U.S. Department of Justice

Civil Rights Division

Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530

October 7, 2009

The Honorable Martin O'Malley
Office of the Governor
100 State Circle
Annapolis, Maryland 21401

Re: Investigation of the Rosewood Center, Owings Mills, Maryland

Dear Governor O'Malley:

I am writing to report the findings of the Civil Rights Division's investigation of conditions and practices at the Rosewood Center ("Rosewood"), in Owings Mills, Maryland. On July 11, 2008, we notified you of our intent to conduct an investigation of Rosewood pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek remedies for any pattern or practice of conduct that violates the constitutional or federal statutory rights of persons with developmental disabilities who are served in public institutions.

On October 6-9, 2008, we conducted an on-site review of care and treatment at Rosewood with expert consultants in various disciplines. During our visit, we interviewed Rosewood administrators, professionals, staff, and consultants, and visited residents in their residences, at activity areas, and during meals. Before, during, and after our site visit, we reviewed a wide variety of relevant State and facility documents, including policies and procedures, incident reports and investigations, and medical and other records relating to the care and treatment of Rosewood residents. In keeping with our pledge of transparency and to provide technical assistance, where appropriate, we conveyed our preliminary findings to State counsel and to certain State and facility administrators and staff during exit briefings at the close of our on-site visit.

We would like to express our appreciation to Rosewood administrators, professionals, and staff and to the State officials who participated in our visit for their assistance, cooperation, professionalism, and courtesy throughout our investigation. At the time of our visit, Rosewood had the benefit of a competent and

caring Facility Director and management team that were expending considerable effort to make changes at Rosewood, some of which we discuss in this letter, and we thank them for their efforts and for their assistance during our tour. We hope to continue to work with the State and Rosewood officials in the same cooperative manner going forward.

In accordance with statutory requirements, we now write to advise you formally of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). We have concluded that certain conditions and practices at Rosewood violated the constitutional and federal statutory rights of its residents. In particular, we find that the State fails to provide Rosewood's former residents with adequate transition planning and placement in the most integrated setting, and that Rosewood failed to provide its residents with adequate protection from harm; behavioral, habilitation, and communication services; and health care, including infection control and physical and nutritional management. See Olmstead v. L.C., 527 U.S. 581 (1999); Youngberg v. Romeo, 457 U.S. 307 (1982); Title XIX of the Social Security Act, 42 U.S.C. § 1396; 42 C.F.R. Part 483, Subpart I (Medicaid Program Provisions); Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12101, 12132 et seq.; and 28 C.F.R. § 35.130(d). These failures are likely to have lingering effects, including placement into inappropriate settings, which must be ameliorated and remedied. Thomas S. v. Flaherty, 902 F.2d 250, 254-55 (4th Cir. 1990).

At the outset, we wish to highlight the context in which our investigation took place. On January 15, 2008, Maryland Governor Martin O'Malley announced that the State intended to close Rosewood by June 30, 2009. Shortly before the Governor's announcement, DDA recommended in November 2007 that 153 of the 166 residents then residing at Rosewood be moved to community settings that meet the safety, health, and habilitation needs of each individual. At the time of our visit in October 2008, Rosewood had just embarked on the process of transitioning residents to other placements, with 128 individuals continuing to reside at Rosewood. On June 3, 2009, the State informed us that Rosewood has now moved all of its residents to other placements and is no longer providing services to persons with developmental disabilities.

Because of the closure, a significant concern that underlies many of the findings we set forth in this letter is particularly troubling: Rosewood's assessments of its residents were critically deficient. Across disciplines, we found that assessments were inaccurate, incomplete, and untimely. The medical, psychiatric, nutritional, behavioral, habilitation, vocational, and communication assessments provided by Rosewood substantially depart from generally accepted professional standards. The harm from the inadequacies of the assessments is

multi-faceted. While in the facility, the inadequate assessments exposed the individuals to physical harm, to regression in treatment of their disabilities, and to unnecessarily prolonged institutionalization. A greater concern in the present context, however, is that the lack of adequate assessments has undermined Rosewood's ability to determine the strengths and needs of its residents so that they can be safely placed in the most integrated setting appropriate to their needs. Similarly, the physical harm, regression in treatment, and prolonged institutionalization may have lingering effects for the individuals' current placement. Indeed, the conditions we found at Rosewood – including inadequate protection from harm; inadequate behavioral, habilitation, and communication services; and inadequate health care, including infection control and physical and nutritional management – all have undermined the care and treatment that Rosewood's residents received while in the facility and may jeopardize their current safety, well-being, and ability to flourish in less-restrictive settings.

Moreover, we have grave concerns regarding the inadequacies in the State's and Rosewood's discharge planning and transition process, especially given the deficiencies we found in Rosewood's assessments. While at Rosewood, we requested copies of the monitoring reports that are periodically performed as to individuals who have recently been discharged. This information is crucial to effective discharge planning, as it affords Rosewood and the State the opportunity to identify problems in the transition process and to implement corrective actions. During our tour, we were given copies of a limited number of these monitoring reports to review. However, the State has refused to provide us with the copies of the additional reports we requested at the end of our tour, on grounds that these documents are not in Rosewood's possession, albeit, apparently, they are in the State's possession. The State's refusal to release these documents is disturbing. As a threshold matter, Rosewood's placement consultant specifically noted that he had reviewed copies of the monitoring reports we requested. Second, this information is essential to effective discharge planning. If Rosewood did not have this information, it is a substantial departure from generally accepted professional standards in discharge planning. Finally, the State appears to be selectively cooperative in providing the United States with information central to the safety and well-being of Rosewood's residents, all of whom the State has placed elsewhere. In any event, as discussed in more detail in Section II.A, the few monitoring reports Rosewood provided to us during our tour revealed critical deficits in the transition process, including failures to conduct assessments and provide services in a timely manner for individuals now in community placements. Because many of Rosewood's former residents who have recently been placed in the community are medically and behaviorally fragile, these deficits expose these individuals to significant risk of harm.

Accordingly, in this letter we describe not only the failures we found in the State's and Rosewood's discharge planning and transition process, but also those failures in the provision of services we found to have existed while Rosewood remained open, including inadequate protection from harm, behavioral, habilitation, and communication services, and health care, as all of these deficiencies are likely to have ongoing effects that the State must take adequate measures to ameliorate.

I. BACKGROUND

Rosewood was one of four residential centers operated by the Maryland Developmental Disabilities Administration ("DDA"). Located in Owings Mills, Maryland, which is approximately 20 miles outside of Baltimore, Maryland, Rosewood was licensed as a 257-bed intermediate care facility for individuals with mental retardation ("ICF/MR"). Additionally, Rosewood operated a forensic unit for individuals with developmental disabilities who have been involved in criminal proceedings.

II. FINDINGS

A. The Process Through Which the State Has Placed Rosewood's Residents Out of the Facility and Is Overseeing Their Transition from the Facility Substantially Departs from Generally Accepted Professional Standards and Exposes Them to Significant Risk of Harm.

We have significant concerns that the discharge process, which we understand was recently completed, may have exposed many of Rosewood's residents to grievous harm. According to the "Rosewood Progress Summary" dated October 8, 2008, which has been used by Rosewood's discharge planning team, at least 101 individuals at Rosewood had no placement target date, only nine months before all the individuals were placed. Given that only approximately 25 to 30 residents were placed from November 2007 to October 2008, Rosewood appears to have placed individuals into the community at an unprecedented rate to meet this schedule. Moreover, as discussed below, we found that, across disciplines, Rosewood's assessments were seriously deficient, and that the process put into place by the State to monitor individuals' well-being after they have been placed is significantly flawed. Furthermore, according to Rosewood's placement consultant, many of these individuals were awaiting housing renovations that take several months to complete. The delays in obtaining suitable housing arrangements, and the other deficiencies outlined above, raise grave concerns about whether individuals were rapidly placed into circumstances that expose them to harm. The

failure to meet individuals' needs in a timely manner jeopardizes their health and safety, with potentially tragic consequences.

Federal law requires that Rosewood have actively pursued the timely discharge of each resident to the most integrated, appropriate setting that is consistent with the resident's needs. Olmstead, 527 U.S. at 607. Thus, at the time of admission and throughout a resident's stay, Rosewood should have: (1) identified, through professional assessments, the factors that likely would foster a safe and successful transition to the most integrated setting appropriate for the resident's needs; and (2) used these factors to drive treatment planning, habilitation, and intervention. Without clear and purposeful identification of such factors, residents would be denied habilitation and other services and supports that would help them function successfully in the most integrated setting appropriate for their needs.

The Rosewood discharge planning and transition process has substantially deviated from generally accepted professional standards. As an initial matter, it is troubling that, in November 2007, Rosewood and the Maryland Developmental Disabilities Administration determined that the community was the most integrated setting for 92 percent of the individuals residing at Rosewood. The fact that the average length of institutionalization for residents at Rosewood is 30 years, and that some residents for whom community placement is planned have been institutionalized for more than 50 years, strongly suggests that Rosewood has not been actively pursuing the timely discharge of residents into the most integrated setting appropriate to their needs for many years.

More immediately, the State's and Rosewood's discharge planning and transition process has not adequately addressed the needs of the individuals who have recently been placed into other settings, exposing these individuals to significant risk of harm. As discussed in Sections II.C and II.D, below, Rosewood's medical, psychiatric, nutritional, behavioral, habilitation, vocational, and communication assessments were inadequate, undermining Rosewood's ability to determine the strengths and needs of individuals so they are placed in a safe and appropriate setting. These assessments, when performed, were often significantly outdated. For example, A.A.[1] has been diagnosed with multiple psychiatric disorders, for which he receives multiple psychotropic medications. His most recent psychiatric evaluation, and the one that was sent to prospective community providers, was dated February 5, 2001 – more than seven years before the date of

[1] To protect residents' privacy, we identify them by initials other than their own. We will separately transmit to the State a schedule that cross-references the initials with resident names.

our tour. Tellingly, Rosewood's placement consultant reported that community providers have complained that "new" behaviors and needs emerge after placement that they were not made aware of when accepting the individual into their program, suggesting that the information they were provided regarding the individual's needs was inadequate.

Furthermore, the discharge planning process that the State and Rosewood instituted has not resulted in a comprehensive picture of an individual's strengths and needs and has not identified essential information regarding the individual's health, psychiatric, and behavioral needs to effect a safe and meaningful transition. As noted, Rosewood's assessments across disciplines were inadequate, yielding an incomplete or inaccurate picture of the individual for community providers. Rosewood's and the State's discharge planning process has not identified these deficiencies in assessments, nor has the process required assessments to be updated before they were sent to providers or prior to discharge.

Similarly, the discharge planning process has not generated sufficient information about an individual in developing the discharge plan. Rosewood laudably instituted, as part of its discharge planning process, the Essential Lifestyle Plan ("ELP") method. We commend Rosewood on including this method in its discharge planning process, particularly for its focus on the individual's personal preferences in the transition to a more integrated setting. Nevertheless, we observed several of the ELP meetings during our tour and reviewed ELP plans for individuals whose ELP meeting has already been held, including meetings and plans for B.B., C.C., D.D., and E.E. Although these meetings produced information about the individuals' preferences and desires, critical information about the individuals' needs was not discussed or included. Essential services, such as medical care, dental care, behavioral supports, communication supports, and vocational skills, were not addressed, and providers of these services at Rosewood were not in attendance at ELP meetings. Historical information in these disciplines was also not included in the plans we reviewed, including the failure to include psychotropic medication history and descriptions of the individual's behavioral symptoms associated with the psychiatric diagnosis. The failure to account for such fundamental information in planning and providing for individuals' transition from the facility is a gross violation of generally accepted professional standards of care that reduces important placement decisions to guesswork, leaves providers ill-equipped to address the individuals' needs, and exposes individuals to a significant risk of harm.

Rosewood's and the State's discharge planning process also contains inadequate follow-up activities after the individual has been placed into the community, and the information that has been gathered reveals that services often were not in place at time of discharge or performed as required by the placement

plan. According to policy, site reviews of the community placement are supposed to be conducted after 30, 60, 90, and 180 days and memorialized in a monitoring report. However, these site reviews lack a standard format to assess quality indicators and ensure that the placement is appropriate and the placement plan is being followed. Without a structured and consistent monitoring approach, it is not possible to identify problematic trends reliably so that systemic remedial actions can be instituted.

Further, as discussed previously, if it is true that community monitoring reports have not been in Rosewood's possession, this indicates a serious deficiency in Rosewood's and the State's discharge planning process. Information regarding the effectiveness of the placement and the discharge planning process, including the adequacy of the assessments and the discharge plan, is essential to correcting problems in the process and maintaining adequate discharge planning.

Our review of the small number of periodic monitoring reports Rosewood did provide revealed troubling lapses in services for the individuals who have been discharged. For example, according to A.A.'s 90-day monitoring report, his nursing assessment has still not been completed three months after his placement, he has not had an ophthalmology appointment as recommended by Rosewood, and he missed his dental appointment. F.F. was discharged on March 21, 2008, but his 60-day monitoring visit was not performed until June 23, 2008, more than 90 days after his discharge. His 60-day monitoring visit found that his individual service plan for his residential and day programs was missing information. On July 24, 2008, F.F. was given a new service coordinator: his fifth coordinator in the four months since he had been discharged. G.G., who was at Rosewood for 51 years, was discharged on January 14, 2008, without appropriate community-based day services in place. According to the monitoring reports, appropriate day services had not been arranged by August 13, 2008, seven months after her placement. The monitoring reports for G.G. also revealed that there had been four case manager changes since she left Rosewood, her "waiver paperwork" – presumably related to her funding – was not completed for months after her placement, and her "30-day" individual service plan meeting was not held until 65 days after her placement. These monitoring reports disclose a discharge process that is uncoordinated and lacking in resources, exposing these individuals to lapses in care and services that could result in significant harm.

Our interviews with Rosewood's facility director and placement consultant indicated that they were aware of deficiencies in the assessments and discharge planning provided at Rosewood. However, they also appeared to be aware of many of the deficiencies in the care provided at Rosewood and the corresponding potential for harm. It appeared that they believed that transition to outside placements, even without adequate assessments and discharge plans, was preferable to

continuing to house individuals at Rosewood because discharging them posed less risk of harm. We do not question this conclusion, but we have grave concerns that the shortcomings in assessments and discharge planning outlined above will result in tragedy, especially for person who are medically and behaviorally fragile, and must be addressed.

B. Rosewood Did Not Protect Individuals From Harm in Accordance with Constitutional Standards.

The Supreme Court has recognized that persons with developmental disabilities who reside in state-operated institutions have a "constitutionally protected liberty interest in safety." Youngberg, 457 U.S. at 318. Therefore, as the Court explained, the state "has the unquestioned duty to provide reasonable safety for all residents" within the institution. Id. at 324. Rosewood failed to provide a living environment that complied with this constitutional mandate. Individuals residing at Rosewood were subject to frequent injuries that often resulted in serious harm, to unchecked self-injurious behavior, and to neglect. Rosewood's ability to address this harm was hampered by inadequate incident, risk, and quality management systems, including deficient investigative practices. Moreover, Rosewood's use of restraints and restrictive interventions substantially departed from generally accepted professional standards. This harm undermined the other care and treatment provided at Rosewood and may have prolonged the time periods that individuals were institutionalized in violation of Olmstead. In short, Rosewood's failure to protect its residents from harm violated their constitutional rights, and these violations may have lingering effects that must be addressed by the State in their current placements.

1. Inadequate Incident and Risk Management

In accordance with Youngberg and generally accepted professional standards, Rosewood should have had in place an incident and risk management system that was designed to prevent incidents of harm to residents and that ensured appropriate corrective action when such incidents did occur. An effective incident and risk management system depends on: (1) accurate data collection and reporting; (2) thorough investigations; (3) identification of actual or potential risks of harm, including the tracking and trending of data; and (4) implementation and monitoring of effective corrective and/or preventive actions. Rosewood's incident and risk management system fell significantly short of these standards. Although we found that Rosewood improved its incident reporting process during the months

before our tour,[2] Rosewood performed inadequate investigations and failed to identify risks and to implement corrective actions. Moreover, Rosewood's incident management process did not have adequate oversight by qualified staff members. As a result, residents living at Rosewood were routinely exposed to actual and potential harm that may have lingering effects on these individuals in their current placements.

a. Inadequate Investigative Practices

To comply with Youngberg's guarantee of reasonable safety, facilities like Rosewood must investigate serious incidents such as alleged abuse and neglect, serious injury, and death. During the investigation, evidence should be systematically identified, collected, preserved, analyzed, and presented. Investigators should attempt to determine the underlying cause of the incident by, among other things, reviewing staff's adherence to programmatic requirements such as policies and procedures.

The investigative process at Rosewood significantly departed from these standards. Investigation reports often lacked written statements from key witnesses and other staffing information relevant to the incident. Moreover, most investigation reports failed to include a complete or thoughtful analysis of the information gathered. Even when Rosewood investigators conducted interviews of witnesses, summaries were rarely recorded or maintained.

One indication of poor investigative practices is a high number of injuries for which a cause cannot be determined. At Rosewood, almost twenty percent of injuries reported and investigated from August 2007 to October 2008 were "of unknown origin." The high percentage of injuries arising from unknown causes strongly suggests a failure to conduct thorough investigations. These are not merely minor injuries for which the origin is unknown: H.H. suffered a fractured clavicle on February 7, 2008, and Rosewood was unable to identify a possible cause.

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[2] Despite improvements in incident reporting shortly before Rosewood's closure, we nevertheless noted a few incidents that were unreported that raise concern. For example, in June 2007 Rosewood had x-rays performed on one individual to determine if he had swallowed any foreign objects. The x-ray revealed that the individual had several fractured ribs, but this injury was not reported or investigated. In May 2008, the same individual, who requires a special diet and supervision due to repeated eating difficulties, had a gagging episode that was recorded in the nursing notes but was not reported as an incident and was not investigated. While we commend Rosewood's efforts to improve the incident reporting process, these reporting failures are troubling.

Despite the severity of the injury, Rosewood's investigation report failed to include written statements by witnesses, summaries or other evidence that witness interviews were conducted, or any analysis of available information. In light of the injury's unknown origin, Rosewood's failure to include these elements in the investigation is particularly troubling. The failure to perform an adequate investigation of this injury is a substantial departure from generally accepted professional standards. Moreover, as discussed in more detail in the next section, the incompleteness of this investigation is particularly troubling in light of the pattern of shoulder and arm injuries at Rosewood occurring from December 2007 to April 2008.

Another example of Rosewood's inadequate investigatory practices is the May 2008 investigation and mortality review of I.I. In early April, I.I. suffered from severe constipation. Rosewood staff attempted various interventions with no success. On April 4, 2008, a staff member ordered the administration of magnesium citrate, a laxative, to be carried out during the "next shift." Although the magnesium citrate was unsuccessful, I.I. was not transferred to Northwest Hospital Center until April 6, 2008, two days after the unsuccessful use of magnesium citrate. At Northwest Hospital Center, he exhibited symptoms of increased abdominal distention and decreased respiration. Shortly thereafter, I.I. was diagnosed with obstipation (severe constipation), a swallowing disorder, and aspiration pneumonia. After spending time in both Northwest and Rosewood's hospice care, I.I. died on May 5, 2008. His death certificate listed his cause of death as "atherosclerotic heart disease," a condition ostensibly unrelated to his reason for hospitalization.

Nevertheless, Rosewood's internal investigation into I.I.'s death substantially departed from generally accepted professional standards. The investigation failed to analyze several factors that could have contributed to I.I.'s death, including factors suggesting that I.I. did not receive adequate care and clinical services while at Rosewood. The investigator failed to explore whether I.I.'s bowel management regimen was adhered to by Rosewood staff in the days preceding his hospitalization. Similarly, the investigator did not evaluate the timeliness of Rosewood's decision to transfer I.I. in light of the fact that attempted interventions were unsuccessful in relieving his severe constipation. Moreover, the investigation did not evaluate Rosewood's decision to hold the administration of magnesium citrate until the following shift. There is also no evidence that Rosewood identified I.I.'s swallowing disorder before he was admitted to the hospital, and there was no analysis of whether this failure was excusable. Additionally, the investigation and mortality review did not include the results of a comprehensive medical record review for I.I. Critically, the investigation and mortality review failed to consider whether the care and services I.I. received at Rosewood, or the lack thereof, contributed to his death in any way.

Rosewood's failure to investigate incidents adequately, particularly incidents of this magnitude, significantly departed from generally accepted professional standards. Without adequate investigation, Rosewood was unable to identify the factors that led to the incident and take corrective action, thus exposing residents then residing at Rosewood to a continued risk of harm. Moreover, for many of Rosewood's residents, the harm that they suffered or were exposed to during their residence at Rosewood impaired the other care and treatment they received and may have lingering effects in their current placements.

b. Failure to Identify Risk of Harm and to Take Sufficient Preventive Actions

Rosewood's risk management systems failed to identify risk of harm adequately based on the incident data collected, and, even when risk of harm was identified, Rosewood failed to take sufficient and timely action to prevent the harm from occurring or recurring. Generally accepted professional standards dictate that a facility's risk management program: (1) identify actual or potential risks of harm based on historical data, diagnoses, and co-occurring conditions; (2) develop timely and appropriate interventions designed to reduce or eliminate the risks of harm; and (3) monitor the efficacy of the interventions and modify them as necessary in response to further data. Rosewood substantially departed from each of these standards, resulting in violations of the constitutional rights of Rosewood's former residents.

Our review found evident trends in Rosewood's existing incident data. Nevertheless, Rosewood failed to identify, analyze, or correct such continuing patterns of incidents and injuries. We found numerous examples of significant incidents or escalating patterns of incidents that remained unaddressed. For example:

- From August 2007 to July 2008, J.J. suffered 17 injuries, although he was on one-to-one supervision, 24 hours a day, for that entire period. There is no evidence that Rosewood examined the effectiveness of J.J.'s staff supervision or otherwise made recommendations to reduce the number of injuries to this individual.

- From August 2007 to July 2008, K.K. suffered 29 injuries. There is no evidence that Rosewood identified or analyzed this pattern of injury. Moreover, Rosewood's Standing Committee, which is responsible for reviewing incidents and investigations, made no recommendation to facility staff to reduce the number of injuries to K.K.

- As previously discussed, Rosewood has a high number of injuries of unknown origin: almost twenty percent of all reported injuries between August 2007 and October 2008. This high rate suggests a failure to recognize a trend in injuries of unknown origin and respond appropriately. While it suggests a failure to perform adequate investigations as discussed above, it also suggests that individuals are not receiving a level of supervision sufficient to protect them from harm, whether inflicted by themselves or other residents. There is no evidence that Rosewood identified or in any way addressed this troubling pattern of injuries.

- From December 2007 to April 2008, three residents suffered fractured clavicles, including H.H.'s fractured clavicle discussed previously, and one resident suffered a compound fracture of her arm. Even though two of the residents lived in the same housing unit, Rosewood took no action to identify or investigate this pattern of shoulder and arm injuries or to take any corrective measure that would reduce the risk of similar harm to residents. All four injuries were deemed to be of unknown origin by Rosewood without further analysis or investigation.

The failure to identify actual or potential risks to residents and respond with appropriate interventions is a significant departure from generally accepted professional standards. Even when risks were identified, however, Rosewood inadequately addressed those known risks and failed to monitor interventions to determine whether they were effective. For example:

- On September 30, 2008, L.L. choked on a dinner roll while on an outing to a restaurant. Rosewood had previously identified that L.L. requires a ground diet, verbal prompts, and supervision to monitor his rate of eating. Nevertheless, following this incident Rosewood made no recommendation for counseling, retraining, or disciplinary action for the staff involved, or any other corrective action. Four days later, L.L. was admitted to the hospital with a diagnosis of possible aspiration pneumonia. Rosewood did not investigate whether there was a link between the choking incident and the aspiration pneumonia or make any recommendation for follow-up action. The failure to investigate the possible relationship between the choking incident and the aspiration pneumonia, to recommend reevaluation of L.L.'s mealtime supervision, and to implement corrective action, left L.L. at risk for a repeat choking incident or another case of aspiration pneumonia.

- In January 2008, M.M. reported to staff that he was sexually assaulted by another resident. M.M. was on one-to-one supervision at the time of the alleged assault. Rosewood investigated and determined that sexual activity did occur, but concluded that it was consensual. The investigation also

indicated that M.M. was not properly supervised at the time the incident occurred, but Rosewood made no recommendation for counseling, retraining, or disciplinary action for the staff members assigned to M.M.

- N.N. experienced at least three choking incidents from April 2007 to May 2008. After the first choking episode, Rosewood performed a swallowing assessment and designed a meal plan requiring close supervision during meals, with a staff member prompting him not to eat too quickly. The investigation into this incident found that staffing during the incident was "two below legal," but the report made no recommendation regarding staffing. Despite the formulation of the meal plan, N.N. continued to experience choking incidents. We observed N.N. several times during our tour, and we found that Rosewood staff continued to fail to implement his eating guidelines. During none of our observations did a staff member prompt him to eat less quickly, despite his rapid consumption of food. Additionally, we observed other instances in which he was not closely supervised during eating.

As shown above, Rosewood consistently failed to analyze patterns and trends in incidents and injuries. Even when staff members identified the potential for harm or a recurring pattern of harm, Rosewood often failed to make recommendations to reduce the potential for harm and to implement corrective actions. When made, recommendations for corrective action were often insufficient to address the problems of supervision, care, and treatment identified by the investigation. Where corrective actions were implemented, such as the meal plan for N.N., Rosewood did not monitor their implementation sufficiently to determine whether the corrective action was effective to address the potential for harm. These failures not only resulted in harm, they also jeopardized the other care and treatment provided at Rosewood, resulting in long-term harm to these individuals that violates their constitutional rights under Youngberg and their statutory rights under Olmstead.

c. Inadequate Quality Management

To meet Youngberg's standards, a facility like Rosewood must develop and maintain an integrated system to monitor and ensure quality of care across all aspects of care and treatment. An effective quality management program must incorporate adequate systems for data capture, retrieval, and statistical analysis to identify and track trends. The program should also include a process for monitoring the effectiveness of corrective actions taken in response to problems that are discovered. Quality management activities should include regular observations throughout the facility, as well as interviews with staff members, residents, and their families concerning the adequacy of services provided. Any committee,

system, or process for monitoring should be objective and be overseen by qualified staff members.

Rosewood's quality management systems substantially departed from generally accepted professional standards. First, the Rosewood Standing Committee, designed to oversee quality, incident, and risk management, routinely failed to identify inadequacies in these systems and thus failed to reduce the risk of harm to residents. Documentation of Standing Committee meetings demonstrates that review of incidents, investigations, and corrective actions was cursory. Review of the Standing Committee minutes revealed that from January 10, 2008 to August 7, 2008, every incident report the committee reviewed was marked "Approved." The minutes do not indicate that the Committee evaluated or discussed the quality of any investigations or corrective actions. The minutes for the January 10, 2008, meeting, which lasted an hour and fifteen minutes, indicate that the Standing Committee reviewed seventeen incidents, including one death, and nine instances of restrictive behavior management intervention. Thus, according to Rosewood's own minutes, the Standing Committee spent an average of less than three minutes on each incident or intervention. At another meeting held February 14, 2008, the minutes indicate that the Standing Committee performed 108 reviews of: annual health care service plans, which include restrictive interventions for medical appointments; behavior intervention plans, including restrictive interventions such as the use of physical restraints and one-to-one supervision; and incident reports, including a death, allegations of abuse, and various injuries. The minutes indicate that each item was approved, and they do not indicate that any questions were raised about any item. The Standing Committee chairperson indicated that meetings typically last between one and two hours, suggesting that, even if the February 14, 2008, meeting lasted two hours, the committee spent an average of barely a minute on each item. In short, the review and oversight performed by Rosewood's Standing Committee substantially departed from generally accepted professional standards and violated the constitutional rights of Rosewood's former residents.

Additionally, the composition of the Standing Committee substantially departed from generally accepted professional standards. During our investigation, the chairperson of the Standing Committee served as both committee chair and lead investigator of serious injuries and deaths suffered by Rosewood residents. The chairperson's dual function presented a conflict of interest, as committee members were charged with reviewing the quality of the chairperson's investigations. Moreover, the Standing Committee did not have as regular members a registered nurse, physician, or staff member with expertise in behavior management. The lack of input from qualified staff was detrimental to an effective review by the Standing Committee, because many reported incidents at Rosewood were the result of resident maladaptive behavior.

Second, Rosewood's Quality Assurance Department failed to ensure that the facility protected resident health and safety and provides quality services. Rosewood's Quality Assurance Department consisted of a Director, a Compliance Officer, a nurse, a part-time investigator, and support staff. According to the Director, the only regular internal quality assurance activity, other than the incident management described above, was an ongoing audit of program and medical records conducted by the Quality Assurance nurse. The Director confirmed that the Quality Assurance Department did not track or trend key indicators of harm to residents, nor did it conduct periodic reviews of the environment or observations of residents to determine if resident program plans were being implemented, and there were no regular interviews with staff to determine the adequacy of their training or understanding of resident treatment plans.

Moreover, the audits performed by the Quality Assurance nurse were inadequate. Her review of program and medical records merely evaluated whether record-keeping procedures were followed and did not undertake any qualitative review of the services provided. For example, while the Quality Assurance nurse ensured that certain documents were in the record, that they were signed, and that nursing assessments were conducted in a timely manner, she did not review whether the assessments were adequate or whether needed interventions were identified and implemented. Furthermore, even when problems were identified, there was no process in place to ensure that they were rectified.

Because of these deficiencies in Rosewood's Standing Committee and Quality Assurance Department, Rosewood's quality management systems substantially departed from generally accepted professional standards and exposed residents living at Rosewood to a significant risk of harm that may have lingering effects on these individuals' care, treatment, and well-being.

2. Inappropriate Restraint Usage

Constitutional standards require that, in an institution like Rosewood, restraints only be used when imminent risk of harm to oneself or others is present. Moreover, Rosewood must have effective procedures in place to safeguard individuals for whom a proposed behavior management program includes a restraint or other restrictive intervention. These procedures must include the receipt of written informed consent and review by the Standing Committee. The committee review should consider whether less restrictive measures to change the resident's maladaptive behavior have been attempted and failed; whether the intervention proposed is the least restrictive intervention likely to be effective; and whether the behavior management plan includes an active treatment component to reduce or eliminate relying upon the restrictive technique. Our review of

Rosewood's records indicated that Rosewood's restraint practices substantially departed from generally accepted professional standards.

As an initial matter, we were unable to discern the overall rate of use of restraints at Rosewood because the facility's reporting of the use of restraints, including the type of restraint and whether any injury occurred, was unreliable. The reports on restraint use that Rosewood provided to us indicated that from August 2007 to September 2008, Rosewood staff used restraints in 15 instances on five residents. Our review of a sample of individuals' records, however, indicated that the actual use of restraints was higher than reported by Rosewood, including the use of restraints for medical and dental procedures as discussed in more detail below. Furthermore, the use of restraints that Rosewood did report suggested the use of practices that substantially depart from generally accepted professional standards. For example, on October 19, 2007, a Rosewood staff member placed a resident in a prone restraint, a highly dangerous technique that exposes the restrained individual to significant risk of harm, including death.

Rosewood routinely used restraints for medical and dental procedures without evidence that less restrictive measures were attempted and failed. Behavior support plans ("BSPs") for these individuals did not include any interventions to reduce or eliminate the need for the restraint, such as a desensitization plan. For example, Rosewood authorized the use of a manual hold on N.N. to undergo medical procedures, and his active treatment program did not reflect any intervention to reduce reliance upon this restraint. O.O. and P.P. were both restrained on a papoose board for dental procedures, but there was no documented evidence that less restrictive measures were attempted. Although the use of restraints for dental procedures appeared to have declined during our investigation, the failure to ensure that appropriate safeguards were taken before restrictive interventions were used was a substantial departure from generally accepted professional standards.

Moreover, Rosewood's Standing Committee did not conduct substantive reviews of all BSPs that include restrictive interventions. For example, as discussed previously, the minutes from the February 14, 2008, meeting indicate that the Standing Committed reviewed 108 annual health care service plans. Each plan describes various interventions needed for residents to cooperate with medical appointments, including the use of seatbelt wheelchair restraints, the use of helmets, and the assignment of residents to locked buildings. The Committee minutes denote each restrictive intervention as "approved," yet do not reflect any discussion weighing the effectiveness or restrictiveness of each intervention. Moreover, because Committee meetings typically last one to two hours, it is highly unlikely that any substantive discussion of the appropriateness of the interventions occurred.

Separately, Rosewood's system for obtaining informed consent for restrictive behavior management programs was inadequate. At Rosewood, written consent to use restrictive interventions was not consistently informed. Although Rosewood's consent form included a standardized paragraph stating that the benefits of the proposed intervention outweigh the risks involved, the form did not consistently include information specific to the particular intervention proposed. Moreover, side effects information was rarely included on medication consent forms.

Rosewood's failure to review and oversee appropriately the use of restraints and restrictive interventions was a substantial departure from generally accepted professional standards and violated the restrained individuals' constitutional rights. Moreover, the unjustified and unlawful use of restrictive interventions, particularly the ongoing use of restraints for medical and dental procedures without any attempts to reduce reliance on the restraint, is likely to have lingering negative effects on them.

C. Rosewood's Behavioral, Habilitation, and Communication Services Substantially Departed From Generally Accepted Professional Standards and Exposed Its Residents to Significant Risk of Harm.

Rosewood's residents are entitled to "the minimally adequate training required by the Constitution . . . as may be reasonable in light of [the residents'] liberty interests in safety and freedom from unreasonable restraints." Youngberg, 457 U.S. at 322. A central purpose of this training is to enable the movement of individuals into the most integrated setting appropriate to their needs as required by Olmstead. 527 U.S. at 607. These standards require that appropriate psychological interventions, such as behavior programs and habilitation plans,[3] be used to address significant behavior problems and assist residents to live in more integrated settings. Rosewood's behavioral, habilitation, and communication services were critically deficient, in part because Rosewood provided inadequate assessments in each of these areas. Adequate assessments are the essential underpinning to the provision of adequate services; without an accurate and comprehensive understanding of the needs and strengths of the individual who is being treated, the treatments themselves cannot be adequate. The failures in these services have resulted in ongoing harm to individuals who have resided at Rosewood, and the State must remedy the lingering effects of this harm.

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[3] Habilitation includes, but is not limited to, individualized training, education, and skill acquisition programs developed and implemented by interdisciplinary teams to promote the growth, development, and independence of individuals.

1. Ineffective Behavior Programs

Challenging, even harmful ("maladaptive") behaviors frequently can be an issue for persons with developmental disabilities, and are often one of the reasons an individual is placed in an institutional setting. The harm from such behaviors can be severe, even fatal. Examples include punching, slapping, scratching oneself or others, intentionally destroying property, or pica.[4] The causes of these behaviors often reflect the primary characteristic of developmental disability – difficulty learning, in this case, learning effective and healthy ways to meet one's needs and wants.

Numerous individuals at Rosewood exhibited challenging behaviors that Rosewood did not adequately address, resulting in repeated instances of harm to those individuals. H.H. exhibited a behavior in which he struck his head against walls with such force that he injured his head and caused damage to the wall. In the building in which H.H. lived, the walls were lined with indentations at the height of his head, demonstrating the repeated nature of this behavior. In 2007 and 2008, H.H. suffered multiple injuries due to self-injurious behaviors, including fractures, facial bruising, and head lacerations requiring sutures to close. Many of these injuries were not observed by staff, but often the cause of the injury is reported as due to a "history of running into walls." Several other individuals, including Q.Q. and R.R., have long histories of repeated self-injurious and/or aggressive behaviors, such as hitting their own heads, biting arms, and attacking others, resulting in injury. The failure to address these behaviors adequately likely results in ongoing harm to these individuals and impair their progress in treatment and habilitation. Rosewood's failure to provide adequate behavior programs before these individuals were discharged suggests that these individuals may still be receiving inadequate treatment and may have been placed into settings that are unnecessarily restrictive or that are inadequate to meet the individuals' needs.

Other individuals, such as I.I. and J.J., suffered similar injuries within a short period of time, suggesting a failure to understand the cause of the first injury and implement a behavior intervention to address it. Within three weeks in March 2008, I.I. removed two of his own teeth. On February 20, 2008, J.J. became upset, bit himself on the right forearm, and hit his head against the wall. Four months later, on June 28, 2008, J.J. became upset, bit his forearm until it bled, and hit himself in the eye. We found no evidence that Rosewood revised these individuals' BSPs in response to the initial incident. Rosewood's failure to respond

[4] Pica is a condition in which a person ingests or attempts to ingest nonfood substances such as clay, chalk, hair, or glue.

appropriately to the initial harm placed these individuals at continued risk of harm, a risk that, for J.J. and I.I., materialized into actual harm.

Additionally, we found that Rosewood substantially departed from generally accepted professional standards concerning the use of psychotropic medication for individuals with intellectual disabilities, suggesting that psychotropic medications were used in place of adequate behavior programs. Our review found a pattern of continuing individuals on high dosages of antipsychotic agents despite the lack of any empirical evidence that the medication had been helpful. At the time of our review, 58 of the 128 individuals at Rosewood received psychotropic medications, and 42 of these individuals received multiple psychotropic medications. However, our review found that the psychiatrist generally did not use behavioral information, such as frequency or intensity of target behaviors, to evaluate the efficacy of the psychotropic medication, and there was a lack of coordination between psychiatric and behavioral services. Continuation of high dosages of psychotropic medication that is not justified by empirical, clinical evidence often has long-term negative effects, such as tardive dyskinesia, that may continue in the individuals' new placements and must be ameliorated.

Remarkably, according to the records provided to us by Rosewood, it appears that less than one-half (27 out of 58) of the individuals who received psychotropic medications had ever had a psychiatric evaluation. The failure to provide a psychiatric evaluation for persons receiving psychotropic medications is an egregious departure from generally accepted professional standards. Furthermore, this practice indicates that psychotropic medications were being used in place of behavioral supports.[5] Compounding this problem was the considerable variance in the quality of the psychiatric evaluations that have been performed, as well as the lack of current evaluations. For example, according to the records Rosewood provided, some individuals had not had a comprehensive psychiatric evaluation in many years: S.S.'s most recent evaluation was on September 24, 1992; T.T.'s most recent evaluation was on February 8, 1993; U.U.'s most recent evaluation was on January 8, 1997; and V.V.'s most recent evaluation was on November 13, 1998. The lack of current evaluations, combined with the lack of coordination between psychiatric and behavioral services, strongly suggests that psychotropic medications were being improperly used as a means of chemical restraint to control behavior, in lieu of therapeutic behavioral interventions. Moreover, not all individuals at Rosewood who received psychotropic medications had a behavior support plan in

[5] If Rosewood's records were wrong, and the remaining 31 individuals did receive a psychiatric evaluation, Rosewood's failure to track this information accurately would also have been a substantial departure from generally accepted professional standards that exposed these individuals to harm.

place: Rosewood reported that 58 individuals were on psychotropic medications, but only 54 individuals had a behavior support plan. Therefore, at least four individuals did not have a behavior support plan despite being on psychotropic medications.

In addition, the behavioral interventions that Rosewood did develop substantially departed from generally accepted professional standards. Generally accepted professional standards of practice provide that behavioral interventions should be: (1) based upon adequate assessments of the causes and "function" (i.e., purpose) of the behavior; (2) be based on the individual's strengths; (3) be implemented as written; and (4) be monitored and evaluated adequately. Ineffective behavioral interventions increase the likelihood that residents engage in maladaptive behaviors, subjecting them to unnecessarily restrictive interventions and treatments. Rosewood's behavioral interventions were often not effective. In particular, they often were not based on adequate assessments and often were not monitored, evaluated, and revised adequately.

a. Behavioral Assessments Substantially Departed From Generally Accepted Professional Standards

Without a thorough assessment of the function of an individual's maladaptive behavior, including clearly identified, appropriate replacement behaviors, behavioral interventions will not be successful in modifying the maladaptive behavior. In this regard, a functional assessment identifies the particular positive or negative factors that prompt or maintain a challenging behavior for a given individual. By understanding the precursors and, separately, the purposes or "functions," of challenging behaviors, professionals can attempt to reduce or eliminate these factors' influence, and thus reduce or eliminate the challenging behaviors. Without such informed understanding of the cause of behaviors, attempted treatments are arbitrary and ineffective.

Rosewood's functional assessments were not adequate for this purpose. The functional assessments that we reviewed all contained significant omissions, including:

- Demographic information, including the individual's social history and treatment experiences;
- Assessment tools used to determine the function of behavior;
- Antecedent, behavior, and consequence ("ABC") data, with analysis;
- Information from the interdisciplinary team;

- Information from direct care staff interviews;
- Structured direct observation data, performed over time and across settings;
- Preference and reinforcement assessments;
- Medical information, particularly about health problems that influence behavior;
- Mental health information, including DSM-IV[6] diagnoses and a description of the clinical and behavioral manifestations associated with each diagnosis;
- A summary of the assessment; and
- Recommended treatments and interventions for developing new skills and replacement behaviors.

The failure to include these elements in the functional assessment of individuals at Rosewood was a substantial departure from generally accepted professional standards. More specifically, without this information, the behavior assessment cannot adequately provide a comprehensive understanding of the individual or effectively guide selection of replacement behaviors or intervention procedures, and the resulting BSP will typically fail to address the individual's maladaptive behaviors. The failure to provide an adequate BSP that addresses these behaviors impairs individuals' ability to move successfully to, and succeed in, less restrictive settings.

Relatedly, we found that the conclusions formed in the assessments were generic, rather than specific to the individual. For example, many of the assessments we reviewed hypothesized that the function of the individual's maladaptive behavior was to "avoid/escape nonpreferred activity and attempt to communicate/express feelings." While this hypothesis may have been generally accurate, it was insufficient to guide selection of replacement behaviors or intervention procedures.

Furthermore, maladaptive behavior is frequently a form of communication for persons with developmental disabilities who lack the tools to communicate more conventionally. Consequently, although a complete functional assessment should address communication, a separate, reliable communication assessment should be

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[6] DSM-IV refers to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

routinely used to identify the role of communication in an individual's maladaptive behaviors and, separately, as discussed below regarding habilitation, to identify appropriate learning objectives and interventions. Relatedly, another common cause of maladaptive behavior is pain. Failure to respond to pain in a timely manner leads to avoidable suffering and is recognized as contributing to increases in maladaptive behaviors. As discussed in more detail below, Rosewood's communication assessments and services were insufficient to meet the needs of the numerous individuals at Rosewood who suffer from speech and language difficulties. The failure to provide adequate communication services undermined Rosewood's ability to provide adequate behavioral services and to transition its residents successfully into less restrictive settings.

b. Inappropriate, Insufficient, or Non-Existent Behavioral Interventions

To meet constitutional standards, effective behavioral interventions should target the function of the maladaptive behavior to the maximum extent possible and be built on replacing the maladaptive behavior with a healthy alternative behavior that serves the same function. To a lesser extent, behavioral interventions may include modifying the environmental causes of the maladaptive behavior. Although effective behavioral interventions typically include a means of redirecting an individual from a maladaptive behavior, this is distinct from seeking only to control or suppress the maladaptive behavior.

Behavioral interventions at Rosewood substantially departed from generally accepted professional standards in important respects. Rosewood's interventions and replacement behaviors, when included, were often generic and did not include information about the individual's personal preferences, skills, and abilities that could be used to build a lifestyle of positive behaviors that would replace the maladaptive behaviors. Replacement behaviors and strategies to reinforce those behaviors were often not related to the function of the maladaptive behavior, and were not designed to promote independence so that the individual could move into the community successfully. Where psychotropic medication was used to address maladaptive behaviors, the rationale for the use of the psychotropic medication did not address the relationship between the psychiatric diagnosis and the behaviors exhibited.

Moreover, we found multiple examples of individuals who had been identified as having significant maladaptive behaviors but who nevertheless were not receiving structured behavioral interventions to address these behaviors. For instance, as previously discussed, although 54 individuals at Rosewood had a BSP, 58 individuals received psychotropic medications, suggesting that at least four individuals with significant maladaptive behaviors did not receive behavioral

support services and did not even have a BSP in place to address their challenging behaviors. Furthermore, our review found that seven individuals had BSPs for pica, but we found that at least two additional individuals had exhibited pica behavior but did not have a BSP addressing it. Specifically, M.M. reported on February 18, 2008, that he swallowed four staples, and on June 13, 2008, staff found W.W. with foam from a cushion in her mouth. Neither individual had a BSP addressing pica. We also found that at least 16 individuals at Rosewood needed specialized behavioral services to address maladaptive sexual behavior. Eleven of these individuals were in sexual behavior support groups, and six were receiving therapy, but reportedly due to cost controls, Rosewood planned to discontinue the therapy. Many of these individuals were recommended for community placement, including at least two individuals, X.X. and Y.Y., who allegedly sexually assaulted minors before their admission to Rosewood. The failure to address these individuals' maladaptive behaviors significantly impairs these individuals' ability to live successfully in less restrictive settings.

c. Implementation of Behavioral Treatment Was Not Documented or Observed

Consistent and correct implementation of appropriate behavioral interventions is essential. As discussed above, however, Rosewood did not consistently or correctly implement behavior interventions required by the residents' BSPs. This may have been due, in part, to Rosewood's failure to institute a reliable system to verify staff members' ability to implement the requirements of the BSP. We could not find any evidence of a system to verify staff members' ability to implement BSPs, including such training as a "behavior drill." In a behavior drill, maladaptive behaviors are described by professional staff, and the competency of the direct care staff to implement the BSP is measured by their ability to respond appropriately. Further, we could not find any evidence that professional staff performed routine observations of individuals with BSPs to ensure that staff members were implementing the BSP correctly. This is a significant deficiency; without relative certainty that plans are being implemented as designed, it is impossible to determine whether a behavioral plan is effective.

During our tour, we observed several individuals engaging in behavior for which they have a BSP, but staff did not intervene as required by the BSP. For example, during a visit to Mandel Cottage on October 8, 2008, we observed Z.Z., H.H., and N.N. slapping their heads repeatedly, but staff failed to intervene as required by their BSPs. The failure to intervene as required by the BSP is a substantial departure from generally accepted professional standards and exposes these individuals to harm. Indeed, the multiple injuries suffered by H.H. that were reportedly unobserved by Rosewood staff members, despite the measures required by his BSP, demonstrate that harm actually occurred. Furthermore, the failure to

provide effective behavioral treatment compromises these individuals' ability to transition successfully to less restrictive settings and undermines the other treatment these individuals received while at Rosewood.

d. Monitoring and Evaluation of Behavioral Programs Was Inadequate

Constitutional standards require that facilities monitor residents who have behavior programs to assess the residents' progress and the program's efficacy. Without the necessary monitoring and evaluation, residents are in danger of being subjected to inadequate and unnecessarily restrictive treatment, to avoidable injuries related to untreated behaviors, and to unnecessarily prolonged institutionalization.

As indicated in the previous section, Rosewood did not assess, for clinical purposes, critical aspects of behavioral services at the facility, such as the development and update of functional assessments and staff implementation of programs. Further, as noted above, Rosewood relied extensively on psychotropic medications as a primary form of behavioral intervention, although Rosewood was seeking to reduce the use of psychotropics. Rosewood did not ensure, however, that psychiatric evaluations were conducted and routinely updated, or that data on target behaviors were routinely provided to the prescribing psychiatrist. As for traditional behavioral interventions, although Rosewood gathered some data to assess the interventions' efficacy, the facility lacked a standard, clinically justified method to gather data and confirm its accuracy. Additionally, the presence and absence of replacement behaviors that mitigate or prevent the maladaptive behavior's occurrence were not tracked. In short, Rosewood lacked a means to ensure that appropriate data were accurately and consistently reported.

Moreover, the BSPs we reviewed failed to provide adequate strategies for measuring the effectiveness of the plan. The outcomes emphasized by Rosewood to measure effectiveness focused on reducing the frequency of problem behaviors but failed to address improving skills or increasing independence adequately, jeopardizing the transition of Rosewood's residents into more integrated settings where these skills and independence are essential. Although all the BSPs we reviewed referred to collecting data regarding the occurrence of problem behaviors, none of the BSPs addressed the methods used to promote positive replacement behaviors. Teams did not monitor data regarding the individual's use of such behaviors, and Rosewood did not collect data tracking the delivery of positive reinforcement strategies.

e. Quality Assurance and Oversight of Behavioral Support Services Were Insufficient

Further, the safeguard of professional review and monitoring of behavioral services, as of our tour, was not taking place at Rosewood. These responsibilities generally fall on an adequate peer review process (an assessment of a practitioner's work by other professionals in the field to foster compliance with the generally accepted professional standards of the discipline) and a functioning behavior management review committee ("BMRC"). Neither of these important safeguards was functioning at Rosewood. Before implementation, BSPs were not reviewed by professionals with expertise in applied behavior analysis and the development and implementation of behavior supports, including, in particular, the use of positive behavior support strategies. Moreover, we found that the BMRC was not appropriately evaluating the content and quality of the behavior programs. Specifically, the BMRC did not ensure that BSPs included: (1) data that were reliable and supported the proposed interventions and replacement behaviors; (2) data-driven treatment that matched the function of the problem behavior; (3) clear implementation instructions; (4) clear and reliable means to assess the BSP's efficacy; and (5) restraints and right restrictions that were the least restrictive means necessary to protect the individual and others from harm. The BMRC's failure to provide critical and substantive review of behavior support plans permitted behavior programs to continue when these programs were ineffective, inefficient, and inconsistent. This failure to provide effective oversight impaired the ability of Rosewood's residents to progress in their treatment and hindered their ability to be transferred successfully to more integrated settings.

Additionally, as discussed in Sections II.B.1.c and II.B.2, above, Rosewood's Standing Committee approved, without modification, every plan submitted to it during the time of our review. Although these plans included restraints and restrictive interventions, there is no evidence that the Standing Committee, which was charged with reviewing incidents, investigations, allegations of abuse and neglect, and the use of restrictive behavior management techniques, provided any substantive review or discussion of these restrictions before approving them. The failure to provide adequate quality assurance and oversight of behavioral support services is a substantial departure from generally accepted professional standards, the effects of which may still linger in individuals' current placements.

2. Habilitation Programs Did Not Meet Generally Accepted Professional Standards

Persons with developmental disabilities are to receive adequate habilitation training and related vocational and day program services and supports so that they may acquire new skills, grow and develop, and enhance their independence, all of

which equip the individual to live successfully in more integrated settings. Federal regulations require that:

> Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services . . . that is directed toward – [t]he acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and . . . [t]he prevention or deceleration of regression or loss of current optimal functional status.

42 C.F.R. § 483.440(a). Rosewood's habilitation programs did not meet these requirements and were inconsistent with generally accepted professional standards. The failure to provide adequate habilitation programs violates the mandates set forth in Olmstead, 527 U.S. at 607, and, following Rosewood's closure, may have led to placement in inappropriately restrictive settings.

As an initial matter, and as indicated above, Rosewood did not conduct comprehensive functional assessments of its residents on a regular basis. The assessments we reviewed were not current at the time of the annual individual service plan meeting, nor were they current when provided to prospective community placement providers or at time of discharge. The failure to perform current assessments, especially as of the time of discharge, and to provide these assessments to prospective community placement providers strongly suggests that individuals may have been placed into settings that are inappropriate to their needs and may be more restrictive than necessary. When assessments were performed, they lacked sufficient detail and did not include a comparative analysis to the previous period of review, making it impossible to gauge whether the individual was progressing in the habilitation program while at Rosewood.

Moreover, the assessment results we reviewed were not integrated into a meaningful plan that was individualized to the preferences, skills, and needs of the resident, and functional and relevant objectives that lead toward independence and success in less restrictive settings were not being targeted. Similarly, the goals, objectives, and strategies included in habilitation plans were not behaviorally stated or measurable, again inhibiting Rosewood's ability to gauge whether the individual was progressing. The training schedules included in the plans were not individualized or implemented as developed and did not reflect the individual's preferred activities as identified in the person-centered planning process. Although Rosewood instituted a new treatment mall, the new programs were not individualized to the residents' needs and strengths. The majority of the training activities at Rosewood appeared to be nonfunctional, occupying individuals' time

but not addressing critical, functional objectives. Specifically, the training objectives at Rosewood did not appear to support the individual's independent functioning, to improve the individual's quality of life, or to facilitate a smoother and more immediate transition to the most integrated setting appropriate for the individual's needs. Relatedly, we found that only 10 of the 128 individuals at Rosewood at the time of our tour attended day programs off of the Rosewood campus, despite the State's plan to transition nearly all of these individuals to community settings. The following illustrate these findings:

- We observed A.B. and A.C., who are 48 and 56 years old, respectively, engaged in sorting shapes into a cube. It is unclear how this activity serves any functional purpose for these individuals.

- We observed A.D. engaged in sorting silverware into a silverware tray during his day program. After he completed sorting the silverware, the staff member emptied the tray and instructed him to do it again. While this activity could be functional in the proper context, the manner in which it was carried out had little therapeutic value.

- We observed staff coloring line drawings while the residents at the table sat idle, with little or no interaction from staff.

- We observed A.E., A.F., and A.G. seated in wheelchairs or lying on mat tables and positioned in front of a mirror. According to staff, the individuals had been placed in this manner for about 30 minutes so they could "look at themselves."

These activities offer little aid to these individuals in acquiring skills that support independent functioning and facilitate transition to the most integrated setting appropriate for their needs. The failure to provide meaningful habilitation activities on a consistent basis is a substantial departure from generally accepted professional standards. More specifically, Rosewood's failure to provide adequate active instruction and treatment denied individuals the opportunity to increase their independence and likely made it more difficult for them to transition to the most integrated setting appropriate for their needs. Indeed, this failure jeopardizes the success of these residents' recent movement to community placements, and the State must take steps to remedy any lingering effects of this inadequate treatment.

Additionally, individuals at Rosewood were typically not provided with alternative active treatment when they were unable to attend their normal day program due to health concerns. While some of these interruptions were relatively brief, others, such as those for A.H., A.I., and A.J., lasted from one week to five weeks. These lengthy interruptions were a significant delay in Rosewood's delivery

of habilitation services and could have led to regression or loss of functional abilities. They also strongly indicate that Rosewood did not provide individualized habilitation services as required by generally accepted professional standards. The failure to provide adequate habilitation services is particularly troubling in light of Rosewood's closure, as habilitation services are essential to preparing individuals for a more integrated environment.

Similarly, we found that the vocational aspect of Rosewood's training and habilitation services was inadequate. Rosewood lacked policies regarding the provision of vocational services, including policies regarding vocational assessments, development of individual job profiles and career plans, and development of employment opportunities. As a result, Rosewood did not provide comprehensive assessments that evaluated residents' vocational needs, interests, and aptitudes. Rosewood also did not perform a systematic assessment of work options in the anticipated community placement setting, so vocational plans, when made, were completed without regard to actual work opportunities.

Further, individuals' vocational needs and skills, including their employment histories and work experiences, were generally not integrated into the individual's support plan or into his or her discharge plan. We found several individuals who have worked during their time at Rosewood, but for whom the facility had made no plans for employment upon discharge from the facility. F.F.'s work experience included contract production mailings and janitorial work, but he had no employment plan when he was discharged on March 21, 2008, beyond the limited opportunities offered by his day program. E.E., who recently completed his GED, worked while at Rosewood, but had no community-based employment plan in place in October 2008, although he was scheduled to be discharged imminently.

In addition, we found that vocational opportunities at Rosewood were generally limited to options dependent on Rosewood operations and were not individualized to the residents' skills and abilities. For example, A.K. worked on the moving crew at Rosewood, and the plan in October 2008 was for him to continue to work at Rosewood after he had been moved to a community placement, as no community employment plans had been made for him at that time. Similarly, A.L. is a former Rosewood resident who has lived in the community for some time, but continued to work at Rosewood after his placement. It is unclear where or whether A.K. and A.L. will work now that Rosewood has closed.

Generally accepted professional standards suggest that the focus of treatment in a facility should address the barriers that prevent individuals from living successfully in community settings. An important part of habilitation is learning and using skills in the environment in which those skills are useful. The appropriate environment is one of the most powerful motivators for skill

acquisition, and this often will be in a community setting. In fact, generally accepted professional standards of care increasingly emphasize use of community settings for skills acquisition. Rosewood's lack of active instruction, treatment, and training in a community setting, coupled with the absence of vocational opportunities in discharge plans, greatly hindered success in this area. Rosewood's failure to provide adequate habilitation and training programs, including vocational services, is a substantial departure from generally accepted professional standards. This failure is particularly troubling given Rosewood's closure, as these programs are important elements in the successful transition into community placements. Rosewood's failure to provide adequate services in these areas jeopardizes its former residents' success in community settings and must be remedied if the State is to comply with the requirements of Youngberg and Olmstead.

3. Communication Services Were Not Adequate

If communication skills deteriorate or are not developed, individuals are more likely to be unable to convey basic needs and concerns, are more likely to engage in maladaptive behavior as a form of communication, and are more likely to be at risk of bodily injury, unnecessary psychotropic medications, and psychological harm from having no means to express needs and wants. Lack of communication skills will also make it more difficult for staff to recognize and diagnose health issues, such as pain, and will hinder an individual's ability to move to the most integrated setting appropriate for his or her needs as required by Olmstead. Rosewood failed to provide its residents with adequate and appropriate communication services and, at the time of our visit, lacked the resources to address this deficiency. This failure impaired Rosewood's ability to prepare its residents for transition into community settings during the recent closure in violation of these individuals' rights.

More specifically, Rosewood's speech and communication services were grossly insufficient to meet the needs of its residents. At the time of our visit, we found that nearly 80 percent of Rosewood residents had difficulty communicating, but according to Rosewood's records, only 13 individuals received communication programs. Rosewood's failure to provide adequate communication services was evident in the high frequency of maladaptive behaviors that have a communicative function. As noted previously, H.H. caused himself repeated injuries from hitting his head on the wall. Our expert found that this repeated self-injurious behavior was likely related to his inability to communicate in socially appropriate ways. Likewise, A.M. did not use typical communication methods. She was described as non-verbal, and had long history of pica, including ingestion of hair. We observed A.M. sitting in the dining room and waiting for her food for 26 minutes while other residents were served and eating. A.M. became increasingly agitated and attempted to scavenge objects from the floor. A staff member intervened and

returned A.M. to her chair, but A.M. began pulling at her own hair and placing it in her mouth. A staff member intervened occasionally, but A.M. succeeded in placing hair in her mouth on several occasions. The longstanding nature of H.H.'s and A.M.'s behavioral difficulties suggests a failure to identify the communication needs of these individuals and provide them with safe and acceptable methods of communication. Without appropriate communication training and services, individuals such as H.H. and A.M. were at significant risk of harm. This risk of harm likely continues in these individuals' current placements, as Rosewood did not recognize the risk and thus failed to communicate it to these individuals' current providers.

Rosewood's failure to provide adequate communication services began with inadequate assessments. At Rosewood, there was a clear absence of communication assessment strategies to identify communication needs and appropriate communication supports to improve communication and functional status. Similarly, Rosewood did not perform formal assistive technology or alternative augmentative communication assessments because there was a lack of equipment to provide those services. We did not observe any communication devices in use at Rosewood during our tour, although according to Rosewood records, at least two individuals, A.N. and A.O., had alternative augmentative communication devices. We observed A.O. several times during our tour, both in his residence and during meals, and a communication device was not accessible to him during these observations. Because of Rosewood's failure to provide adequate communication assessments, these individuals may still be without adequate communication services in their current placements, as their communication needs would not have been included in their discharge plan.

Furthermore, there was a significant lack of coordination between communication and behavior specialists in the development of habilitation, training, and behavioral interventions, whether or not a communication difficulty had been specifically identified. We found that communication specialists were generally not consulted regarding maladaptive behaviors or the development and implementation of plans for replacement behaviors in the BSP process. Likewise, there was a substantial deficit of speech and communication services in developing individual service plans. Communication specialists generally were not identified in the plan as the person responsible for developing a communication program when the maladaptive behavior has a communicative intent.

Similarly, we also noted that the facility served a significant number of individuals with hearing impairments. According to the Speech and Language Director, however, Rosewood did not have any data regarding the number of individuals with hearing impairments or total hearing loss. Furthermore, Rosewood did not provide treatment that was designed by trained professionals to

address the specialized needs of individuals with hearing loss. Where Rosewood does provide communication assistance to individuals with hearing loss, the program is often inappropriate or not implemented correctly. For example, A.P. had worn hearing aids in the past to address his hearing loss, but, at the time of our visit, refused to wear them. Rosewood did not implement any program interventions to address this refusal, such as desensitization training. Another individual, Q.Q., is deaf and, according to his individual service plan, had a full-time interpreter to accommodate his hearing loss. Rosewood only had one full-time interpreter, however, and during our observations of Q.Q., the interpreter was working with other residents and was not accessible to Q.Q. Rosewood's failure to provide adequate services to those with hearing impairments denies these individuals their voice, limited their ability to express preferences and choices, and deprived them of an opportunity to participate in their treatment. The failure to provide adequate services to those with hearing impairments may well continue in the individuals' current placements because, in most instances, Rosewood did not recognize its failure to provide these services and thus would not have indicated a need for them in the individuals' discharge plans.

D. Rosewood's Medical and Nursing Care Substantially Departed from Generally Accepted Professional Standards and Exposed Its Residents to Significant Risk of Harm.

The Supreme Court has determined that institutionalized persons with developmental disabilities are entitled to adequate medical care, Youngberg, 457 U.S. at 324. Indeed, adequate medical care is one of the "essentials of care that the State must provide." Id.

Rosewood did not provide adequate medical and nursing care. Both Rosewood's general approach to medical care and its execution of the specifics of such care were significantly flawed. In its approach, Rosewood was essentially reactive in the care it provided; the facility typically responded to health problems when those problems were brought to its attention, usually through health conditions reaching acute status. Adequate medical services are, in contrast, proactive. Such proactive services involve medical professionals accurately identifying at-risk individuals, performing regular assessments, and providing coordinated treatment before the onset of serious medical issues. Such proactive, rather than reactive, medical services are particularly necessary at a facility like Rosewood, where residents often had complex medical issues and frequently could not articulate their health status or communicate medical problems. The failure to provide proactive care that treats health conditions before they become acute can, in many instances, result in the degradation of a person's heath condition and make the individual more susceptible to adverse conditions in the future, such as infection or aspiration pneumonia. The lingering effects of these deficiencies may persist

after the individual's placement into the community and must be monitored closely to prevent further harm.

Rosewood's reactive approach often resulted in the delaying in, or absence of, necessary medical and nursing services. Further, the services Rosewood did provide were flawed. More particularly, Rosewood had inadequate nursing services, including inadequate assessments, nursing care plans, and quality assurance. In addition, Rosewood's infection control and physical and nutritional management services also departed from generally accepted professional standards and exposed residents to significant risk of harm. This risk of harm likely continues in the individuals' current community placements, because the inadequate assessments and care plans they received inhibited the ability to provide appropriate supports and services upon discharge.

1. Rosewood's Nursing Assessments and Nursing Care Plans Departed from Generally Accepted Professional Standards of Care

As noted above, a preliminary stage in providing appropriate medical care for this population is the screening of individuals to determine their health care needs and risk status. However, Rosewood often did not correctly identify which of its residents were at high-risk for a variety of significant medical issues common to the population it serves. Rosewood's lists of high-risk individuals often omitted residents that the facility's own medical records showed should be included, a phenomenon we discuss below in detail. Consequently, Rosewood did not fulfill the first requirement of adequate medical care. We have grave concerns that many of these individuals who are high-risk for certain conditions continue to be exposed to significant harm because their medical needs and risk status were not communicated to the providers in their current placement.

Furthermore, when high-risk individuals were correctly identified, the nursing assessments and nursing care plans for these individuals failed to meet generally accepted professional standards. These standards require nursing assessments to be designed to collect specific, individual data to assist the team and the individual with case formulation, diagnosis, and treatment planning. However, the nursing assessments we reviewed were replete with omissions; information that generally accepted professional standards require assessments to produce was often missing. Without adequate assessments, proactive care cannot be provided, whether at Rosewood or in the community.

Similar deficits existed in nursing care plans. Nursing care plans should contain nursing diagnoses, measurable outcomes, and, most crucially, additions to and deletions from the care plan as the particular health needs of an individual change. None of the nursing care plans we reviewed met these standards. As a

result, nursing care plans did not contain adequate interventions, and these inadequate interventions may continue in the individuals' current placement. Furthermore, nursing care plans did not provide the means to evaluate their effectiveness, and Rosewood lacked other mechanisms to evaluate its nursing interventions. Consequently, there was no systematic way in which Rosewood could determine whether the interventions its nurses made were appropriate for a given individual. As a result of these deficiencies, individuals at Rosewood were subject to interventions that were unsupported and unconnected to their specific needs.

The care of two individuals illustrates these problems:

- A.F., a resident with a history of hospitalizations related to gastronomy tube ("g-tube") complications, had a standing order for an abdominal binder to protect the integrity of the tube. Nevertheless, our review of her nursing records from January through June of 2008 revealed only sporadic documentation regarding use of an abdominal binder to protect the gastronomy tube. The failure to use the abdominal binder, or to document its use

  correctly, is particularly troubling because A.F. was hospitalized again in February 2008 due to g-tube complications. The failure to ensure that the abdominal binder was used likely contributed to this negative outcome.

- Generally accepted professional standards require that nursing assessments of respiratory changes include, at a minimum, lung sounds and respiratory rate. However, our review found these assessments to be generally lacking. In the case of one individual, L.L., the absence of a appropriate respiratory assessment may have contributed to a negative outcome: L.L. was hospitalized in October 2008 due to a worsening respiratory condition that an adequate assessment might have prevented. Our review of L.L.'s nursing notes revealed that nurses had recorded that he sounded congested for 12 days before his hospitalization, but the notes did not demonstrate that appropriate nursing assessments were completed.

The deficiencies in the care of these two individuals may have compromised their health on an ongoing basis and may require close monitoring to prevent recurrence or other complications.

Moreover, Rosewood's failures regarding nursing screening, assessments, and interventions can be concretely seen in its response to a number of conditions for which its residents were at high risk, such as bowel impaction and obstruction, aspiration pneumonia, compromised skin integrity, and bone fractures. Inaccuracies and gaps in Rosewood's data collection made analysis of its treatment

of these conditions difficult, but we nevertheless found numerous instances in which Rosewood's care substantially departed from generally accepted professional standards.

a. Care for Individuals at Risk of Bowel Impaction and Obstruction Substantially Departed from Generally Accepted Professional Standards

Individuals with developmental disabilities are often at risk of bowel impaction and obstruction because of physical inactivity due to their physical limitations, medication regimen, inability to communicate their needs, or a combination of these factors. Nevertheless, bowel impaction and obstruction are typically preventable conditions, but they can result in significant physical harm and even death if adequate care is not provided. Although Rosewood provided us with a list identifying eight individuals at high risk of bowel impaction and obstruction, our review found that another nine individuals met the high-risk criteria because they previously were either treated for, or admitted to the hospital with, fecal impactions. For example, at the time of our review, A.Q. was not on Rosewood's high-risk list, although A.Q. had been admitted to an acute care hospital on May 17, 2008, four months before our review, and was discharged with a diagnosis of bowel obstruction. These individuals may well continue to be at risk in their current placements because their risk of bowel obstruction was not communicated to their current provider.

In addition to failing to identify high-risk individuals adequately, Rosewood did not adequately assess the conditions of those it identified. Generally accepted professional standards for interventions in cases of constipation require nurses to make a variety of assessments, including bowel elimination patterns, bowel sounds, abdominal distention, and dietary and fluid intake, so that they may intervene appropriately.

We found a number of individuals for whom appropriate interventions are significantly hampered because these assessments were not performed consistent with generally accepted professional standards. In the case of abdominal distention, a cardinal sign of bowel obstruction, nursing assessments should include abdominal girth measurements and monitoring of elimination patterns. However, Rosewood did not adequately perform such assessments. For example, the records for two individuals, A.R. and I.I., who have histories of chronic constipation and documented abdominal distentions, did not contain adequate nursing assessments. As a result, these individuals experienced recurring bowel issues that required acute care hospitalization. In the case of I.I., discussed previously in Section II.B.1.a, nursing staff was notified that he had not had a bowel movement for three days. Rosewood staff attempted several interventions, all of which were

unsuccessful. Despite the ineffectiveness of its interventions, Rosewood failed to promptly move I.I. to the hospital. Upon his eventual arrival at the hospital, I.I. was found to have severe constipation, a swallowing disorder, and aspiration pneumonia.

Similarly, A.S., A.F., A.T., and H.H. had each been previously diagnosed with constipation, but their nursing care plans failed to address this condition. Consequently, there could be no expectation that the potentially life-threatening condition they suffered from would receive treatment until it had an acute manifestation, at which point the individuals had already suffered significant harm and be in danger of greater harm.

The absence of adequate assessments, comprehensive nursing care plans, and accompanying interventions placed these individuals at risk of harm from bowel impaction and obstruction. Accordingly, Rosewood substantially departed from generally accepted professional standards of nursing assessment and intervention regarding these conditions. These individuals may continue to be at increased risk of harm in their current placements because of the inadequate care they received for bowel obstruction during their residence at Rosewood, and they likely require increased monitoring to ensure they do not suffer further complications.

b. Care for Individuals at Risk of Aspiration Pneumonia Substantially Departed from Generally Accepted Professional Standards

Similarly, Rosewood did not assess individuals at risk of aspiration pneumonia consistent with constitutional standards. Aspiration pneumonia is a generally preventable condition that is caused by the presence of foreign materials, such as food or vomit, in the lungs. The contributing factors to aspiration pneumonia, including impaired ability to swallow or maintain posture, the use of gastronomy tubes for nutrition, and gastroesophageal reflux, place many of the individuals at Rosewood at high risk. Notably, as of the time of our tour, there had been three deaths at Rosewood resulting from pneumonia in the past year.

As with bowel impaction and obstruction, Rosewood's list of high-risk individuals for aspiration pneumonia was incomplete. The list lacked at least three individuals, A.U., C.C., and L.L., who had all been hospitalized within the past year for pneumonia. These individuals likely continue to be at risk of harm, because their aspiration pneumonia risk would not have been communicated to their current placement providers.

The number of individuals residing at Rosewood who experienced acute hospital admissions for aspiration pneumonia was particularly disturbing. From March 2008 to July 2008, a five-month period, ten individuals were hospitalized for aspiration pneumonia collectively fourteen times. Six of the ten individuals hospitalized for aspiration pneumonia putatively received 24-hour nursing care in the clinic. Constant nursing care should not typically result in acute care hospitalizations for aspiration pneumonia, and strongly suggests that the care these six individuals received at Rosewood substantially departed from generally accepted professional standards.

More egregiously, A.R. was hospitalized four times in a five-month period in 2008 for aspiration pneumonia and three times the previous year. However, no comprehensive post-hospitalization review was performed and no recommendations or alterations to A.R.'s care plan were identified after any hospitalization. Rosewood's failure to recognize the increasing danger to A.R. and respond appropriately placed this individual at significantly heightened risk for continued aspiration pneumonia and death.

Similarly, the nurses' notes for L.L., an individual discussed previously, state that he sounded congested for 12 consecutive days prior to his hospitalization for aspiration pneumonia. Despite the observations in the nurses' notes, nothing in his record indicates that an assessment or intervention was performed. This delay placed L.L. at significant risk of harm.

Another individual, N.N., had repeated choking and gagging episodes. X-rays taken in June 2007 revealed multiple rib fractures in various stages of healing, likely related to the repeated use of the Heimlich maneuver. Nevertheless, on several occasions, Rosewood assessed N.N. and determined that he did not have a swallowing disorder. The repeated nature of N.N.'s choking and gagging episodes strongly suggests that Rosewood's determination that he did not have a swallowing disorder was incorrect. Further, as described in more detail below, our observations of N.N. revealed that staff members were not implementing his eating guidelines, thereby exposing N.N. to risk of further choking episodes.

The pervasive absence of adequate nursing assessments and interventions for individuals such as A.R., L.L., and N.N. placed them at significant risk of harm. Because of the inadequate assessments and interventions they received, this risk may continue in their current placements, as their risk would not have been adequately communicated to their current placement providers. Moreover, the ongoing failure to treat these conditions has likely compromised these individuals' health, an effect that may linger in their current placement and likely requires ongoing monitoring and treatment.

c. Care for Individuals With Skin Integrity Problems Substantially Departed from Generally Accepted Professional Standards

Rosewood's nursing care plans, assessments and interventions for individuals who have skin integrity issues, such as pressure ulcers, also did not meet constitutional standards. Alterations in skin integrity can cause serious harm, including death. Rosewood's identification of individuals experiencing this risk was again inadequate: the high-risk list that the facility provided us did not identify which individuals required additional nursing monitoring based on their increased level of risk due to impaired mobility, impaired nutritional status, incontinence, and/or impaired cognitive ability, all conditions that increase the risk of skin-integrity problems. Similarly, nursing care plans did not consistently identify skin-integrity risks for non-ambulatory residents. Because this inadequate information was likely communicated to the individuals' current placement providers, these individuals may continue to be at significant risk of harm.

Generally accepted professional standards require targeted nursing interventions for individuals with skin integrity issues, including repositioning every two hours and monitoring to ensure adequate nutrition and hydration. However, this information was absent from the facility's nursing care plans. One individual, A.R., was treated for a lesion or wound on his right lateral ankle for several months. However, wound care did not appear on his current nursing care plan, nor was it identified on the 45-day nursing assessment that we reviewed. The failure to include wound care in the assessment and plan casts significant doubt on the accuracy of nursing documents at the facility. Moreover, this failure placed A.R. at risk of harm; without accurate nursing assessments and plans, he could have received lapses in care, or received care that was counterproductive to his wound care, by staff members who were unaware of his condition. These risks may continue in his current placement if, as is likely given the deficits in his assessments and nursing care plan, his wound care needs were not adequately communicated to his current placement providers.

With respect to repositioning, we observed an individual, A.V., lying on a mat table with both of her feet bandaged. Staff reported that A.V. had "wounds" from skin breakdown. A.V.'s injury suggests that she was not adequately repositioned, an intervention necessary for individuals who are not able to reposition themselves. The failure to intervene appropriately exposed A.V., and others like her, to an ongoing risk of harm while at Rosewood, and these conditions may persist in the individuals' current placement if the need for repositioning was not communicated.

d. Care for Individuals At Risk for Fractures Substantially Departed from Generally Accepted Professional Standards

Individuals with developmental disabilities are also at high risk for fractures from falls due to early onset osteoporosis, side effects of medications, impaired cognitive function, impaired mobility, or non-ambulatory status. As with the conditions discussed above, Rosewood did not conform to constitutional standards for nursing assessment or intervention in the nursing services it provided to individuals at high risk for fractures from falls.

Generally accepted professional standards of nursing care for these individuals require risk assessment and review of medications, functional and sensory status, and physical environment, as well as referral to physical therapy. Generally accepted professional standards for nursing interventions for such individuals require the identification of safety precautions necessary for activities of daily living, as well as specific placement in therapeutic positioning that promotes weight bearing.

Rosewood substantially departed from these standards. For example, A.P. was diagnosed with osteoporosis, unsteady gait, and seizure disorder. His nursing care plan, however, did not adequately address his unsteady gate; it simply called for monitoring for injuries from falls, a purely reactive approach that was of little benefit to A.P. Worse, A.P. suffered from a total of nine falls in 12 months, but there was no indication that he had been evaluated after these incidents. Thus, Rosewood did not adhere to even the minimal, reactive nursing care plan that it had in place for A.P. Accordingly, A.P. was at continuing risk of harm due to inadequate nursing services while at Rosewood. Similarly, the nursing care plans for two non-ambulatory individuals with osteoporosis, A.F. and A.T., did not address any of the interventions necessary to prevent fractures. These at-risk individuals were thereby placed at an increased risk of harm by Rosewood's failure to respond appropriately to their unique needs, and this risk may continue in their current placements because of the deficits in their nursing care plans.

Rosewood housed a population in which fractures from falls were a known and regular risk. Further, hip fractures are a leading cause of death in older, medically fragile individuals in any population. Rosewood's failure to identify the risks faced by individuals in its care and to implement preventative strategies to reduce the occurrence of falls was a substantial departure from generally accepted professional standards, violated these individuals' constitutional rights, and placed them at significant and continuing risk of harm.

Rosewood's inadequate response to the common conditions described above demonstrates a distinct and disturbing pattern in the medical and nursing care that the facility provided. Rosewood regularly failed to identify the members of its population who are at high risk for a variety of medical issues, and where it did identify those individuals, it failed to assess and treat them adequately. As such, Rosewood's medical and nursing care typically reacted to health issues if and when they became so serious that they could not escape notice. Rosewood therefore failed to conform to generally accepted professional standards in nursing care and, consequently, placed those it served at significant risk of harm. Moreover, these individuals may continue to be at risk, because the failures in their assessments and nursing care plans suggests that inaccurate and incomplete information about their health risks was provided to their current placement providers.

2. Rosewood's Nursing Quality Assurance Substantially Departed from Generally Accepted Professional Standards

Generally accepted professional standards for a nursing quality assurance program require a number of monitoring instruments that measure the quality and effectiveness of nursing care and services. An effective quality assurance program should allow the facility to identify problematic areas in nursing care and develop and implement corrective action plans accordingly.

Rosewood's nursing quality assurance program substantially departed from these standards. The data we reviewed at Rosewood did not reflect a quality assurance program capable of improving care: data collected for quality assurance were not complete and were not utilized appropriately. For instance, the forms used for nursing quality assurance contained significant omissions, resulting in a failure to collect information that is essential to assess the quality of nursing services. Even more troubling was Rosewood's failure to use the information the quality assurance program did gather. Specifically, the quality assurance nurse collected some data regarding nursing services. However, this information, and any analysis of it that may have been performed, was not regularly shared with the nursing department. As a result, to the limited extent that the quality assurance program identified areas needing correction, this information was not used by the nursing department to correct inadequacies in the provision of care.

Moreover, as previously discussed, Rosewood's repeated failure to identify as high-risk even those individuals whose records indicated that they were at such risk further evidences inadequacies in Rosewood's quality assurance program. Beyond the examples discussed in Section II.D.1, we found numerous other areas in which Rosewood failed to identify individuals who are at high risk. Rosewood's list of individuals having significant physical health risks or behavioral health risks omitted three residents who received gastronomy tube feedings and require 24-hour

positioning. The list also omitted two residents with seizure disorders who required thickened liquids. Rosewood's list of residents who were hospitalized for medical emergencies was similarly incomplete. The list failed to comprehensively identify the circumstances of the hospitalization and did not identify all the hospitalizations for each individual. As previously discussed, Rosewood's failure to identify individuals who are at risk strongly suggests that inaccurate and incomplete information was given to these individuals' current placement providers, placing these individuals at ongoing risk of harm in their current settings.

The inadequacies of Rosewood's quality assurance program were also demonstrated by the failure to document medication administration errors correctly. In Rosewood's internal ten-month list of medication errors, only three errors were identified, an implausibly low number for a facility of Rosewood's size that suggests the facility suffers from a major under-reporting problem regarding medication errors. Our review confirmed that Rosewood's medication administration error reporting did not comply with generally accepted professional standards. As an initial matter, Rosewood appeared to be utilizing an incorrect definition of a medication administration error. At the time of our visit, the nursing department examined the medical administration records at the change of shift meeting and, if a blank was found, signed the records at that time. In fact, each of these blanks should have been recorded as an administration error. Reconciling medication administration records after the fact, as Rosewood did, is a substantial departure from generally accepted professional standards. Our review found still other medication errors, including errors for A.W., A.X., and A.V., not reflected in the facility's own report. The medication error for A.V. was particularly egregious, as it led to an acute hospitalization, and she may continue to suffer from its effects.

Nursing quality assurance programs depend on comprehensive data to evaluate the quality and effectiveness of nursing care. When that data are incomplete, the quality assurance program is unable to assess the provision of nursing services reliably and to initiate necessary corrections and improvement. As discussed above, Rosewood's nursing care data were incomplete and unreliable. Further, we found no corrective action taken as a result of issues the quality assurance program identified. These significant departures from generally accepted professional standards placed residents of Rosewood at considerable risk of harm, a risk that may continue in these individuals' current placements because of the inaccuracy of the information given to their current providers.

3. Rosewood's Infection Control Program Substantially Departed from Generally Accepted Professional Standards

Constitutional standards require that an adequate infection control program be in place at facilities such as Rosewood. An effective infection control program

requires the ability to identify and report instances of infectious disease and the ability to control and prevent infectious disease. Data collected in the course of carrying out the former function should be used to establish baseline infection rates and can be used to identify infection outbreaks. These data and the accompany analysis should be put to use in developing policies and procedures and in conducting staff training and resident educational programs to aid in controlling and preventing infection.

Although Rosewood took the positive step of establishing an infection control nurse position, our review of the infection control program found that it substantially departed from generally accepted professional standards. First, Rosewood's infection control data and documentation suffered from the same lack of reliability that pervades the facility's medical documentation. Infections identified in nurses' notes were absent from nursing care plans and, therefore, were not adequately monitored or tracked to determine if the infection had spread. Without accurate reporting and collection of data on infections, effective infection control is impossible. More pertinently for present purposes, however, the inaccuracies in Rosewood's infection data suggest that current placement providers may not have been adequately informed about the potentially heightened infection risks posed by the population that Rosewood was transitioning into the community, inhibiting the providers' ability to assess and care for these individuals and potentially placing other individuals at risk of infection.

Moreover, Rosewood did not use the information it collected on infections to control the outbreak of infections in a manner consistent with generally accepted professional standards. The minutes of the infection control meetings showed that Rosewood's infection control program did not address the substantive issues of infection control, including the analysis of data to control the spread of infections and prevent future infections. The minutes indicate that Rosewood's infection control program was only engaged in the most basic of infection control practices, such as assuring that staff were adhering to universal precautionary procedures. While the meeting minutes show that lists of residents suffering from infectious diseases were discussed, there is no evidence of any analysis regarding unit transmission, trends of infection, or any other analysis related to the cause of infection or controlling infection. This was true even when residents in the same unit had the same infectious disease. The minutes for one meeting note a spike in pneumonia and cellulitis, but include a correction plan limited to discussing adjustments to the residential heating systems with the maintenance department. No root cause analysis or other meaningful data analysis appears to have been performed in any instance identified in the facility's infection control records that were provided to us. Thus, even in the circumstances where Rosewood adequately identified individuals with an infectious disease, it did not engage in the substantive steps necessary for providing effective infection control. Rosewood's

infection control program therefore departed substantially from generally accepted professional standards and exposed residents at Rosewood to harm. The failure to control the outbreak of infections adequately may have led to the unnecessary spread of infection, the effects of which may continue to compromise the health of those individuals who were infected.

4. Rosewood's Physical and Nutritional Management Substantially Departed from Generally Accepted Professional Standards

Generally accepted professional standards dictate that an effective physical and nutritional management system include: the identification of residents who are at risk for aspiration, choking, and dysphagia[7] and the assignment of an appropriate risk level; the identification of residents' triggers or symptoms of aspiration; adequate assessments of safe positioning for the 24-hour day; clinically-justified techniques, based on the assessment, that ensure safety during daily activities; the development and implementation of a plan containing specific instructions for the techniques determined by the assessment, with clinical justifications; and the provision of competency-based training to all staff assisting these residents regarding individualized physical and nutritional management plans.

Rosewood's provision of physical and nutritional management substantially departed from generally accepted professional standards. As described in Section II.D.1.b, above, we found critical deficits in nursing assessments, plans, and interventions for individuals at high risk of aspiration pneumonia. Further, Rosewood did not meet generally accepted professional standards relating to safe positioning. We observed fourteen individuals receiving 20-hours-per-day continuous tube feeding, an unusually high number. More importantly, the positioning for many of these individuals resulted in them being poorly supported and, accordingly, in poor alignment, whether in their hospital beds, in recliners, or on positioning-mat tables supported by pillows and bean-bags. These apparatuses generally do not provide the stabilization needed to maintain postural alignment and, worse, increase the risks of aspiration and gastroesophageal reflux while also reducing the ability to breathe and digest food safely and effectively. Indeed, some of the primary supports that Rosewood used, such as bean-bags, recliners, and

[7] "Dysphagia" refers to difficulty in swallowing, a condition that confers health risks on populations like those at Rosewood: it may result in aspiration into the airway and respiratory compromise, it may confer nutritional risks culminating in malnutrition because of insufficient intake of food and fluids, and it predisposes to choking, which has its own associated morbidity and mortality risks.

pillows, are known to increase the risk of harm from aspiration. These supports also increase the risk that deformities will become worse because they do not provide proper support. Thus, Rosewood's positioning, rather than being therapeutic, increased the risk of harm that its residents faced. The effects of this inadequate positioning likely continue in these individuals' current community placements, as many of the effects are long-term, including such conditions as increased deformities and increased susceptibility to aspiration and aspiration pneumonia.

Rosewood's inadequate physical therapy interventions may be seen in the example of four individuals, A.Y., U.U., A.Z., and A.G., whom we observed with inadequate seating systems. Disturbingly, the Rosewood physical therapist stated that the seating systems, although new and state-of-the-art, had been designed for comfort and not proper positioning; the seating systems therefore simply conformed to the established pattern of deformity for the individuals using them. As a result, the seating systems utilized at Rosewood did not appear to be used to prevent the further progression of known deformities; as noted above, they appeared to be generally used for comfort rather than care. Rosewood therefore placed individuals at increased risk of harm through inadequate support systems, a risk that likely continues in the residents' current placement, because the seating systems likely went with the residents when discharged.

Rosewood also substantially departed from generally accepted professional standards with respect to risks associated with food consumption. During mealtimes we observed, staff were frequently unfamiliar with the individuals they were serving. Mealtime cards, designed to inform staff as to a particular resident's eating needs, were often unavailable and, in other instances, staff members were unable to locate them or were unaware of their existence. Nursing was not an active participant in mealtimes, either in monitoring residents with known swallowing issues or in assisting staff with mealtime activities. Our observations revealed a general lack of attentiveness: one resident, B.A., coughed throughout the mealtime and another, B.C., spent the meal with his chest harness strap draped across his shoulder and the side of his face, but there were no interventions in either case. Similarly, N.N., an individual described above, was supposed to receive close supervision during meals, including interventions to encourage him to eat more slowly. However, Rosewood failed to implement these guidelines during the mealtime we observed. Further, staff members supervising N.N. while he was eating a snack during a morning break in his day program were unaware that N.N. was at risk of choking and aspiration. Failure to adhere to meal plans and supervise N.N. placed him at significant risk of harm. Moreover, the hospitalizations for aspiration pneumonia described in Section II.D.1.b, above, strongly suggest that inadequate nutritional management, including poor supervision at mealtimes, occurred. The health effects of the harm suffered due to

this failure to supervise individuals adequately may be long-term, and we have concerns that these individuals may continue to be exposed to harm if their need for supervision was not adequately communicated to their current providers.

In summary, Rosewood substantially departed from generally accepted professional standards of medical and nursing care. As discussed above, the medical and nursing care that Rosewood provided did not focus on preventing or mitigating health problems before the problems reached acute status. Instead, Rosewood addressed health problems when they reached the acute stage, a reactive approach that placed residents at Rosewood at a significant risk of harm. Compounding this reactive approach to care was the facility's failure to adequately monitor, and respond to changes in, an individual's health status, and to monitor and address facility-wide health-related indicators. Rosewood's failure to provide adequate care jeopardized its residents' health, and the lingering effects of these failures may persist after their placement into the community. Moreover, the critical deficits in assessments, nursing care plans, and data collection suggests that inaccurate and incomplete data was provided to their current placement providers, placing these individuals at an ongoing risk of harm.

III. MINIMUM REMEDIAL MEASURES

To remedy the identified deficiencies in the care provided to Rosewood's former residents during their time at the facility, as well as the identified deficiencies in the process through which the State has placed Rosewood's residents out of the facility and is overseeing their transition to other settings, and to protect the constitutional and statutory rights of former Rosewood residents, the State should promptly implement, at a minimum, the remedial measures set forth below:

A. Transition and Placement in the Most Integrated Setting

1. Principal Requirement: In accordance with Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132, and implementing regulation 28 C.F.R. § 35.130(d), the State should ensure that each former Rosewood resident is served in the most integrated setting appropriate to meet each person's individualized needs and should remedy any inappropriate community placements. To this end, the State should provide individuals transitioning from Rosewood with adequate and appropriate protections, supports, and services, consistent with each person's individualized needs, in the most integrated setting in which they can be reasonably accommodated, and where the individual does not object.

2. Appropriateness of Placement:

   a. The State should perform and maintain current, complete, and accurate interdisciplinary assessments of each individual to determine whether the individual is in the most integrated setting appropriate to the individual's needs. The State should ensure that those performing these assessments are demonstrably competent to do so and have adequate information regarding options for placements, programs, and other supports and services.

   b. If it is determined that a more integrated setting than the individual's current placement would appropriately meet the individual's needs and the individual does not oppose that placement, the State should promptly develop and implement a transition and community support plan that specifies actions necessary to ensure safe, successful transition to a more integrated setting, the names and positions of those responsible for these actions, and corresponding time frames.

   c. Subject to the conditions of court confinement, all individuals can be served in integrated community settings when adequate protections, supports, and other necessary resources are identified as available by service coordination. The State should ensure that this is clearly set forth in each individual's written interdisciplinary team recommendation contained within each individual's transition and community support plan, or equivalent, as a means to protect against needless reinstitutionalization.

3. Individual Involvement and Choice:

   a. In determining whether individuals are placed appropriately, each individual should be involved in the team evaluation, decision-making, and planning process to the maximum extent practicable, using whatever communication method he or she prefers.

   b. To foster each individual's self-determination and independence, the State should use person-centered planning principles at every stage of the process. This should facilitate the identification of the individual's specific interests, goals, likes

and dislikes, abilities and strengths, as well as deficits and support needs.

c. Each individual should be given the opportunity to express a choice regarding his or her placement. The State should provide individuals with choice counseling to help each individual make an informed choice; the State should provide enhanced counseling to those individuals who lived at Rosewood for many years.

d. If the current placement is determined to be inappropriate and the individual opposes movement toward a more integrated setting, the State should document the steps taken to ensure that any individual objection is an informed one. The State should set forth and implement individualized strategies to address concerns and objections to placement in the more integrated setting.

e. Throughout the process, the State should regularly educate individuals about the various community options open to them. Any written materials or presentations should be easy for individuals to understand.

f. If the current placement is determined to be inappropriate, the State should provide each individual with several viable placement alternatives to consider whenever possible. The State should provide field trips to these viable alternative placements and facilitate overnight stays at certain of the placements, where appropriate.

g. Where family members and/or guardians have reservations about the individual's current placement or movement to a more integrated setting, the State should provide ongoing educational opportunities to such family members and/or guardians with regard to placement and programming alternatives and options. These educational opportunities should include information about how the individual may have viable options other than living with the family members and/or guardians. The State should identify and address the concerns of family members and/or guardians with regard to community placement. The State should encourage family members and/or guardians to participate, whenever possible, in individuals' on-site, community home field trips.

4. Transition and Community Support Plans:

a. The State should develop or revise, as appropriate, a written transition and community support plan specifying the particular protections, supports, and services that each individual needs to live in the community safely and successfully.

b. Each transition and community support plan should be developed or revised using person-centered planning principles. Each transition and community support plan should specify with particularity the individualized protections, supports, and services needed to meet the needs and preferences of the individual in the most integrated setting appropriate to their needs, whether that be their current placement or another yet to be determined, including the scope, frequency, and duration of the individualized protections, supports, and services. Each transition and community support plan should include all individually-necessary protections, supports, and services, including but not limited to: housing and residential services; transportation; staffing; health care and other professional services; specialty health care services; therapy services; psychological, behavioral, and psychiatric services; communication and mobility supports; programming, vocational, and employment supports; and assistance with activities of daily living. Each plan should include specific details about which particular community providers, including residential, health care, and program providers, can furnish needed protections, services, and supports.

c. In developing and/or revising and implementing these plans, the State should avoid placing individuals into nursing homes or other institutional settings whenever possible. Nursing homes are often not well-suited to provide needed habilitation to persons with developmental disabilities. The State should develop and implement a systemic plan to develop integrated community alternatives to nursing homes for all individuals with unique or more intense and complex health care needs.

d. If it is determined that the individual is not currently in the most integrated setting appropriate to their needs, the transition and community support plan should identify the date movement to the most integrated setting can occur, as well as timeframes for completion of needed steps to effect the

transition. The transition and community support plan should include the name of the person or entity responsible for: commencing transition planning; identifying providers and other protections, supports, and services; connecting the individual with providers; and assisting in transition activities as necessary. The responsible person or entity should be experienced and capable of performing these functions.

e. Each transition and community support plan should be developed sufficiently prior to movement to another placement so as to enable the careful development and implementation of needed actions to occur before, during, and after the transition. This should include identifying and overcoming, whenever possible, any barriers to transition. The State should work closely with pertinent community agencies so that the protections, supports, and services that the individual needs are developed and in place at the alternate site prior to the individual's movement to the other placement.

f. The State should update the transition and community support plans as needed throughout the planning and transition process based on new information and/or developments.

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

h. If it is determined that the individual is not currently in the most integrated setting appropriate to their needs, the State should provide as many individual on-site and overnight visits to various proposed residential placement sites in the community as are appropriate and needed to ensure that the placement ultimately selected is, and will be, adequate and appropriate to meet the needs of each individual. The State should modify the transition and community support plans, as needed, based on these community visits.

i. In developing or revising the transition and community support plans, the State should include a schedule for monitoring visits to the new residence to assess whether the ongoing needs of the

individual are being met. Each plan should specify more regular visits in the days and weeks after any initial placement.

5. Implementation of Transition and Community Support Plans: The State should implement, in an expeditious manner, the newly developed or revised transition and community support plans that can be reasonably accommodated, by transferring each individual to an adequate and appropriate alternative community setting pursuant to the details set forth in each transition and community support plan, or by providing those supports and services determined to be necessary in the revised transition and community support plan.

6. Developing and Expanding Community Capacity:

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

   b. The State should develop and implement a plan with effective steps to expand and improve expert health care and expert psychological, behavioral, and mental health services in the community for community residents with complex health care needs, and/or behavior problems and/or mental illness. The intent of the plan should be to better meet individuals' health care, behavioral, and mental health needs in the community, avoid crises marked by the escalation of health care and/or behavior problems, and to minimize or eliminate failed or troubled community placements due to poorly addressed individual behaviors and, thus, minimize or eliminate re-institutionalization.

   c. To assist in this process, the State should develop and implement a plan to utilize and/or expand the State's existing information systems to better meet the needs of persons with developmental disabilities. The plan should address how to provide more immediate and better access to records and expert professionals, transmit lab results and radiological reports

between health care and other professionals, better track quality of care, improve communication with local hospitals and specialists, and generally provide better proactive care and treatment through a more seamless continuum of care to enhance individual outcomes.

7. Monitoring of Community Placements and Quality Assurance Measures:

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

b. Former Rosewood residents who have been placed in the community should be served by an adequate number of service coordinators to meet individuals' needs. The State's service coordination program should provide for various levels of follow-up and intervention, including more intensive service coordination for those individuals with more complex needs. All service coordinators should receive appropriate and adequate supervision and competency-based training.

c. The State should provide prompt and effective support and intervention services to individuals who present adjustment problems related to the transition process such that each individual may stay in his or her community residence when appropriate, or be placed in a different, adequate, and appropriate community setting as soon as possible. These services may include, but not be limited to: providing heightened and enhanced service coordination to the individual/home; providing professional consultation, expert

assistance, training, or other technical assistance to the individual/home; providing short-term supplemental staffing and/or other assistance at the home as long as the problem exists; and developing and implementing other community residential alternative solutions for the individual.

d. The State should maintain individuals in the most integrated community setting appropriate for their needs. Any admission or re-admission to a State institution should be considered short-term. If a individual is re-admitted to a State institution, the State should document the basis for the re-admission and then conduct a prompt assessment to identify and resolve any factors necessitating the re-admission.

e. The State should regularly collect, aggregate, and analyze data related to transition and placement efforts, including but not limited to information related to both successful and unsuccessful placements, as well as the problems or barriers to placing and/or keeping individuals in the most integrated and appropriate setting. Such problems or barriers may include, but not be limited to insufficient or inadequate: housing, community resources, health care, behavior management and services, and meaningful day activities including supported employment. The State should review this information on a regular basis and develop and implement prompt and effective strategies to overcome the problems and barriers identified.

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

B. Amelioration of Improper Treatment

1. Principal Requirement: The State should ameliorate any lingering effects of the improper treatment provided at Rosewood, by ensuring that former residents receive compensatory services in the most integrated setting appropriate to their individual needs.

2. Behavioral, Habilitation, and Communication Services:

a. Provide training, including behavioral and habilitative services, consistent with generally accepted professional standards to individuals who received inadequate services while at Rosewood. These services should be developed by qualified professionals consistent with accepted professional standards to reduce or eliminate risks to personal safety, to reduce or eliminate unreasonable use of bodily restraints, to prevent regression, and to facilitate the growth, development, and independence of every individual. To this end, the State should take the following steps:

i. Provide individuals who have behavior problems with an adequate functional assessment so as to determine the appropriate treatments and interventions for each person. Ensure that this assessment is interdisciplinary and incorporates medical and other unaddressed conditions that may contribute to a individual's behavior;

ii. Develop and implement comprehensive, individualized behavior programs for the individuals who need them. Ensure that the appropriate staff in the individuals' current placement know how to implement the behavior programs and ensure that they are implemented consistently and effectively. Ensure that appropriate behavioral data and notes with regard to the individual's progress on the programs is recorded by the current placement provider;

iii. Ensure that current placement providers monitor adequately the individuals' progress on the programs and revise the programs when necessary to ensure that individuals' behavioral needs are being met, and that ongoing training for staff is provided whenever a revision is required;

iv. Ensure that each individual who is receiving psychotropic medications has first been thoroughly evaluated and diagnosed according to generally accepted professional standards. Ensure that each individual diagnosed with mental illness is provided with a comprehensive psychiatric assessment, a DSM-IV diagnosis, appropriate

psychiatric treatment including appropriate medication at the minimum effective dose that fits the diagnosis, and regular and ongoing monitoring of psychiatric treatments to ensure that they are meeting the needs of each person. Ensure that psychiatrist(s) provide new assessments and/or revisions to any aspect of the treatment regimen whenever appropriate. Ensure that reliable behavioral and other data are provided to psychiatrists in making their assessments. Ensure that psychiatric services are implemented in close collaboration with psychologists and others, when warranted, to provide coordinated behavioral care;

v. Ensure that all individuals receive meaningful habilitation daily in their current placement, including but not limited to individualized training, education, and skill acquisition programs developed and implemented to promote the growth, development, and independence of each individual, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue restraint. Ensure that there is a comprehensive, interdisciplinary habilitative plan for each individual for the provision of such training, services and supports, formulated by a qualified interdisciplinary team that identifies individuals' strengths, needs, preferences, and interests. Ensure that the plans address the individuals' needs, preferences, and interests in an integrated fashion that utilizes the individuals' existing strengths. Ensure that staff in the current placement are trained in how to implement the written plans and that the plans are implemented properly; and

vi. Provide an assessment of all individuals and develop and implement plans based on these assessments to ensure that individuals are receiving vocational and/or day programming services in the most integrated setting appropriate to meet their needs. Ensure that there is sufficient staffing and transportation to enable individuals to work in an appropriate setting or to attend appropriate programming or activities when necessary.

b. Provide communication services consistent with generally accepted professional standards to individuals who received inadequate services while at Rosewood. To this end, the State should take these steps:

i. Assess or reassess all individuals discharged from Rosewood to identify those who would benefit from speech and communication therapy and ensure that adequate and appropriate services are provided to all individuals who would benefit from this service; and

ii. Ensure that speech and language services are developed and implemented in collaboration with psychologists and other services to provide coordinated care.

3. Health Care:

a. Provide medical care and nursing services consistent with generally accepted professional standards to individuals who received inadequate services while at Rosewood. To this end, the State should take these steps:

i. Ensure that each individual is provided with proactive, coordinated, and collaborative health care and therapy planning and treatment based on his or her individualized needs in their current placement;

ii. Assess or reassess all individuals discharged from Rosewood to identify, diagnose, and treat health problems in a timely manner, including health conditions such as infection, bowel impaction and obstruction, aspiration and aspiration pneumonia, skin care, and fractures ;

iii. Ensure that all individuals with a health problem are treated in a timely manner. To that end, ensure that individuals' current nursing care plans include individualized proactive interventions so that individuals who are at "high risk" are identified, monitored consistent with their risk status, and treated according to generally accepted professional standards;

iv. Ensure that all individuals who are at risk for aspiration or dysphagia are provided with an effective physical and

nutritional management program, but not limited to the development and implementation of assessments, risk assessments, interventions for mealtimes and other activities involving swallowing, and monitoring to ensure that interventions are effective. Ensure that staff at these individuals' current placements with responsibilities for individuals at risk for aspiration and dysphagia have successfully completed competency-based training commensurate with their responsibilities.

IV. CONCLUSION

We appreciate the cooperation we received from the Maryland Developmental Disabilities Administration and the State's Attorney General's Office. We also wish to thank the administration and staff at Rosewood for their professional conduct, their generally timely responses to our information requests, and the extensive assistance they provided during our tours. Further, we wish especially to thank those individual hospital staff members who made daily efforts to provide appropriate care and treatment, and who improved the lives of residents at Rosewood. Those efforts were noted and appreciated by the Department of Justice and our expert consultants.

Please note that this findings letter is a public document. It will be posted on the website of the Civil Rights Division. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on our website until 10 calendar days from the date of this letter.

Provided that our cooperative relationship continues, we will forward our expert consultants' reports under separate cover. These reports are not public documents. Although our expert consultants' reports are their work – and do not necessarily represent the official conclusions of the Department of Justice – their observations, analyses, and recommendations provide further elaboration of the issues discussed in this letter and offer practical technical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in your efforts at promptly remediating areas that require attention.

We are obliged by statute to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to initiate a lawsuit, pursuant to CRIPA, to correct deficiencies of the kind identified in this letter, 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to

do so in this case. The lawyers assigned to this matter will be contacting your attorneys to discuss next steps in further detail.

If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s Loretta King

Loretta King
Acting Assistant Attorney General
Civil Rights Division

cc: The Honorable Douglas F. Gansler
Attorney General for the State of Maryland

John M. Colmers, Secretary
Maryland Department of Health and Mental Hygiene

Michael S. Chapman, Executive Director
Maryland Developmental Disabilities Administration

Robert M. Day, Facility Director
Rosewood Center

Rod J. Rosenstein
United States Attorney
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