Disability Rights Nebraska

Protection and Advocacy for People with Disabilities

Testimony on LB 597
Before the Health and Human Services Committee
Nebraska Legislature
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Good afternoon Senator Howard and members of the committee. For the record, my name is Brad B-R-A-D Meurrens M-E-U-R-R-E-N-S and I am the Public Policy Director for Disability Rights Nebraska, the designated Protection and Advocacy organization for people with disabilities in Nebraska. I am here today in full support of LB 597.

In the summer of 2017, concerns were raised regarding the health and safety of residents living at the Life Quest facility at the Coolidge Center in Palmer, Nebraska and Life Quest at Bel Amis in Blue Hill. Inspections of the facilities were done by the state Division of Public Health and both facilities failed to meet standards of Nebraska's Department of Health and Human Services. The 80-page inspection report[1] of the Palmer facility described a chaotic and dangerous environment, rife with incidents of violence between residents, where residents were "not properly cared for, were unclean and not properly fed. There was not sufficient staff on duty at all times to meet clients' needs and staff was not properly trained. There was evidence clients were abused and neglected, and did not get proper medical and mental health care."[2] As the egregious

[1]For the Palmer Inspection Report, a timeline of activities, and other resources, see https://www.disabilityrightsnebraska.org/what_we_do/palmer-ne-lifequest-incidents.html

[2] Joanne Young, "Nebraska assisted-living facility oversight committee approved", Lincoln Journal Star, April 11, 2018, available at https://journalstar.com/legislature/nebraska-assisted-living-facility-oversight-committee-approved/article_40a9f85f-f186-5c13-ab36-53cd55ac70bd.html

incidents at Life Quest facilities and (potentially) at others like them demonstrate, increased direct oversight and accountability is sorely needed.

Given the number of individuals with mental health diagnoses at LifeQuest and similar facilities[3], we agree that the Division of Behavioral Health would be the proper entity to receive reports of such activities as listed in LB 597. Facility owners should have a clear understanding that they are responsible for reporting these incidents to the Division so that all the pertinent actors are working collaboratively to ensure the health, safety, and security of this vulnerable population.

We urge that LB 597 be advanced.

[3] For example of other facilities, see "Letter to Director Phillips", October 23, 2017, p. 3-4, available at https://www.disabilityrightsnebraska.org/file_download/4b7aebfc-2d1e-4d73-ab9c-831ad6715428