Disability Rights Nebraska

October 23, 2017

SENT VIA U.S. MAIL AND E-MAIL (courtney.phillips@nebraska.gov)

Courtney N. Phillips, CEO
Department of Health
and Human Services
State of Nebraska
301 Centennial Mall South
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Dear CEO Phillips:

While the Division of Behavioral Health's three-year housing plan sits on the shelf, people are dying. A sense of urgency is lacking. Yet this is not the first time the Department has been asked to act regarding this crisis. [1]

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[1] *See DHHS report: Hotel Pawnee in violation of state regulations,* NPTelegraph.com, available at http://www.nptelegraph.com/breaking_news/dhhs-report-hotel-pawnee-in-violation-of-state-regulations/article_6614c2d8-d1ee-11e1-9727-0019bb2963f4.html (last visited October 23, 2017); *This could be the end for the Hotel Pawnee.*, NPTelegrapoh.com, available at http://www.nptelegraph.com/news/this-could-be-the-end-for-the-hotel-pawnee/article_2eb5cee2-dd77-11e1-b724-0019bb2963f4.html (last visited October 23, 2017); *see also Pawnee's doors stay open*, NPTelegrapoh.com, available at http://www.nptelegraph.com/news/pawnee-s-doors-stay-open/article_14697035-1260-5ddd-97b7-ebe3492a397e.html (last visited October 23, 2017); *Concerns over care, living conditions at assisted living homes prompts mental health meeting*, Lincoln Journal Star.com, available at http://journalstar.com/news/local/concerns-over-care-living-conditions-at-assisted-living-homes-prompt/article_e947693d-4a54-5552-bb1f-7068bb00935b.html (last visited October 23, 2017); *Local View: Mentally Ill Need Supportive Housing*, Lincoln Journal Star.com, available at http://journalstar.com/news/opinion/editorial/columnists/local-view-mentally-ill-need-supportive-housing/article_c5aec077-cfc9-57fa-a106-f8ecf3e8db78.html (last visited October 23, 2017); NDHHS Notice of Disciplinary Action, Park View Villa, October 27, 2014, available at https://www.nebraska.gov/LISSearch/actions/225005/DAN102714.PDF (last visited October 23, 2017).

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In June and July of 2017, the Division of Public Health conducted an inspection of Life Quest at the Coolidge Center in Palmer, NE. This led to an 80-page report that identified widespread failures by the facility to provide for its residents' basic needs. That lengthy report should have been enough for the Division to revoke the facility's license and help residents find a safe place to live. Unfortunately, that report had little practical impact. In fact, it was only after a tragedy occurred and the involvement of law enforcement that the revocation wheels began to grind:

- On September 3, a U.S. military veteran died at Life Quest as a result of the facility's complete disregard of her health.
- Following her death, law enforcement launched an investigation into the facility.
- On September 22, the Division issued an investigative report into the resident's death.
- On October 5, the Division finally revoked Life Quest's license to operate as a mental health center.

When the violations at issue posed an imminent danger to the health and safety of Life Quest's residents, why did it take so long to act?

In the last five months, two military veterans died in this dangerous facility. The Department's lengthy report describes multiple episodes of chaos, mismanagement and lack of supervision on the part of Life Quest. In one instance, a Nebraska HHS surveyor described staff locking themselves in a medication room when an individual became aggressive, leaving the remaining residents to fend for themselves. The July report demonstrated that this facility was wholly incapable of providing for the most basic medical and nutritional needs of its residents, and certainly not an ability to provide for their mental and emotional needs. None of these were sufficiently egregious for the Division of Public Health—or the Department of Health and Human Services—to take action.

Over the last four years, three state-licensed facilities have closed their doors under the weight of abuse, neglect and mismanagement. In an endless round of "musical facilities," residents are shuffled from one terrible facility to another. Residents and guardians scramble to find housing, but no quality housing is available. Instead, these places collapse under their own weight while vulnerable Nebraskans are shipped off to other facilities and continue to suffer. No Division within the Department is willing to take responsibility for what is happening to people with mental health conditions in Nebraska

and the Department as a whole continues with plans that have not as of yet led to any meaningful action.

This is not only about abuse and neglect, but a right to live in integrated settings. The Department's ongoing failure to act continues to place the lives of Nebraska's most vulnerable citizens at risk. The Department's reliance on facilities like Life Quest violates Title II of the Americans with Disabilities Act as interpreted by the U.S. Supreme Court in *Olmstead v. L.C.* Although the Department has a legislative mandate to develop an *Olmstead* plan, and efforts have been made to develop a plan, no actual change has happened. A "plan to plan" is not an *Olmstead* plan and the State remains vulnerable until it does something to protect people like the residents of Life Quest and the numerous other facilities serving this population. That can be done only by developing systems, supports, and services that allow individuals with mental health conditions to live free from the congregation, isolation, and danger of facilities like this. The urgency is apparent and the Department has no more excuses and must act now.

The U.S. Department of Justice has been involved in numerous *Olmstead* enforcement actions involving private facilities. For example, after a lengthy investigation of North Carolina's mental health service system, the Department issued a findings letter in July of 2011 concluding that the State violated Title II by administering its behavioral health system in a manner that unnecessarily segregated persons with mental illness in large, privately-owned adult care homes. The Department entered into a settlement agreement with North Carolina on August 23, 2012. In addition to other provisions contained in the settlement agreement from August 23, 2012, the agreement expands access to community-based supported housing. Supported housing provides integrated housing that promotes inclusion and independence, and enables individuals with mental illness to participate fully in community life.[2]

The Department is aware of other facilities that have consistently failed to perform and have been under investigation for years by the Division of Public Health, as well as Disability Rights Nebraska. These facilities include:

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[2] Settlement Agreement, *U.S. v. North Carolina*, No. 5:12-cv-557 (E.D.N.C. filed August 23, 2012), *available at* https://www.ada.gov/olmstead/olmstead_enforcement.htm#four (last visited October 20, 2017).

Prescott Place, Lincoln, NE
Bel-Air, Lincoln, NE
O.U.R. Homes Domiciliary, Lincoln, NE
Princess Anne, Omaha, NE
Golden Manor Assisted Living, Omaha, NE
Improved Living Inc., House 1, Norfolk, NE
Hoffmeister Home, Genoa, NE
Liberty House, Wahoo, NE
Life Quest, Blue Hill, NE
Spring Creek Home, Inavale, NE
Champion Homes of Hastings, Hastings, NE
Liberty House, North Platte, NE
CC Live, Central City, NE
Central City Assisted Living, Central City, NE
Life Essential Assisted Living, Central City, NE

The answer to this crisis is not more institutional beds, but increasing the capacity for more supportive housing and community supports. The Department must assume a leadership role and act quickly to protect Nebraska's most vulnerable citizens. The Department can begin now by conducting assessments of those individuals living in problem facilities to ascertain whether they are receiving care based on their identified needs. Increased inspections of the above noted facilities need to be conducted along with specialized response teams focused on problem facilities that continue to fail inspections. The Department must provide in-reach to assist individuals in these facilities to understand the housing and supportive options currently available to them, as well as providing assistance in applying for those services.

We would be happy to meet with you and members of your Leadership Team to discuss the implementation of the above suggestions at your earliest convenience.

Respectfully,

Eric A. Evans
CEO Disability Rights Nebraska

Encls: DHHS, Div. of Public Health, Inspection Report dated July 21, 2017
DHHS, Div. of Public Health, Investigation Report dated Sept. 22, 2017
DHHS, Div. of Public Health, Notice of Disciplinary Action, dated Oct. 5, 2017

Cc: Governor of Nebraska Pete Ricketts
Lieutenant Governor Mike Foley
Sheri Dawson, Director, Division of Behavioral Health
Matt Wallen, Director, Division of Children and Family Services
Courtney Miller, Director, Division of Developmental Disabilities
Rocky Thompson, Interim Director, Division of Medicaid and Long-Term Care
Tom Williams, M.D., Chief Medical Officer, Director, Public Health
Marshall Lux, State Ombudsman's Office
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