169. The examples contained in United States' Exhibits 85 and 791 reflect injuries from the types of unsafe practices identified by Ms. McAllister in the excerpts of lifting and transfers on her videotape. They include injuries from failing to support residents' heads, grasping people under their arms, failing to reposition individuals once they are transferred into their wheelchairs, and failing to adequately prepare the environment in advance (Paul G., Thomas C., David V., Michael A., Michael U., Harvey B., George S., Beth S., Mary Lou F., Melanie H., Michael F., Edward T.). U.S. Exh. 791 (attached). The injuries that Ebensburg residents have suffered include three fractured femurs, a fractured clavicle, a fractured humeral head, a fractured foot, a fractured tibia, a spiral fracture of the leg, lacerations requiring sutures, and multiple abrasions and bruises. Id. Some Ebensburg residents have sustained multiple injuries. For example, George S., a

Keystone resident who is confined to a wheelchair, was found with a fracture of the humeral head and a large bruise on his upper arm on November 11, 1992, as Ms. McAllister was touring Ebensburg. U.S. Exh. 85, 971. Based upon this injury, the Unit Manager decided staff needed training on lifting and transferring. Five months earlier, George was found with a sprained foot. Supervisors recommended that staff need to "exercise caution transferring or moving him." Id. In October of 1990, George was found with a fracture of his left femur. His occurrence report notes that the probable cause and time of the injury was while he was at physical therapy. Id. Michael U. suffered a lacerated forehead on October 31, 1992 when a staff person lifted and transferred him without any assistance from the floor to his bed. Id. On January 17, 1993, a staff person was changing Michael without any assistance and Michael rolled off the changing table, abrading his chest. Id. There are other instances in which Ebensburg residents have been lifted and transferred by only one staff person despite the fact that Ebensburg's policy requires at least two staff. U.S. Exh. 705. For instance, a staff person transferred Michael A. without assistance from his wheelchair to his bed. Michael threw his head back, hitting his ear, which required sutures. Id. Mr. Tackett confirmed that he had also lifted individuals up to 150 pounds by himself when he worked in Keystone. Tr. 8/3/93 (Tackett) at 9.

Occurrence reports frequently note the need for greater care in handling non-ambulatory residents and a need for staff training in lifting, transferring, and positioning residents (Thomas C., Harold B., Harvey B., George S., Linda S., Mary Lou F., Melanie H., Charles S., and Edward T.). U.S. Exh. 791. Harvey B., for example, was found with numerous bruises and scratches on his body which an Ebensburg physician concluded were

most likely caused by incorrect lifting procedures on more than one occasion. U.S. Exh. 131. The physician's sketch of the assorted injuries on Harvey's body fills an entire page. U.S. Exh. 131 at 00006153. It includes the following injuries: 11 bruises and scratches on his upper arms that were varying shades of colors from light blue and brown to dark purple; 4 red, brown, and purple bruises, scratches, and scabs on the back of his neck; and 10 brown and purple bruises and puncture like abrasions on his upper thigh. Id. Ebensburg staff involved with Harvey's care "indicated a deep concern for lifting training." Id. at 00006150. In other occurrence reports, staff seem to dismiss the injuries as inevitable or the normal risk of transferring a person with physical disabilities. Tr. 7/28/93 (McAllister) at 226. For instance, Beth S. was found with a fractured femur on April 16, 1993 which staff surmise may have occurred "simply" while she was being lifted or being changed. Id., U.S. Exh. 791. Paul G. lacerated his head on April 2, 1993 when his head hit the side of the bathtub while staff were transferring him. Ebensburg staff conclude "injury not preventable." Id. Duane P.'s arm was caught between the lift and the bath tub while he was being transferred on July 16, 1992. Staff excuse this incident as a "normal handling accident." Id.

Keystone has also had its "share" of staff injuries due to lifting. U.S. Exh. 604 (Bonfanti Dep.) at 16. Several weeks before Mr. Bonfanti was deposed in December 1992, two staff from Keystone were placed on disability leave because of injuries caused by lifting. U.S. Exh. 604 (Bonfanti Dep.) at 15-16.

6. Staff Training In Physical Management Is Inadequate At Ebensburg.

Ebensburg staff do not receive adequate training in lifting and transferring residents with physical disabilities. This was reflected in the lifts and transfers observed by Ms. McAllister during her tour of Ebensburg. Tr. 7/28/93 (McAllister) at 234. All Ebensburg staff have not received a formal training program in body mechanics, transfer techniques, and positioning. Tr. 7/28/93 (McAllister) at 233. Instead, staff training consists of watching a video tape about moving boxes, rather than moving individuals with the types of physical challenges that Ebensburg residents pose. *Id.* at 232. Specific types of transfers are not demonstrated during staff training and the opportunity to practice transfers before being assigned to a unit is a hit or miss proposition, depending upon the size of the class. *Id.* Although it is accepted professional practice to require competency based training or return demonstrations in which staff must demonstrate their competency, Ebensburg did not even begin this training until June 23, 1993 --weeks before the trial began in this case. Tr. 9/17/93 (Arnall) at 161. The training was limited to lifting and transfers and did not cover repositioning residents. Tr. 9/17/93 (Arnall) at 176. As of September 17, 1993 -- more than a month after the United States rested its case -- only a fraction of staff had received competency based training. Tr. 9/17/93 (Arnall) at 105. Staff sometimes do not demonstrate their competency in all components of the lifting and transfer due to time constraints. Tr. 9/17/93 (Arnall) at 166. There are no outlines or reference materials for staff as part of the training. Tr. 9/17/93 (Arnall) at 164. Although restrictions are placed on staff when they are unable to perform a lift or transfer, Mr. Arnall does not know how these restrictions are monitored. Tr. 9/17/93 (Arnall) at 167. He also does not know whether

Ebensburg has any plans for follow-up monitoring at regular intervals to assess each staff person's continuing competency in lifting and transfers. Tr. 9/17/93 (Arnall) at 167. Prior to the competency based training in which he became involved in June, Mr. Arnall had not been involved in Ebensburg's orientation sessions for new employees. Tr. 9/17/93 (Arnall) at 160-161.

When Mr. Tackett started working in Keystone in the late fall of 1991, he was responsible for handling residents on his very first day without having had any training in how to handle them. Tr. 8/3/93 (Tackett) at 7-8. The only training that Mr. Tackett received in lifting and transferring Keystone residents during the entire time he worked there was "impromptu" and "learn as you go." Id. When staff are pulled from the building to which they are regularly assigned to work in another building, such as Keystone, they do not receive any training about the particular needs of the residents. U.S. Exh. 604 (Bonfanti Dep.) at 19. In particular, they do not receive any special training in lifting and transferring or bathing individuals at Keystone. U.S. Exh. 604 (Bonfanti Dep.) at 20-21.

It is common practice among physical therapists working with individuals with developmental disabilities to develop individualized written plans and photographic instructions for staff to follow in transferring and positioning people with significant physical disabilities. Tr. 7/28/93 (McAllister) at 64. Every Ebensburg resident who must be transferred and positioned does not have a specific individualized written plan or photographic instructions for transferring and positioning. Tr. 7/28/93 (McAllister) at 233. Mr. Arnall agrees that lifts should be individualized for clients if they have special needs.

Tr. 9/17/93 (Arnall) at 175-176. Yet, he did not know that Ebensburg residents did not have individual plans. Tr. 9/17/93 (Arnall) at 176. 22/

The paraprofessional staff at Ebensburg also do not receive adequate training in physical management techniques and issues. For example, Ms. Geriak, a LOTA at Ebensburg, thinks that the LOTA's need more inservices. U.S. Exh. 615 (Geriak Dep.) at 113. There are changes occurring in the field of occupational therapy about which Ms. Geriak would like to keep abreast. U.S. Exh. 615 (Geriak Dep.) at 82. In particular, Ms. Geriak thinks there is a need to learn more and to increase the occupational therapists' skills in the area of splinting. U.S. Exh. 615 (Geriak Dep.) at 113. She has asked for inservicing but was told "no." U.S. Exh. 615 (Geriak Dep.) at 81.

Ms. Fagan is one of the two LOTA's assigned to Keystone House. She had never worked with a population similar to the individuals at Keystone before she started working there. U.S. Exh. 610 (Fagan Dep.) at 25. In addition, she has never received any training either while she was working on her occupational therapy assistant degree, or after, that specifically dealt with physical disabilities such as the types of disabilities that the people at Keystone have. U.S. Exh. 610 (Fagan Dep.) at 25. Ms. Fagan did not receive any training from Ebensburg about the specialized needs of individuals who live at Keystone before she

22/ Ebensburg belatedly began an effort to provide photographic instructions for residents in Laurel sometime during the summer of 1993. Tr. 10/15/93 (O'Brien) at 91. As of October 1993, however, this is the only living unit in which photographic instructions were developed. *Id.* There are only nineteen individuals who live in Laurel who use wheelchairs. U.S. Exh. 1015 (Laurel House). Mr. Arnall had never seen these pictures. Tr. 9/17/93 (Arnall) at 176. Although Mr. O'Brien testified on direct examination that the idea to take pictures came from Mr. Arnall and his staff, on cross-examination, Mr. O'Brien corrected his testimony and agreed that he did not in fact speak with Mr. Arnall about the positioning pictures. Tr. 10/15/93 at 91; Tr. 10/19/93 (O'Brien) at 82.

began her work there. U.S. Exh. 610 (Fagan Dep.) at 25. Ms. Fagan admits that she needs more training in positioning individuals with physical disabilities. U.S. Exh. 610 (Fagan Dep.) at 35. She states:

There might be something we need to know, you know, that we're not aware of that would help. Like when Suzanne [sic][McAllister] was here, that's what made me really feel that it would be great to know more. . . I want to learn more about it. I definitely do.

U.S. Exh. 610 (Fagan Dep.) at 35, line 25; 36, lines 1-3, 11-12.

XV. DIRECT CARE STAFFING AT EBENSBURG IS INADEQUATE.

There is no dispute that Ebensburg has an inadequate number of direct care staff. Experts for the United States and staff at Ebensburg, including Ebensburg's facility director, agree that Ebensburg needs more direct care staff. Tr. 7/26/93 (Stark) at 222, 231; Tr. 8/4/93 (Amado) at 49-54; U.S. Exh. 600 (Bellomo Dep.) at 92-100; Bellomo Dep. Exh. 11; U.S. Exh. 608 (Devine Dep.) at 96, 98; U.S. Exh. 640 (Stratton Dep.) at 228; U.S. Exh. 615 (Goldschmidt Dep.) at 87-88; U.S. Exh. 604 (Bonfanti Dep.) at 99; U.S. Exh. 631 (Seymour Dep.) at 23-24; U.S. Exh. 623 (McGuire Dep.) at 44.

A. Ebensburg Is Not Meeting Its Direct Care Staff Quotas.

On some occasions when Dr. Stark walked into a living area, there was only one staff person for 24 residents. Tr. 7/26/93 (Stark) at 169. The other staff were in the bathroom, charting, or on break. Tr. 7/26/93 (Stark) at 169. During his tours of Ebensburg, Dr. Amado also observed situations where there was insufficient direct care staff. Tr. 8/4/93 (Amado) at 48-49. For instance, during his 1992 tour, Dr. Amado walked into a day room in Sunset House at about 8:00 p.m. and found 22 residents sitting or walking around doing nothing. Not a single staff member was present when Dr. Amado arrived. Tr. 8/4/93 (Amado) at 63.

Although Dr. Reid collected data on staffing levels during his tours of Ebensburg's day programs and living areas, he did not offer any testimony on the adequacy of the numbers of direct care staff at Ebensburg. Tr. 9/16/93 (Reid) at 128-129. The numbers of staff Dr. Reid observed as he conducted his tours are captured in United States' Exhibits 959-962. Dr. Reid's data reveals that in 1993, even as experts for the Commonwealth were

touring Ebensburg, there were still insufficient numbers of direct care staff. For example, United States' Exhibit 959 is the data collected by Dr. Reid and his colleague on 13 of the living areas at Ebensburg between the hours of 3:15 p.m. and 5:10 p.m. on weekdays in February 1993. Dr. Reid's data reveals that Ebensburg was not meeting its own quotas in 10 of the 13 areas surveyed.^{1/} For example, when Dr. Reid entered Sunset House, East I at 4:30 p.m., there were 10 clients and one staff person. Similarly, when Dr. Reid left Sunset House, West I at about 4:45 p.m., there were 19 clients and 2 staff. United States' Exhibit 960 is the data collected by Dr. Reid and his colleague on 10 of the living areas at Ebensburg between the hours of 1:50 p.m. and 4:25 p.m. on weekdays in April 1993. For the seven areas on which Dr. Reid collected staffing data, three were not meeting quotas. In Villa West I, at 3:35 p.m., there were nine clients and one staff. United States' Exhibit 961 is the data collected in April 1993 in the day programming areas. It, too, reveals that there were areas out of compliance with Ebensburg's requirements. For instance, when Dr. Reid left one area of Gary Bain at 1:05 p.m., there were 10 clients and one staff, and when he arrived at a different area of Gary Bain at 1:25 p.m., there were seven clients and no staff.

Ebensburg administrators have also observed situations where residents are left with little or no staff on both the living areas and at day programs. For example, during an evening Justice Department tour on September 22, 1992, Mr. O'Brien confirms that there were eleven residents in a day room in Laurel House without any staff and only one staff with 12 residents in a day room in Sunset House. U.S. Exhs. 179, 180. On October 24,

^{1/} As reflected in U.S. Exh. 608 (Devine Dep.) Exh. 7, Ebensburg's standards generally require a 1:5 or 1:6 ratio on the first and second shifts during the weekdays. See discussion infra § XV.E at 12.

1992, Mr. Bellomo observed 23 clients in East I at Keystone at noon, with only one staff who was putting clothes into a cart. U.S. Exh. 84. During his tour of Harmony House Learning Center on September 30, 1992, during day programming, Mr. Devine noted a staffing ratio of 1:11 on East 1 and that "we would not have met Title XIX Standards in the dayroom." U.S. Exh. 212. During that same observation tour, Mr. Devine spent a full half hour observing East II of Harmony House Learning Center. He documented that during that period, the ratio for ten minutes was 1:12, and the ratio was never better than 1:10. Mr. Devine observed several individuals sleeping and "no meaningful interaction." U.S. Exh. 212.

On the evening of July 13, 1992, Ebensburg's abuse investigator toured the living areas of Villa, Horizon, Harmony, Sunset and Keystone houses between the hours of 6:00 p.m. and 9:00 p.m. U.S. Exh. 614 (Fulton Dep.) Exh. 7. He recorded staffing information for 14 of the 16 living areas that he observed. Not one of the 14 areas that he observed that evening had a full complement of staff present at the time of his observations. For 7 of the 14 areas documented, the staff to client ratio was only one to eight.

Surveyors from the Association of Retarded Citizens have also documented instances of inadequate direct care staff. For instance, in June 1992, ARC surveyors toured Villa between 4:00 and 6:00 p.m. and found 24 residents and only 2 staff; one staff person was busy folding clothes. U.S. Exh. 934 at 521156.

B. Injuries And Abuse Occur When There Are Not Enough Direct Care Staff.

Employees who are the targets of abuse investigations have defended their actions or inactions by claiming that they had too many responsibilities to adequately attend to the needs

of the clients. U.S. Exh. 614 (Fulton Dep.) at 131. Ebensburg's chief abuse investigator admits that the frustrations of taking care of so many individuals may have been a factor in abuse by direct care staff. U.S. Exh. 614 (Fulton Dep.) at 150-151; Fulton Dep. Exh. 3. For instance, Ebensburg investigated suspected abuse against Michael M. that occurred on Sunday, October 18, 1992 at 1:15 p.m. At the time of the incident, there were 2 direct care staff in the bath area with clients. One overheard the other cursing at Michael and hitting him. At the time of the incident, the 2 other direct care staff assigned to the living area were on break. There was a supervisor in the chart room, and not in the living area with the clients, at the time of the incident. Although the supervisor did hear the direct care staff yelling at Michael M., she failed to intervene. Id.

Ebensburg also investigated suspected abuse against Sandra W. Ebensburg's abuse investigator, Mr. Fulton, wrote a memo to Mr. Bellomo about his findings. U.S. Exh. 614 (Fulton Dep.) at 143-144; Fulton Dep. Exh. 4. Sandra was injured at 3:20 p.m. on her living unit, when minimum staffing on the unit was supposed to be 4, i.e., 3 direct care workers and one direct care supervisor. The supervisor was not on the unit at the time of the injury. Mr. Fulton asks whether Ebensburg could "justify" the staffing at the time of the injury. Id.

C. There Are Not Enough Staff To Implement Behavior Programs At Ebensburg.

Dr. Goldschmidt believes that Ebensburg needs more direct care staff. U.S. Exh. 615 (Goldschmidt Dep.) at 87-88. If there were more direct care staff, the individuals at Ebensburg could take less psychotropic medication and when the individuals became agitated and potentially dangerous to others, there would be enough staff to work directly with the

agitated individual. U.S. Exh. 615 (Goldschmidt Dep.) at 88. Dr. Goldschmidt believes that some clients are "very violent and potentially dangerous and need more direct involvement [by staff] mostly for their own sake and to protect the other clients." U.S. Exh. 615 (Goldschmidt Dep.) at 89, lines 18-21. In addition, direct care staff are too busy with the custodial care of individuals to have time to observe the clients' behaviors and implement behavior programs. U.S. Exh. 615 (Goldschmidt Dep.) at 90. For instance, if a client pulls hair out and a one-to-one is required to implement a behavior program, that is not currently feasible. U.S. Exh. 615 (Goldschmidt Dep.) at 92. See also infra § V.D, V.E, and VII.H.

D. The Commonwealth Refuses To Provide More Staff To Ebensburg.

Direct care staffing at Ebensburg is "significantly below" the mean in other facilities in Pennsylvania. U.S. Exh. 600 (Bellomo Dep.) Exh. 11. There are only about 250 direct care staff out of the 811 full time equivalent staff employed at Ebensburg. Tr. 9/13/93 (Kastner) at 79; Def. Exh. HH at Table 9. Budgetary constraints have kept Mr. Bellomo from hiring direct care staff at Ebensburg. U.S. Exh. 600 (Bellomo Dep.) at 92. He has requested funding for more staff and authorization for additional staff positions from the Commonwealth and his requests have been denied. U.S. Exh. 600 (Bellomo Dep.) at 95-96, 97.

In 1992 alone, Mr. Bellomo requested additional direct care staff at least two or three times from the Commonwealth and each time his request was disapproved. U.S. Exh. 600 (Bellomo Dep.) at 100. He requested additional staff "because of what I perceived potentially as an opportunity to make things better." U.S. Exh. 600 (Bellomo Dep.) at 92, lines 18-20.

Some of Mr. Bellomo's requests for additional staffing were directly in response to the United States' lawsuit. U.S. Exh. 600 (Bellomo Dep.) at 101-102. For example, on October 19, 1992, he requested the authority to hire 50 direct care staff on a staggered basis over a six month period between September 1992 and March 1993. U.S. Exh. 600 (Bellomo Dep.) Exhs 10 & 11. By hiring 50 additional direct care staff, the staffing ratios at Ebensburg would be closer to a 1:4 ratio on the first and second shifts and 1:8 ratio on the third shift. U.S. Exh. 600 (Bellomo Dep.) at 114. Mr. Bellomo determined that Ebensburg could hire 50 additional staff and still be within the average per diem of other facilities in Pennsylvania. U.S. Exh. 600 (Bellomo Dep.) at 123.^{2/} His request for the 50 additional staff was not granted. U.S. Exh. 603 (Bellomo Dep.) at 30.

On October 19, 1992, Mr. Bellomo also requested six additional licensed occupational therapy aide positions for Ebensburg from the Office of Mental Retardation. U.S. Exh. 603 (Bellomo Dep.) at 31; Bellomo Dep. Exh. 10. He requested that they work from 11:00 a.m. to 7:00 p.m. to monitor, assist, and assess all dining programs in the facility during lunch and dinner. *Id.* He was also not granted the six additional LOTA positions. U.S. Exh. 603 (Bellomo Dep.) at 32.

When taking the number of residents and per diem into account, the operational costs for Ebensburg are more than a million dollars below the operable costs at other facilities in the Commonwealth of Pennsylvania. U.S. Exh. 603 (Bellomo Dep.) Dep. Exh. 11 at 1. To

^{2/} Ebensburg Center also operates for "significantly fewer dollars" than other mental retardation facilities operated by the Commonwealth of Pennsylvania. U.S. Exh. 600 (Bellomo Dep.) Exh. 11. Ebensburg Center's per diem was \$182.45 for each resident during FY 91/92, whereas the average per diem statewide in Pennsylvania was \$188.31. U.S. Exh. 600 (Bellomo Dep.) Exh. 11.

hire the 50 direct care staff and 6 LOTA's that he requested, along with 4 LPN's, it would cost the Commonwealth only slightly more than half a million dollars. U.S. Exh. 603 (Bellomo Dep.) Dep. Exh. 11 at 2. Mr. Bellomo felt that in order to put the State into a "defensible" position for this litigation, it was necessary to hire these staff. U.S. Exh. 603 (Bellomo Dep.) Dep. Exh. 11 at 3. Despite the fact that he felt that Ebensburg would be better served by hiring more staff than by spending significant dollars for litigation, he was not given authorization to hire the direct care staff and LOTA's. U.S. Exh. 603 (Bellomo Dep.) Exh. 11 at 3; U.S. Exh. 603 (Bellomo Dep.) at 30, 32.

The Office of Mental Retardation allocates a certain number of staff positions to each State Center for the fiscal year. U.S. Exh. 635 (Sneed Dep.) at 120.^{3/} Staff at Ebensburg were furloughed during February 1991 due to budgetary reasons. U.S. Exh. 635 (Sneed Dep.) at 123. In addition, a hiring freeze was imposed on Ebensburg beginning November 1992. U.S. Exh. 635 (Sneed Dep.) at 124. The hiring freeze was in existence through March 1993 and Dr. Sneed expected it to continue until June 1993. U.S. Exh. 635 (Sneed

^{3/} Dr. Sneed, Director of the Bureau of Direct Program Operations in the Office of Mental Retardation describes the funding process as follows: The Office of Mental Retardation submits a proposed budget to the Department of Public Welfare that reflects the minimum amount of funding needed for the residents of State facilities. U.S. Exh. 635 (Sneed Dep.) at 126. Generally, however, the proposed budget for staffing that OMR submits to DPW for State centers is a "maintenance" budget that does not project staffing increases. U.S. Exh. 635 (Sneed Dep.) at 117. The Department of Public Welfare has reduced the proposed budget for funding State centers submitted by the Office of Mental Retardation. U.S. Exh. 635 (Sneed Dep.) at 115. The Governor's budget office, in turn, has decreased the proposed budget, particularly with regard to staffing positions. U.S. Exh. 635 (Sneed Dep.) at 117, 118. The Governor's office does not consult the Office of Mental Retardation before reducing the proposed budget. U.S. Exh. 635 (Sneed Dep.) at 126. The State legislature has further reduced the budget and number of staff positions. U.S. Exh. 635 (Sneed Dep.) at 119.

Dep.) at 126-127. The hiring freeze was imposed because there was a decrease in the Commonwealth's budget for State centers during the fiscal year and the Governor's budget office miscalculated the concomitant decrease in matching federal funds available for State centers. U.S. Exh. 635 (Sneed Dep.) at 125. Dr. Sneed, who was responsible for all state-operated mental retardation facilities in Pennsylvania, recognizes that if a need arises at a State center that exceeds the allocated budget, the Office of Mental Retardation has "an obligation to be more creative or to go to bat for the persons we serve and bring it to the attention of our Deputy Secretary, Secretary and the Governor's office." U.S. Exh. 635 (Sneed Dep.) at 110, lines 16-20.

E. Ebensburg Administrators Have Repeatedly Requested Additional Staff.

The number of staff assigned to each residential building at Ebensburg remained relatively constant for the six year period between July 1986 and July 1992. U.S. Exh. 608 (Devine Dep.) Exh. 7. All of the unit managers have requested additional staff from Mr. Devine throughout at least the past five years. U.S. Exh. 608 (Devine Dep.) at 132, 135.

As of the end of December 1992, the number of staff at Ebensburg in each residential unit still did not meet the expectations of Ebensburg administrators. Unit managers have discussed with Mr. Devine the need for a 1:4 staffing ratios in their units. U.S. Exh. 608 (Devine Dep.) at 165. Most of the administrators believe that there should be at least 20 staff for the first and second shift and ten staff for the third shift in each of the five residential buildings. For example, Mr. Devine would "probably be pretty satisfied" if each unit had this staffing configuration. U.S. Exh. 608 (Devine Dep.) at 96, lines 14-16, 98. See also U.S. Exh. 604 (Bonfanti Dep.) at 22. Laurel House was the only residential

building that had 20 staff assigned as of December 1992 and this was only for one of the shifts, excluding holidays and weekends. U.S. Exh. 608 (Devine Dep.) Exh. 7.^{4/}

Mr. Bonfanti believes that the individuals at Keystone need a 1:4 staff ratio to provide them with the care they require. U.S. Exh. 604 (Bonfanti Dep.) at 99. Among the benefits that he sees from a 1:4 staff ratio is providing individuals with additional time and attention, improving their health and safety, and reducing accidents. U.S. Exh. 604 (Bonfanti Dep.) at 100.

Mr. Seymour believes that, at a minimum, the staffing ratio should be 1:4.5 to meet the needs of individuals. U.S. Exh. 631 (Seymour Dep.) at 23. He arrives at this ratio, however, by taking fiscal restraints into account. U.S. Exh. 631 (Seymour Dep.) at 24. Without basing his opinion on fiscal restraints, Mr. Seymour believes that a 1:4 ratio should be in place to provide adequate services. Id. With a 1:4 ratio:

- individuals' safety would be enhanced;
- staff would better be able to intervene in self-injurious behavior;
- individuals' health would be better protected;
- staff would be better able to provide functional, purposeful and useful activities; and
- individuals' overall welfare would be enhanced.

U.S. Exh. 631 (Seymour Dep.) at 24-25.

Mr. McGuire believes that a ratio of one to four staff is needed in order to provide adequate care to the clients in Horizon House. U.S. Exh. 623 (McGuire Dep.) at 44. Client welfare is enhanced by having a one to four ratio. U.S. Exh. 623 (McGuire Dep.) at 52.

^{4/} There are fewer staff at Ebensburg on weekends than there are during the week. Tr. 8/4/93 (Amado) at 53. This raises additional concerns because Ebensburg does not provide any day programs on the weekends and residents are left to their own devices even more than they are during the week. Id.

Client safety is better insured by having a one to four ratio. U.S. Exh. 623 (McGuire Dep.) at 52. The benefit of a one to four ratio is primarily in earlier intervention in situations that lead to altercations between individuals. U.S. Exh. 623 (McGuire Dep.) at 51.

There have been times that Mr. McGuire has not been able to achieve his goals given the level of staffing he currently has. U.S. Exh. 623 (McGuire Dep.) at 46. He has been frustrated in the area of functional programs because he does not have adequate staff to teach individuals the functional tasks of their programs. U.S. Exh. 623 (McGuire Dep.) at 46. There is also insufficient staff to provide adequate socialization with the clients during meal times. U.S. Exh. 623 (McGuire Dep.) at 47. 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. Mr. McGuire is not satisfied with the level of individualized attention from staff during program time. U.S. Exh. 623 (McGuire Dep.) at 53.

Ms. Pisula, who has headed the union representing direct care staff at Ebensburg for the past three-and-a-half years agrees that there are benefits to a one to four ratio, including increased individualized attention and occupying the individual's time, so that individuals have less time to do harm to each other. U.S. Exh. 626 (Pisula Dep.) at 44-45. In addition, with a one to four ratio, there is a better chance of intervening in aggressive or self-abusive behaviors, and that benefits the individuals' health, welfare and safety. U.S. Exh. 626 (Pisula Dep.) at 45. All individuals at Ebensburg would benefit from a one to four staff ratio because "the more staff you have, the better service you could deliver." U.S. Exh. 626 (Pisula Dep.) at 45, line 25 to 46, line 1.

Other Ebensburg administrators acknowledge the benefits of increased staff ratios. For example, according to Mr. Devine, Ebensburg residents benefit from increased staff to client ratios because they receive "more individual care and attention and opportunities to do more things." U.S. Exh. 608 (Devine Dep.) at 95, lines 9-10. According to Dr. Stratton, more direct care staff would help improve the environmental deficiencies that exist at Ebensburg and would allow individuals to break into smaller groups. U.S. Exh. 640 (Stratton Dep.) at 228. In Dr. Stratton's opinion, Sunset and Keystone would greatly benefit from additional direct care staff. U.S. Exh. 640 (Stratton Dep.) at 228-229. Mr. Bonfanti thinks that an increase in staff at Keystone will "absolutely" enhance client welfare; "most certainly" better protect individuals' safety; and better protect client health. U.S. Exh. 604 (Bonfanti Dep.) at 24. Mr. Weimer believes that if there were additional staff on Sunset, the number of injuries would decrease. U.S. Exh. 642 at 74. He also believes that additional staff would "certainly" help Ebensburg achieve the goal of five hours of training programs off of the living units. U.S. Exh. 642 at 113.

Mr. Bellomo is ultimately responsible for deciding on staff ratios at Ebensburg. U.S. Exh. 608 (Devine Dep.) at 94. Mr. Bellomo has denied requests for additional staff from unit managers. U.S. Exh. 600 (Bellomo Dep.) at 142. For example, during February 1993, the unit manager in Horizon asked for more staff. U.S. Exh. 600 (Bellomo Dep.) at 143. Mr. Bellomo denied the request. *Id.* The rationale, in his words, was as follows:

I had three other quota increases sitting on my desk waiting for me to render a decision. So I could not give that particular unit manager everything he was asking for. Even though he may have had some reasonable plans.

U.S. Exh. 600 (Bellomo Dep.) at 143, lines 17-21 (emphasis added).

Mr. Devine prepared a chart that breaks down the census of each residential building at Ebensburg since 1986, the number of staff assigned for each of the three shifts (quota), and the staff-resident ratio. U.S. Exh. 608 (Devine Dep.) Exh. 7; U.S. Exh. 608 (Devine Dep.) at 83, 84, 89, 90.^{5/} Where there are 19 staff assigned to a building, one of the four living units only has four staff assigned. U.S. Exh. 604 (Bonfanti Dep.) at 21-22. When only 18 staff are assigned to a building, two of the four living units only have four staff assigned. U.S. Exh. 604 (Bonfanti Dep.) at 22. Based upon an average of 24 residents in a living area, when there are four staff assigned each staff person is responsible for six residents. When there are five staff assigned, four staff are responsible for five residents and one staff person is responsible for four residents. In actuality, therefore, the staffing ratios are actually lower (i.e., staff are responsible for a larger number of residents) than those reflected on Devine Deposition Exhibit 7, which only take the aggregate number of residents in a building and divide the number by the total number of staff assigned to the building.

As is apparent in Devine Deposition Exhibit 7, when the United States began its expert tours as part of the discovery process in this litigation August 1992, the number of staff assigned to duty in each residential building at Ebensburg began increasing. U.S. Exh. 608 (Devine Dep.) Exh. 7. In some situations, however, even with the increased number of staff, the actual staff-resident ratios as of December 1992 at Ebensburg was worse than it was in prior years. For instance, overall, the staff ratios in Horizon House were better

^{5/} Where there is a slash in the quota and ratio columns in the census/quotas/ratios chart, the first number that appears is the total number of staff and the ratio assigned to the building on weekdays. The number appearing after the slash is the total number of staff and the ratio assigned to the building on weekends and holidays. See, e.g., U.S. Exh. 604 (Bonfanti Dep.) at 21-22.

during July 1989 on all three shifts than the staff ratios in the succeeding years through December 1992. The staff ratio in Sunset House on the third shift during July 1990 and 1991 was better than at any point in 1992. U.S. Exh. 608 (Devine Dep.) Exh. 7.

F. Staff Breaks Further Reduce The Number Of Staff Actually Present During Shifts.

The number of staff assigned to each residential building in Devine Deposition Exhibit 7 (identified as "quota") only reflects the total number of staff assigned to the building at the beginning of the shift, rather than throughout the duration of the shift. U.S. Exh. 608 (Devine Dep.) at 100, 105. These numbers do not take into account the fact that each staff person has a one hour break during the shift. U.S. Exh. 608 (Devine Dep.) at 100.^{6/} The number of staff that are actually present throughout the shift is therefore lower during the time that staff are on their breaks. U.S. Exh. 608 (Devine Dep.) at 104-105. Due to staff breaks, there are significant blocks of time during each shift where the staff ratio falls below the minimum quotas set by Ebensburg.

Staff take their breaks on the first and second shifts during mealtimes and program times.^{7/} Since each staff person has a one hour break during the shift, staff are on breaks a

^{6/} These breaks consist of two 15 minute "rest" breaks and a half-hour break for a meal. U.S. Exh. 608 (Devine Dep.) at 101; U.S. Exh. 604 (Bonfanti Dep.) at 25.

^{7/} For instance, breaks at Keystone during the first shift are from 9:15 a.m. - 10:15 a.m., 10:45 a.m. - 1:00 p.m., and 1:15 p.m. - 2:15 p.m. U.S. Exh. 604 (Bonfanti Dep.) at 26. Breaks during the second shift are from 3:45 p.m. - 4:45 p.m., 6:00 p.m. - 8:00 p.m., and 9:15 p.m. - 10:15 p.m. *Id.* at 27. Breakfast at Keystone generally takes place between 7:20 a.m. and 9:30 a.m.; lunch generally takes place between 11:20 a.m. and 1:30 p.m.; and dinner takes place between 5:20 p.m. and 7 p.m. *Id.* at 40, 42, 43. Breaks at Laurel take place during approximately the same period of time. On first shift, the breaks are between 8:30 a.m. and 9:30 a.m., 10:45 a.m. and 12:25 p.m., and 1:00 and 2:00 p.m. On second (continued...)

total of 4 hours during both the first and second shifts. When there are four staff assigned to a living area, they normally each take their break sequentially. U.S. Exh. 604 (Bonfanti Dep.) at 27. Consequently, there are only three staff (or a staff ratio of 1:8) for a total of at least four hours, or approximately one-half of the shift. When there are five staff assigned to a living area, three staff take their breaks sequentially and two staff take their break at the same time. U.S. Exh. 604 (Bonfanti Dep.) at 27; U.S. Exh. 611 (Ferut Dep.) at 21. As a result, for three hours during the first and second shift, there are four staff present for a ratio of 1:6. For one hour during the first and second shift, there are three staff present for a ratio of 1:8.

Staff breaks during the third shift result in situations where one staff person is responsible for 23 to 24 individuals. U.S. Exh. 623 (McGuire Dep.) at 59. For instance, as of December 1992, Keystone house had only nine staff assigned to the third shift. U.S. Exh. 604 (Bonfanti Dep.) at 25; U.S. Exh. 608 (Devine Dep.) Exh. 7. This means that one of the four living areas had three staff assigned and the remaining three had only two staff assigned. U.S. Exh. 604 (Bonfanti Dep.) at 25; U.S. Exh. 608 (Devine Dep.) at 101. Consequently, during both of the one hour breaks, or for two hours between the 11:15 p.m. - 7:00 a.m. shift, there is only one staff person to cover the 23 residents who live in the area. U.S. Exh. 608 (Devine Dep.) at 101-102, 103. Rather than a ratio of one staff person to 10.22 residents, the ratio during this two hour time block is really only one staff person to 23

²/(...continued)

shift, the breaks are between 3:30 and 4:45 p.m., 5:15 and 7:45 p.m., and 9:20 and 10:30 p.m. U.S. Exh. 631 (Seymour Dep.) Exh. 15.

residents. According to Mr. Bonfanti, this happens "every night" at Keystone House. U.S. Exh. 604 (Bonfanti Dep.) at 29. A similar situation existed in Laurel House. As of November 1992, two of the four living areas had only two staff assigned during the third shift. U.S. Exh. 630 (Seymour Dep.) at 116. During the time that staff were on break in these living areas, there was only one staff for 24 residents. Id. at 116, 118.

As of the time of his deposition on December 2, 1992, Mr. Bonfanti had four direct care staff vacancies on the second shift for Keystone that had been unfilled for two months. U.S. Exh. 604 (Bonfanti Dep.) at 17. He had to rely on pulling staff from other units and overtime to cover these staff positions. U.S. Exh. 604 (Bonfanti Dep.) at 18. In general, Mr. Bonfanti has to rely on overtime "almost daily" to meet minimum staffing standards at Keystone. U.S. Exh. 604 (Bonfanti Dep.) at 144. He questions how effective staff can be working 16 hour days. U.S. Exh. 604 (Bonfanti Dep.) at 145.

Budgetary considerations dictate the amount of staff that are allocated to a particular unit at Ebensburg. U.S. Exh. 608 (Devine Dep.) at 169, 174. Ebensburg has not been able to meet the quotas set forth in U.S. Exh. 608 (Devine Dep.) Exh. 7 without resort to overtime on a weekly basis. U.S. Exh. 608 (Devine Dep.) at 129, 130, 233; U.S. Exh. 626 (Pisula Dep) at 47-48.^{8/} In addition, supervisors often have to work "in complement," which means working as a direct care staff person, in order to meet staff quotas. U.S. Exh. 608 (Devine Dep.) at 189, 207, 208; U.S. Exh. 608 (Devine Dep.) Exh. 3; U.S. Exh. 626

^{8/} Mr. McGuire, the Unit Manager at Horizon, admits that the utilization of overtime is an integral part of maintaining minimum staffing ratios. U.S. Exh. 623 (McGuire Dep.) at 63. He estimates that eight to ten shifts of overtime are required to meet minimum staffing levels during any given week at Horizon. U.S. Exh. 623 (McGuire Dep.) at 62.

(Pisula Dep) at 47-48. Supervisors have frequently complained that they have had to work too many hours as direct care staff. U.S. Exh. 608 (Devine Dep.) at 210-211.^{9/} Supervisors have to work in complement on practically a daily basis and this has become the norm on the second and third shift at Ebensburg. U.S. Exh. 627 (Pisula Dep.) at 32. When supervisors are put into complement, they are performing two jobs and Ms. Pisula does not think supervisors can perform two jobs. U.S. Exh. 627 (Pisula Dep.) at 20. Moreover, staff are frequently "pulled" from their regularly assigned building to work in another building in order to meet staff quotas. U.S. Exh. 608 (Devine Dep.) at 222-223; U.S. Exh. 608 (Devine Dep.) Exh. 12; U.S. Exh. 626 (Pisula Dep) at 47-48. Mr. Devine recognizes that it is preferable to have the same staff work with the same residents, rather than having to pull staff from other buildings who are not familiar with the residents. U.S. Exh. 608 (Devine Dep.) at 227, 261. The union has also grieved the practice of pulling staff because direct care staff are more familiar with the individuals they serve on a daily basis and living areas function better when regular staff are serving the residents. U.S. Exh. 627 (Pisula Dep.) at 21-24. There would be less overtime, pulling of staff, and supervisors working in complement if there were more direct care staff at Ebensburg. U.S. Exh. 608 (Devine Dep.) at 208, 230-231, 233.

^{9/} For example, United States' Exhibit 621 (Kleman Dep.) Exhibit 2, is a July 4, 1991 memorandum from Mr. Kleman to Mr. Bellomo. In it, Mr. Kleman recounts the difficulties that he was having performing his job as a residential services aide supervisor because during the preceding month, he had worked as an aide rather than a supervisor during 85% of the shifts he had worked in June. Mr. Kleman was working as an aide during this time due to a shortage of staff and in order that Ebensburg could meet the quota. U.S. Exh. 621 (Kleman Dep.) at 25; Kleman Dep. Exh. 2.

Another way in which Ebensburg attempted to meet its staff quotas was by closing one of the residential buildings (Harmony House) and consolidating it with other units. U.S. Exh. 608 (Devine Dep.) at 60-61. This increased the number of people living in each building and resulted in what Mr. Bonfanti described as overcrowding in Keystone. U.S. Exh. 604 (Bonfanti Dep.) at 96.

Staff at Laurel House, including Betty Ferut, have expressed concerns to Ebensburg management about their ability to care for the individuals who live there because of the number of responsibilities they have. U.S. Exh. 631 (Seymour Dep.) at 106. One of Ms. Ferut's concerns is that direct care staff on the second shift have too much responsibility for ordering, logging, sorting and putting away individuals' clothes. U.S. Exh. 611 (Ferut Dep.) at 25; Ferut Dep. Exh. 1. She believes "second shift should be concentrated on the individuals and not having to worry about getting clothes put away." Id. She specifically made the recommendation that third shift, instead of second shift, should be responsible for these clothing duties after an incident on January 9, 1992 in which Eileen (Benita) B. was found coming out of the bathroom at 10:40 p.m. with blood on her face from lacerations on her eyelid and chin and feces smeared on her hands, face and feet. U.S. Exh. 611 (Ferut Dep.) Exh. 1. The laceration required sutures. Id. Staff did not witness how the injury occurred. Id. At the time at which the injury occurred, Ms. Ferut was in the office area logging clothes. U.S. Exh. 611 (Ferut Dep.) at 25; Ferut Dep. Exh. 1. The majority of direct care staff on West II agree with Ms. Ferut's concerns that clothing responsibilities take away from their client responsibilities. U.S. Exh. 611 (Ferut Dep.) at 27. Mr. Seymour, the Laurel House Unit Manager, admits that staff have expressed concerns to him about

clothing responsibilities detracting from their ability to provide the necessary care to individuals at Laurel House. U.S. Exh. 631 (Seymour Dep.) at 109. No changes, however, have been made in the clothing responsibilities on second shift. U.S. Exh. 611 (Ferut Dep.) at 26.

XVI. CONDITIONS DURING SURVEYS REFLECT EBENSBURG'S BEST EFFORTS.

The United States announced each and every tour of Ebensburg before it occurred. The United States' experts observed deficiencies at Ebensburg during their tours even though Ebensburg was on its best behavior during surveys. Mr. Bellomo agrees that during inspections of Ebensburg, "you would probably want to make sure that everything is as good as you can get it." U.S. Exh. 603 (Bellomo Dep.) at 178, line 24 through 179, line 1. In fact, he has expected things to be "perfect" when outside surveyors are touring and has issued memos when they are not. For instance, on August 13, 1992, Mr. Bellomo visited the Villa Learning Center and the JFK Area at 10:21 a.m., 20 minutes into day programs, and found that no one had arrived yet. He asked Mr. Devine to determine "why on a day when surveys are being conducted that we still don't have people here at mid-morning." U.S. Exh. 196; see also U.S. Exh. 162.

Both Mr. Tackett and Ms. Hebenthal agree that Ebensburg takes special steps when a survey is in process. For example, an inspection by the Association for Retarded Citizens occurred on one of the days that Mr. Tackett was working at Keystone. Tr. 8/3/93 (Tackett) at 19. On that day, the "typical" routine at Keystone was not followed. Id. As soon as the announcement was made that an inspection was taking place, he describes the transformation in preparation for the inspection as "incredible," "like night and day." Id. at 18. There were more staff than he can ever remember being present, including two physical therapists. Id. He was given a group of three residents to take outside. Id. Materials were brought out and suddenly a lot of attention was paid to the residents. Id.

Robin Hebenthal was sent to one of Ebensburg's living units, the Villa, on the Wednesday and Thursday of her second week of training at Ebensburg. Tr. 8/3/93 (Hebenthal) at 197. Ms. Hebenthal was training at Ebensburg during the last week in May and the first week in June 1992 in preparation for a position as a direct care staff person with mentally retarded individuals who are also mentally ill at the Commonwealth's Torrance State Hospital. Id. at 195. Ms. Hebenthal understands that the reason she was sent to the Villa was because surveyors were at Ebensburg and Ebensburg wanted to show a good staff ratio. Id. at 197. United States' Exhibit 59 shows that MA surveyors were at Ebensburg during the days that Ms. Hebenthal was assigned to Villa. The schedule of training activities given to Ms. Hebenthal at the beginning of her training did not include being assigned to Villa at the end of her training. Id. at 197. Ms. Hebenthal did not receive training regarding the needs of the individuals living at Villa or any other type of training when she was assigned to work at Villa. Id. at 198-199. When she was assigned to Villa, Ms. Hebenthal had never before worked with mentally retarded individuals, and she did not know what to do. Id. at 199.

Mr. Bellomo should have at least been aware that conditions at Ebensburg during surveys reflect the staff's best efforts because in June of 1990, a caller left a message on Ebensburg Center's Hotline pleading with Mr. Bellomo to give supervisors "a break" by not writing a memo to staff telling them "what a wonderful job they're doing." U.S. Exh. 931.^{1/} The caller stated that staff were "not doing a good job" except when "somebody is around to see what they are doing." Id. In particular, the caller was concerned that during

^{1/} The caller did not identify him or herself.

the MA survey which had just taken place, staff had "put on a good show" but "otherwise, it's sad what they're doing to the clients, or what they're not doing, which is more to the point." Id.

Although each of the experts for the United States' case-in-chief testified about what they observed during their tours of Ebensburg, four of the experts illustrated their testimony with videotapes, slides, and pictures. Each of these four experts testified that the vignettes on the videotapes and the scenes depicted in slides and pictures that were entered into evidence are characteristic of what they had observed during their tours of Ebensburg -- regardless of whether the scenes were being filmed or not. See, e.g., Tr. 7/26/93 (Stark) at 164, 165, 169; Tr. 7/28/93 (McAllister) at 223-224; Tr. 7/29/93 (McGowan) at 137; Tr. 8/1/93 (Russo) at 82, 86.

XVII. EBENSBURG IS TOO LARGE TO ADEQUATELY SERVE THE PEOPLE WHO LIVE THERE

Dr. Stark believes that there are both too many people at Ebensburg and too many people congregated together in one area. Tr. 7/26/93 (Stark) at 233-234. The result is a lack of individualization of services, which is the essence of providing services to people with mental retardation. Tr. 7/26/93 (Stark) at 65, 223. The large number of people at Ebensburg has also fostered a custodial care mode, as opposed to a habilitative one, in providing services to Ebensburg residents. Tr. 7/26/93 (Stark) at 223. Nancy Thaler, the Director of the State Office of Mental Retardation, admits that it is detrimental to the growth and development of individuals with mental retardation to congregate them in groups of 24 on one residential living unit where they spend the majority of their time. U.S. Exh. 870 (Thaler Dep.) at 57. Ms. Degretto, the Unit Manager at Villa, agrees that when 24 individuals are congregated together in one living area, aggression, self-abuse, and property damage increase as a result of the sheer number of people. U.S. Exh. 607 (Degretto Dep.) at 121, 122. She describes the scene at Villa when there are 24 individuals in one area getting ready for work as "bedlam." U.S. Exh. 607 (Degretto Dep.) at 123. Ms. Degretto has found that when individuals are in smaller groups, there are less injuries. U.S. Exh. 607 (Degretto Dep.) at 159. 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 sufficiently meaningful activity. U.S. Exh. 603 (Bellomo Dep.) at 160. There were about 18 women in an area, which he thought was too many people together. U.S. Exh. 603 (Bellomo Dep.) at 161. This is the same area from

which Diana D. frequently escapes because it is too noisy, there are too many aggressive people, and she just wants some quiet time to be able to look at a book or magazine. U.S. Exhs. 594, 594(a).

Both Dr. Stark and Ms. McAllister had significant concerns about overcrowding and the safety of individuals placed on the floor on mats while other residents are navigating in their wheelchairs. Tr. 7/28/93 (McAllister) at 228; Tr. 7/26/93 (Stark) at 164.^{1/} The impression that Ms. McAllister had when she toured Ebensburg was one "of everything just being scattered around the room and haphazard." *Id.* at 228, lines 20-21. Mr. Fulton, who heads Ebensburg's risk management committee, has shared Ms. McAllister concerns. When he toured Keystone during the evening of July 13, 1992, he found it to be "extremely noisy" and "extremely cluttered." U.S. Exh. 614 (Fulton Dep.) Exh. 7.

State surveyors have also found Keystone to be overcrowded and unsafe. For example, in 1989, surveyors found that Keystone was so overcrowded, space was inadequate for staff and clients to maneuver. U.S. Exh. 55 at 2. In response to this deficiency, Ebensburg promised to reduce the census in Keystone. *Id.*

When Harmony House was closed in June 1992, however, the census at Keystone increased from 88 to 94. U.S. 604 (Bonfanti Dep.) at 96. Mr. Bonfanti, the Unit Manager at Keystone, was concerned about the increase. In his words:

we knew darn well it's not going to work in Keystone. Given the carts, the chairs, there's no room. . . That's been one of my biggest complaints out there. You just can't move around

^{1/} United States' Exhibit 1023 contains examples of injuries that Ebensburg residents have sustained while crawling around the floor and on mats.

those bedrooms with those wheelchairs. It's tough on my staff, it's hard. It really is.

U.S. 604 (Bonfanti Dep.) at 96, lines 4-6, 21-24. Mr. Bonfanti admits that Keystone is overcrowded and a reduction in the number of people who live in Keystone would enhance client welfare. U.S. 604 (Bonfanti Dep.) at 95, 98. Indeed, when State surveyors returned in 1992, they again cited Ebensburg for overcrowded conditions in Keystone. U.S. Exh. 67 at 00542862. In particular, they were concerned, as was Dr. Stark some seven months later, that areas were so congested, residents were placed on mats on the floor so close together that they were "touching each other." Id.; U.S. Exh.794 at 3.

XVIII. INDIVIDUALS REMAIN AT EBENSBURG IN SPITE OF DEFENDANTS' UNANIMOUS BELIEF THAT THEY WOULD BE BETTER SERVED IN THE COMMUNITY.

In 1991 and 1992, more people were discharged from Ebensburg due to death than due to community placement. Tr. 7/27/93 (Stark) at 68-69; U.S. Exh. 36 at 10; U.S. Exh. 37 at 15. Ebensburg placed three individuals into the community in 1991 and four in 1992. Id.

A. Defendants Recognize The Need For Community Placement.

Without exception, defendants believe that all Ebensburg residents are capable of living in the community and would be better served in the community as opposed to living at Ebensburg. U.S. Exh. 870 (Thaler Dep.) at 23; U.S. Exh. 635 (Sneed Dep.) at 67-69; Tr. 10/14/93 (Bellomo) at 167; U.S. Exh. 600 (Bellomo Dep.) at 83-84; U.S. Exh. 603 (Bellomo Dep.) at 102; U.S. Exh. 639 (Stratton Dep.) at 18; U.S. Exh. 640 (Stratton Dep.) at 94; U.S. Exh. 628 (Ratchford Dep.) at 50-52.

Before being appointed Director of the Commonwealth's Office of Mental Retardation, defendant Nancy Thaler was in charge of community services for the Department of Public Welfare ("DPW"). U.S. Exh. 870 (Thaler Dep.) at 9-10. Ms. Thaler does not believe that mentally retarded people should live in large facilities. She would like to see every person with mental retardation living in the community. "The question has been answered a thousand times in many environments and there's no doubt that large facilities must end." U.S. Exh. 870 (Thaler Dep.) at 57, lines 16-18. Ms. Thaler acknowledged that some of the most meaningful things in an individual's life cannot occur in an institution, such as the opportunity to establish and develop relationships with peers in the community who do

not have disabilities and the ability to access all of what is available to everyone else in the community. U.S. Exh. 870 (Thaler Dep.) at 39. Ms. Thaler also acknowledged that isolation and segregation in the institution limits experiences in life, which means it limits the opportunity to grow and learn and expand and develop relationships. U.S. Exh. 870 (Thaler Dep.) at 39.

The Office of Mental Retardation's philosophy is that "all the people that we serve are capable of living in the community." U.S. Exh. 635 (Sneed Dep.) at 68, lines 15-16. Dr. Sneed believes that the needs of people with mental retardation are better met in a smaller setting and that people have "thrived" in this type of setting. U.S. Exh. 635 (Sneed Dep.) at 80.

Based upon his experience working for the Commonwealth and his experience as a surveyor for the Joint Commission on Accreditation of Hospitals for four years, surveying 200 sites in 37 different states, Mr. Snauffer knows what Pennsylvania is doing and what other states are doing. In his opinion, Pennsylvania is not where it should be. U.S. Exh. 634 (Snauffer Dep.) at 62. Pennsylvania is not moving individuals with mental retardation into the community, "when, in fact, they could live in the community." U.S. Exh. 634 (Snauffer Dep.) at 63, lines 4-5. According to Mr. Snauffer, Pennsylvania, although it has improved, has a lot to do. U.S. Exh. 634 (Snauffer Dep.) at 62. "[Pennsylvania is] not where it should be because we're dissatisfied with the way in which we deliver services. Dissatisfied in that we're not doing everything for people that we should be doing for people." U.S. Exh. 634 (Snauffer Dep.) at 62, line 23, through 63, line 2. "Pennsylvania has a lot to do relative to the provision of services to individuals living in institutions in

Pennsylvania and also living in the community because there are individuals who have specific needs that are not being met, not being addressed." U.S. Exh. 634 (Snauffer Dep.) at 64, lines 10-15. Pennsylvania, Mr. Snauffer continues, is not where it wants to be with respect to providing opportunities for work and employment, for individuals living in both institutions and in the community. U.S. Exh. 634 (Snauffer Dep.) at 64.^{1/} Mentally retarded individuals in Pennsylvania "need to be able to exercise their rights and participate in citizenship," U.S. Exh. 634 (Snauffer Dep.) at 64, lines 23-24, and Pennsylvania is not where it wants to be on that. Id. Individuals with mental retardation "need opportunities to be integrated within the community and receive services within the community, whether or not they live at a state residential facility or whether they live" in the community. U.S. Exh. 634 (Snauffer Dep.) at 64, lines 18-21.

Mr. Bellomo also believes that all individuals who are currently residing at Ebensburg would benefit from living in the community. Tr. 10/14/93 (Bellomo) at 167. He believes that "congregate facilities are inferior to small community placements." U.S. Exh. 602 (Bellomo Dep.) at 9, lines 7-8.

Dr. Stratton testified that Ebensburg's overriding goal is to have all of its individuals placed in the community. U.S. Exh. 640 (Stratton Dep.) at 94. One of the goals of the psychology department is to prepare all of the individuals who live at Ebensburg for life in the community. U.S. Exh. 639 (Stratton Dep.) at 18.

^{1/} Only seven people at Ebensburg have jobs in the community. U.S. Exh. 37. The small number of client workers at Ebensburg has remained virtually unchanged since 1990. U.S. Exhs. 36, 37, 640 (Stratton Dep.) Exh. 17.

According to the head of Ebensburg's Therapeutic Activity Services Department, Alan Ratchford, the goal of the Commonwealth of Pennsylvania, of Ebensburg Center, of the Therapeutic Activity Services Department, and Mr. Ratchford's personal goal is to prepare all of the individuals living at Ebensburg to leave Ebensburg and move into the community. U.S. Exh. 628 (Ratchford Dep.) at 47-48. Mr. Ratchford testified that there are many benefits of living in the community rather than living at Ebensburg, including normalization and exposure to many things that are not available at Ebensburg. U.S. Exh. 628 (Ratchford Dep.) at 48-49. "Living in a large facility, I think, has a lot of drawbacks." U.S. Exh. 628 (Ratchford Dep.) at 48 line 25 to 49 line 1. The benefits of living in a group home rather than a facility like Ebensburg include living with a lot fewer people; increased integration into the physical environment of the community; and a more normalized lifestyle. U.S. Exh. 628 (Ratchford Dep.) at 50.

B. Lack Of Funds Is Preventing Individuals Who Could Live In The Community From Moving Into The Community.

Ebensburg has specifically requested that every resident be placed in the community in the county of their origin. U.S. Exh. 602 (Bellomo Dep.) at 9. Mr. Bellomo has "made it known" to his superiors that every individual at Ebensburg "could profit from living in the community." U.S. Exh. 602 (Bellomo Dep.) at 14, line 25 through 15, line 1.

Of the 150 slots allocated by the Office of Mental Retardation for placing individuals in institutions into the community, however, none were allocated for Ebensburg residents for fiscal year 1992-93. U.S. Exh. 602 (Bellomo Dep.) at 6-7. Not a single person at Ebensburg is targeted for community placement in the 1993-94 fiscal year. U.S. Exh. 870 (Thaler Dep.) at 61.

Funding is the main obstacle to providing sufficient community services to Ebensburg residents. U.S. Exh. 635 (Sneed Dep.) at 71; U.S. Exh. 634 (Snauffer Dep.) at 63; see also U.S. Exh. 640 (Stratton Dep.) at 204-205 (there are individuals at Ebensburg who should be living in the community, but the supports are not available at this time due, in part, to budgetary reasons). The legislature has not made funds available in order to establish sufficient community services. U.S. Exh. 634 (Snauffer Dep.) at 63. The Office of Mental Retardation has requested additional funds to place individuals from institutions into the community but the funds have not always been granted. U.S. Exh. 635 (Sneed Dep.) at 76. The lack of available community services enters into Ebensburg's decision about individuals' discharge plans. U.S. Exh. 640 (Stratton Dep.) at 206.

The community placement system in the Commonwealth is funded by the Department of Public Welfare. Typically, the Department allocates resources to each county government, and the counties decide who will receive services and in what form. U.S. Exh. 870 (Thaler Dep.) at 10-11. However, the Commonwealth has the ability to target a group and allocate resources to that group. U.S. Exh. 870 (Thaler Dep.) at 11. For instance, a group could be targeted because they are a class in litigation or because they live in a public facility that the Commonwealth wishes to downsize or close. U.S. Exh. 870 (Thaler Dep.) at 11.

The Commonwealth appropriated money in the 1992-93 budget and in the current 1993-94 budget to create community opportunities for individuals living in two state institutions -- Western Center and Embreeville Center. U.S. Exh. 870 (Thaler Dep.) at 15. The Commonwealth has directed the counties to develop a budget request for the 1994-95

budget that includes identification of the individuals from Western, Embreeville, and Ebensburg that could be served in the respective communities in the upcoming fiscal year. U.S. Exh. 870 (Thaler Dep.) at 28-29. The Commonwealth is interested in learning how many individuals at Ebensburg the counties could serve and what the cost would be. U.S. Exh. 870 (Thaler Dep.) at 29. Funds allocated by the Commonwealth for community services are matched by the federal government. U.S. Exh. 870 (Thaler Dep.) at 17.

The Office of Mental Retardation has control over community placements to the extent that it allocates financial resources to the County for community services. U.S. Exh. 635 (Sneed Dep.) at 71. The amount of funding that the Office of Mental Retardation requests for community placement are self-censored by what the Office thinks the Secretary for the Department of Public Welfare will honor. U.S. Exh. 635 (Sneed Dep.) at 76. Dr. Sneed "most certainly" wishes that he could direct more efforts and more of the Commonwealth's money away from institutions towards placing more residents into the community. U.S. Exh. 635 (Sneed Dep.) at 81.

C. **Individuals Who Remain At Ebensburg Despite Determinations That They Would Be Better Served In The Community Are Being Harmed.**

Dr. Amado found a plan for community placement in the record of every individual that he reviewed. Tr. 8/2/93 (Amado) at 43. However, Dr. Amado found that in many cases, the target dates for community placement for individuals identified as appropriate and ready for community placement have come and gone because the county to which the individual would return has no place for the individual. Tr. 8/4/93 (Amado) at 43-44. In other cases, the target date for community placement for individuals identified as appropriate and ready for community placement has been crossed out and a new date for community

placement is picked in the future. For example, Dr. Amado found that a typical community placement plan at Ebensburg will note that "'There are no [community] openings for five years,' so the target date is set five years down the road." Tr. 8/4/93 (Amado) at 44, lines 8-10. Dr. Amado concluded that the community placement plans at Ebensburg have nothing to do with the individuals who live at Ebensburg, but are dictated by the community living spaces in the counties in the Commonwealth. Tr. 8/4/93 (Amado) at 44. Dr. Stark believes that, as is being done in other states, Ebensburg must develop a plan to place residents in the community. Tr. 7/26/93 (Stark) at 236.

Individuals who have been identified as appropriate and ready for community placement who remain at Ebensburg are being harmed while they wait for openings in the community. For instance, as early as 1991, Ebensburg staff concluded that Sandra W. needed to live in an environment that was more enriched than the environment at Ebensburg. Tr. 8/2/93 (Russo) at 70. Staff determined that the environment at Ebensburg is inappropriate for Sandra. Tr. 8/2/93 (Russo) at 70. Since this determination, Sandra has both suffered and caused many significant injuries and has been restrained more than 50 times while she awaits placement in the community. *Id.*; U.S. Exhs. 42(c), 993. Since 1991, she has been bitten 16 times; has 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 four of her toenails. Tr. 8/2/93 (Russo) at 70; U.S. Exh. 958. Between January 1991 and August 1993, Sandra bit her peers on 14 occasions, including biting off a piece of Debra S.'s nose. U.S. Exhs. 267(c), 958.

As far back as August 1988, Dr. Goldschmidt, Ebensburg's consulting psychiatrist, stated that Clifford P. need to be in another setting, either a group home or university facility for rehabilitation. U.S. Exh. 440 at 1; U.S. Exh. 440(a) at 390371. Dr. Goldschmidt believed that his inappropriate behaviors were learned behaviors from years of institutionalization and might have been avoided if he had grown up in a different setting. Id. In September 1990, Clifford's psychologist recommended in his annual review that Ebensburg should "seek alternative placement in a community living or other facility affording opportunity for social development." U.S. Exh. 440 at 1; U.S. Exh. 440(a) at 61033. In November 1990, an Ebensburg staff person noted that "Clifford has few peers that he is willing to interact with during structured activities." U.S. Exh. 440(a) at 610361. The staff person stated "I also feel that Clifford will continue to regress unless a suitable community living arrangement can be found for Clifford." Id. For the next two years, Clifford's psychologist made the same recommendation. U.S. Exh. 440 at 1, 2; U.S. Exh. 440(a) at 610333, 390116. Mr. Bellomo also believes that Clifford should live in the community. Tr. 10/14/93 (Bellomo) at 116. Clifford is still at Ebensburg and is still exhibiting his "learned" inappropriate behaviors. Tr. 10/14/93 (Bellomo) at 120, 123.

In September 1992, James W. was severely injured by a peer. Tr. 7/26/93 (Weakland) at 196, 198. James suffered three broken ribs, a punctured and collapsed lung, internal bleeding, including two quarts of blood drained from his stomach with a tube, and a ruptured spleen, which had to be removed. Tr. 7/26/93 (Weakland) at 196; U.S. Exh. 501(dd). Following the September 1992 injury, James' Unit Manager wrote a memo pursuant to his responsibility to "establish a safe living area for [James W.] and his peers."

James' Unit Manager wrote that "[i]deally, a community placement in a small CLA would best serve to meet his many personal daily needs in the most quiet, unrestricted environment." U.S. Exh. 501(dd) at 200339. James remains at Ebensburg. Tr. 7/26/93 (Weakland) at 186. Since September 1992, James has been injured several times. U.S. Exhs. 135, 136.

In July 1986, an episode of agitation, self-injury and aggression resulted in John C.'s placement at Ebensburg. U.S. Exh. 156. Before he moved to Ebensburg, John C. had been living in the community. U.S. Exh. 156. Shortly before he moved to Ebensburg, John was seen in his community group home by a psychologist from the Kennedy Institute. U.S. Exh. 156. A few days after he moved to Ebensburg, John was seen at the Kennedy Institute by a psychiatrist and a physician. U.S. Exh. 156. The Kennedy Institute recommended that John be placed in a "controlled environment with at least two-to-one staffing availability for intense programming periods, where he has access to a daily activity program. This environment should optimally be one of a dual diagnosis facility that can attend to his psychiatric and developmental disabilities concurrently." Id. at 1. Following this intense programming period, the doctors at the Kennedy Institute anticipated that John would be transferred back to the community. Id. at 2. Instead of being placed in a dual diagnosis facility or other similar controlled environment, followed by return to the community, John has remained at Ebensburg since that 1986 consult. In the 15 months between January 1991 and April 1992, Ebensburg restrained John for his behavior 50 times -- 31 times in a restraint jacket, three times in floor control, and 16 times using emergency chemical

restraints. U.S. Exh. 993; see also United States' Exhibit 222 for photographs of John's straight jacket.

D. Ebensburg's Community Placement Plans Depart From Accepted Professional Standards.

Ebensburg's community placement plans do not comport with accepted professional standards. Tr. 8/4/93 (Amado) at 43. They are not individualized and do not specify skills that need to be worked on to facilitate community placement. Tr. 8/4/93 (Amado) at 43. Oftentimes, the community placement plan objective has nothing to do with the needs of the individual -- it is a function of the needs of the county. Tr. 8/4/93 (Amado) at 44. Representatives from the county of the resident's origin are required by Pennsylvania law to participate in residents' annual reviews, but they do not consistently attend the reviews, sometimes due to budget problems. Tr. 10/15/93 (Bellomo) at 36-37. Dr. Amado also testified that Ebensburg staff do not have adequate guidance to tailor their training programs to prepare individuals at Ebensburg to live in the community. Tr. 8/4/93 (Amado) at 98-99. In August 1992, the IOC surveyors found that community living skills are not adequately addressed by Ebensburg. U.S. Exh. 67 at 542851.

XIX. THE DEFENDANTS HAVE BEEN AWARE OF THE DEFICIENCIES AT ISSUE IN THIS LAWSUIT FOR A LONG PERIOD OF TIME.

The defendants have been aware of the significant deficiencies at Ebensburg at issue in this lawsuit since at least 1987 and, in some cases, for more than a decade. In 1987, the Department of Justice notified defendants of the conditions at Ebensburg that were depriving the residents who are confined there of their constitutional rights. U.S. Exh. 638 (Sponsky Dep.) Exh. 49. As far back as 1987, the United States advised the Commonwealth of serious problems in need of correction. Based upon the United States' notification, the Commonwealth was aware that Ebensburg:

- was failing to provide Ebensburg residents a reasonably safe environment and that injuries due to behaviors were excessive;
- had insufficient numbers of direct care staff at Ebensburg and that this was leading to preventable injuries and failures to implement behavior programs;
- was failing to provide its residents with minimally adequate training programs, and, as a result, its residents were being unduly restrained and injured;
- was failing to provide residents with self-injurious and physically abusive or destructive behaviors with behavior programs to address these behaviors; the Commonwealth was also notified that the behavior programs that did exist were "so deficient as to fall below the level of any acceptable professional standard;"
- needed to 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;
- was not providing residents "essential" physical therapy services, placing its residents at undue risk of contractures, bodily deformity, and other serious threats to physical health. The Commonwealth was notified that both the number and competency of the physical therapists at Ebensburg were deficient;
- had an inadequate evaluation process for determining who was in need of physical therapy;

- was not providing residents with adequate and appropriate wheelchairs; instead, wheelchairs were ill-fitted or broken, thereby causing new physical problems or exacerbating old ones;
- did not provide individualized health care plans to identify and provide for each resident's needs; and
- had inadequate infection control practices.

In 1990, following tours by the Department of Justice to determine which corrections, if any, the defendants had made at Ebensburg, the United States again notified the Commonwealth that residents confined at Ebensburg continued to be subjected to conditions that deprived them of their constitutional rights. U.S. Exh. 638 (Sponsky Dep.) Exh. 50.

These conditions included:

- continuing problems in behavior management services;
- excessive injuries due to behaviors;
- a "significant" number of residents who needed behavior programs and did not have them;
- "most of the existing [behavior programs] are too similar to reflect the individual needs of the resident;"
- a systemic failure to implement behavior programs, resulting in otherwise preventable injuries;
- an excessive use of physical and chemical restraints as substitutes for behavior programs;
- continuing deficiencies in physical therapy services, including the fact that residents were suffering injuries as a result of broken or ill-fitting wheelchairs and the fact that residents were deteriorating as a result of lack of support afforded by Ebensburg's wheelchairs;
- insufficient communication between the physical therapy department and occupational therapists;
- failing to provide adequate medical care to Ebensburg residents;

- failing to feed residents safely as evidenced by the United States' experts observing residents coughing and choking on food and mucus during meals;
- residents facing serious risks of aspiration and malnutrition;
- inadequate nutritional assessments;
- failure to document actual nutritional intake;
- incomplete medical records that frequently omitted essential and/or current information, including information about recent hospitalizations;
- inadequate psychiatric care, including a failure to appropriately diagnose residents' psychiatric problems; the United States specifically advised the Commonwealth that adequate evaluation and diagnosis are essential in selecting the appropriate psychotropic drug, if any, and evaluating the efficacy of treatment and that Ebensburg's failure to do this departed from generally accepted professional standards;
- inadequate neurology services, including the practice of maintaining anticonvulsant polypharmacy, placing the long term health of its residents at risk;
- keeping residents on low, questionably effective doses of anticonvulsants for prolonged periods of time;
- erratic documentation and description of seizure activity, impeding efforts to reduce seizure activity;
- reliance on multiple medications; and
- direct care staff who were inadequately trained and improperly responding to residents' maladaptive behaviors.

In addition to the Commonwealth being on notice through the United States' investigatory findings, the Commonwealth was also on notice of deficiencies at Ebensburg through its own State surveyors who inspect Ebensburg two times each year to determine its compliance with Title XIX federal regulations (referred to herein as "MA surveys") and once a year to determine whether the care of specific individuals complies with Title XIX federal regulations (referred to herein as "IOC surveys" or inspection of care surveys). Tr.

10/13/93 (Bellomo) at 157-159. State surveyors have consistently identified deficiencies in mealtime practices, active treatment, lack of staff interaction, lack of meaningful activities, lack of privacy, failure to provide for residents' basic care needs, and inadequate behavior management practices, psychiatric treatment, data collection, and medical record keeping. U.S. Exhs. 48-67; 668; 779; 792; 794. In the face of repeated, persistent deficiencies at Ebensburg, State surveyors informed Mr. Bellomo in January 1993 that Ebensburg has had a number of deficiencies that it failed to correct following the 1990 and 1991 surveys and which still needed improvement in 1992. U.S. Exh. 67. The State surveyors concluded that Ebensburg's corrective action plans in areas in which there have been repeated deficiencies over the years have simply "not been successful." U.S. Exh. 67 at 054287.

Respectfully submitted,

James P. Turner
Acting Assistant Attorney General
Civil Rights Division

Robinsue Frohboese
Richard J. Farano
Judith C. Preston
Attorneys
U.S. Department of Justice
Civil Rights Division
Special Litigation Section
P.O. Box 66400
Washington, D.C. 20035-6400