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

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

APPENDIX TO UNITED STATES'

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Alan Bellomo:	Director of Ebensburg Center since 1985. Tr. 10/13/93 at 130. Since June 1991, has also been the Director of Altoona Center. Id.
Richard Bonfanti:	Unit Manager of Keystone since December 1988. U.S. Exh. 604 (Bonfanti Dep.) at 9.
William Bordner:	MR facility surveyor for the Commonwealth's Bureau of Quality Assurance, Division of Long Term Care since 1990. U.S. Exh. 605 (Bordner Dep.) at 13-15.
Irvin Chamovitz:	Consultant neurologist for Ebensburg since about 1970 except for a five year period in the late 1980's. U.S. Exh. 606 (Chamovitz Dep.) at 9.
Deborah Degretto:	Unit Manager of Villa since 1989. U.S. Exh. 607 (Degretto Dep.) at 9, 24.
David Devine:	Director of Residential Unit Management (DRUM) since October 1980. U.S. Exh. 608 (Devine Dep.) at 13, 68.
Claire Domino:	Residential Services Supervisor (RSS) at Keystone since 1986 and also serves as a Qualified Mental Retardation Professional (QMRP) for Keystone clients. U.S. Exh. 609 (Domino Dep.) at 8, 9, 13.
Susan Fagan:	LOTA at Ebensburg since October 1977. U.S. Exh. 610 (Fagan Dep.) at 9-10. Has worked as a LOTA at Keystone since 1988. Id. at 15.
Betty Ferut:	Residential Services Aide (RSA) who has worked on the second shift in West II in Laurel House since 1984. U.S. Exh. 611 (Ferut Dep.) at 10-12.
John Fris:	Chief Pharmacist at Ebensburg since about 1983. U.S. Exh. 612 (Fris Dep.) at 10-11.

Mary Frye:	LOTA at Ebensburg since June 1977. U.S. Exh. 613 (Frye Dep.) at 8-9. Has been the occupational therapy representative on the Dysphagia Team since it was formed in June 1990. Id. at 12, 13, 14.
David Fulton:	Safety Manager at Ebensburg since 1985. U.S. Exh. 614 (Fulton Dep.) at 9.
Lana Geriak:	LOTA at Ebensburg since 1985. U.S. Exh. 615 (Geriak Dep.) at 8, 11, 13.
Pauline Goldschmidt:	Consultant psychiatrist from 1986 until July 1993 when she resigned. U.S. Exh. 615 (Goldschmidt Dep.) at 11; Tr. 10/19/93 (O'Brien) at 81-82.
Lois Graham:	Director of Occupational Therapy Services at Ebensburg from 1988 through 1993. U.S. Exh. 617 (Graham Dep.) at 9. Had worked as an Occupational Therapist at Ebensburg since 1984. Id. at 10.
Spencer Hauenstein:	Physical Therapist who worked at Ebensburg for one day a week between July 1991 and December 1992. U.S. Exh. 122 (Hauenstein Dep.) at 10, 11. Spent approximately 70% of his time at Keystone. Id. at 49.
Tom Huber:	Coordinator of speech and hearing services at Ebensburg since July 1979. U.S. Exh. 620 (Huber Dep.) at 9, 11.
Elwood Kleman:	Recently became a Residential Services Worker (RSW) in the Villa. Worked first as a residential services aide and then as a residential services aide supervisor at Ebensburg since 1982. U.S. Exh. 621 (Kleman Dep.) at 10-11.
Velda Malloy:	Registered Nurse Supervisor (RNS) who has worked at Ebensburg since 1963. U.S. Exh. 622 (Malloy Dep.) at 7-8. Has been the nurse supervisor who is responsible for Keystone since January 1992. Id. at 8. Over the years, she has worked in every building at Ebensburg. Id. at 9.
Michael McGuire:	Unit Manager of Horizon since February 1991. U.S. Exh. 623 (McGuire Dep.) at 9.

Richard O'Brien:	Director of Program Services at Ebensburg since 1971. Tr. 10/15/93 (O'Brien) at 65.
Jeanne Pisula:	Worked at Ebensburg since 1972. U.S. Exh. 626 (Pisula Dep.) at 24. For most of the past 15 years, has worked as a residential services aide in Sunset House. Id. at 8-9. Ms. Pisula has been president of a union representing 600 employees of Ebensburg since 1989. U.S. Exh. 626 (Pisula Dep.) at 24-25.
Don Ratchford:	Director of Therapeutic Activity Services since 1984. U.S. Exh. 628 (Ratchford Dep.) at 11.
Lois Schofield:	LOTA who works three days a week at Ebensburg. Worked at Keystone between 1989 -May 1992. U.S. Exh. 629 (Schofield Dep.) at 8, 11.
Frank Seymour:	Unit Manager of Laurel House since February 1991. U.S. Exh. 630 (Seymour Dep.) at 10.
Edward Shertz:	Medical Director at Ebensburg since August 1986. U.S. Exh. 632 (Shertz Dep.) at 9.
Ralph Sneed:	Director, Bureau of Direct Program Operations in the Office of Mental Retardation with the Pennsylvania Department of Public Welfare. U.S. Exh. 635 (Sneed Dep.) at 12. In this capacity, Dr. Sneed was Mr. Bellomo's immediate supervisor. Id. at 41. Dr. Sneed held this position from June 1989 through 1993. Id. at 12.
William Snauffer:	Chief of the Division of Program Management for the Commonwealth's Office of Mental Retardation since 1985. U.S. Exh. 634 (Snauffer Dep.) at 14-15.
Carole Sponsky:	Director of Nursing at Ebensburg since June 1989. Was Acting Director of Nurses between December 1988 and June 1989. U.S. Exh. 636 (Sponsky Dep.) at 13. Has worked at Ebensburg for the past 32 years. Id. at 16.
Marcia Stiles:	Registered Nurse Supervisor at Ebensburg for the past 14 years. Serves as infection control coordinator at Ebensburg and was appointed to the Dysphagia Team in September 1992. U.S. Exh. 638(a) (Stiles Dep.) at 9, 56-57.

James Stratton:	Psychology discipline coordinator at Ebensburg for about 10 years. U.S. Exh. 639 (Stratton Dep.) at 11. Has worked at Ebensburg since 1976. Id. at 15.
Nancy Thaler:	Deputy Secretary of the Pennsylvania Department of Public Welfare since January 1993. Responsible for all the services for individuals in the Commonwealth with mental retardation - what the Commonwealth is going to do, how they are going to do it, and when they are going to do it. U.S. Exh. 870 (Thaler Dep.) at 19.
Kathleen Wagner:	Speech and hearing specialist at Ebensburg who has also served as the head of the Dysphagia Team since its inception in June 1990. U.S. Exh. 641 (Wagner Dep.) at 11,12, 25.
Wayne Weimer:	Unit Manager of Sunset since 1978. U.S. Exh. 642 (Weimer Dep.) at 10.
Sharon Zoskey:	LOTA at Ebensburg since 1985. U.S. Exh. 643 (Zoskey Dep.) at 8.

ACRONYMS

AAMR:	American Association on Mental Retardation
ARC:	Association for Retarded Citizens
AAUAP:	American Association of University Affiliated Programs
ATP:	Active Treatment Plan (also known as IHP--Individualized Habilitation Plan)
BIC:	Behavior Intervention Committee
CRIPA:	Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 et seq.
DPW:	Department of Public Welfare
DRO:	Differential reinforcement of other behavior
EEG:	Electroencephalogram
EFA:	Epilepsy Foundation of America
EPS:	Extra-Pyramidal Symptoms
GER:	Gastroesophageal reflux
GI:	Gastrointestinal
HCFA:	Health Care Financing Administration
ICF/MR:	Intermediate Care Facility for the Mentally Retarded
IDT:	Interdisciplinary Team
IHP:	Individualized Habilitation Plan (also known as ATP--Active Treatment Plan)
IM:	Intramuscular medication
IOC:	Inspection of Care Survey
IV:	Intravenous medication
JAMA:	Journal of the American Medical Association

LOTA:	Licensed Occupational Therapy Assistant
MA Survey:	Medical Assistance Survey
MRUM:	Mental Retardation Unit Manager
NMS:	Neuroleptic Malignant Syndrome
OMR:	Office of Mental Retardation
OT:	Occupational Therapy/Occupational Therapist
PAB:	Professional Advisory Board of the Epilepsy Foundation of America
PO:	Oral medication
PSA:	Psychology Services Associate
PT:	Physical Therapy/Physical Therapist
PTA:	Physical Therapy Aide
QMRP:	Qualified Mental Retardation Professional (term defined by Title XIX regulations § 483.430. Def. Exh. T.)
RSA:	Residential Services Aide
RSAS:	Residential Services Aide Supervisor
RSW:	Residential Services Worker
SIB:	Self-Injurious Behavior
TD:	Tardive Dyskinesia
Title XIX:	Federal law creating ICF/MR's, 42 U.S.C. § 1396 et seq.; and regulations promulgated thereunder and used to survey facilities, 42 C.F.R. § 435.1009 et seq..
UAP:	University affiliated program (or facility)

QUALIFICATIONS AND METHODOLOGIES OF THE UNITED STATES' EXPERTS

The United States called ten expert witnesses, including five physicians, a nurse, a physical therapist, and three Ph.D. psychologists. A brief summary of their qualifications and methodologies follows:

Norberto Alvarez, M.D., was accepted as a medical expert qualified to testify about neurological services and issues surrounding neurological disorders among the developmentally disabled. Tr. 7/30/93 (Alvarez) at 45.

Dr. Alvarez is a pediatric neurologist who is licensed to practice medicine in Massachusetts. Tr. 7/30/93 (Alvarez) at 40. Dr. Alvarez currently works on the medical staff of the Children's Hospital in Boston where he works as a staff physician in the neurology department. Tr. 7/30/93 (Alvarez) at 42-43. Dr. Alvarez is also currently an assistant professor in neurology at Harvard Medical School. Tr. 7/30/93 (Alvarez) at 45.

Dr. Alvarez is board certified by the American Academy of Neurology and Psychiatry with a special competence in child neurology. Tr. 7/30/93 (Alvarez) at 42. He is also board certified by the American Board of Electroencephalography. Tr. 7/30/93 (Alvarez) at 42.

Dr. Alvarez has received extensive training in neurology. For two years, beginning in 1971, Dr. Alvarez was trained in neurology at Wayne State University. Tr. 7/30/93 (Alvarez) at 40. From 1973-75, Dr. Alvarez continued his neurology training as a fellow at Children's Hospital in Boston where he trained in electroencephalography, epilepsy, pediatric neurology and general neurology. Tr. 7/30/93 (Alvarez) at 41-42. Dr. Alvarez then spent one year working as a fellow in training at the Developmental Evaluation Clinic, which is a program devoted to persons with mental retardation and physical handicaps. Tr. 7/30/93 (Alvarez) at 42. In that year, he also trained in psychiatry. Tr. 7/30/93 (Alvarez) at 42. During that year, ninety-nine percent of the patients that Dr. Alvarez treated were handicapped and mentally retarded. Tr. 7/30/93 (Alvarez) at 42.

Dr. Alvarez has a great deal of experience working at state-run residential facilities for the developmentally disabled like Ebensburg Center. For example, as part of his responsibilities at Children's Hospital, Dr. Alvarez also provides neurological consultation services to the Wrentham State School. Tr. 7/30/93 (Alvarez) at 43. Wrentham is a state-run residential facility serving the developmentally disabled and mentally retarded. The Commonwealth of Massachusetts is responsible for running Wrentham. Tr. 7/30/93 (Alvarez) at 43. Approximately 520 individuals with developmental disabilities reside at Wrentham. Tr. 7/30/93 (Alvarez) at 43. At the present time, the individuals fall mostly in the profound to severely retarded range. Tr. 7/30/93 (Alvarez) at 43. Practically all of the residents at Wrentham have neurological problems. Tr. 7/30/93 (Alvarez) at 44. Dr.

Alvarez is responsible for providing neurologic care to all of these residents. Tr. 7/30/93 (Alvarez) at 44. Dr. Alvarez estimated that he spends about 60-70 percent of his time working at this state-run institution. Tr. 7/30/93 (Alvarez) at 43. At Wrentham, he serves as the Director of the Neurology Seizure Program. Tr. 7/30/93 (Alvarez) at 43-44. Specifically, he is responsible for performing medical examinations, assessments, diagnoses and for monitoring the residents' neurological care; he participates in inter-disciplinary team meetings when neurological issues are to be discussed; he is involved in Wrentham's psychiatric and neuropsychiatric programs; and he is involved in interpreting electroencephalograms (EEGs) which better enable a neurologist to see how the brain works. Tr. 7/30/93 (Alvarez) at 44. For more details about Dr. Alvarez, see U.S. Exh. 1.

Dr. Alvarez was hired by the Justice Department to visit Ebensburg Center and to provide his expert opinion on the neurological services offered there. Tr. 7/30/93 (Alvarez) at 45. Dr. Alvarez visited Ebensburg Center on two separate occasions in October 1992. Tr. 7/30/93 (Alvarez) at 46. In the course of his two visits, he spent a total of five full days at the facility. Tr. 7/30/93 (Alvarez) at 46.

On his tours, Dr. Alvarez visited the living areas and talked with the persons directly involved with the care of the residents, such as the primary care physicians, the nurses and the consult neurologist. Tr. 7/30/93 (Alvarez) at 46. Dr. Alvarez also reviewed about fifty to fifty-five resident records of individuals with a diagnosis of epilepsy. Tr. 7/30/93 (Alvarez) at 46-7. He testified that this was an adequate number of records to enable him to sufficiently evaluate the neurological services at Ebensburg Center. Tr. 7/30/93 (Alvarez) at 46-47.

In forming his conclusions about Ebensburg Center, Dr. Alvarez testified that he looked at systemic issues as opposed to merely looking at individual cases. Tr. 7/30/93 (Alvarez) at 221-222. He concluded that most of the problems he discovered at Ebensburg Center were systemic in nature. Tr. 7/30/93 (Alvarez) at 222.

Richard S. Amado, Ph.D., was qualified as an expert in the training and treatment of people with mental retardation, particularly those with behavioral and learning difficulties. Tr. 8/4/93 (Amado) at 8-9.

Dr. Amado has a doctoral degree in educational psychology and has worked with people with severe behavioral problems since 1969. Tr. 8/4/93 (Amado) at 3.

In 1978, when a state-operated residential facility for mentally retarded people in Minnesota was making a transition from a custodial care model to an active treatment model, Dr. Amado was hired as a building director to direct all facets of care for about 50 mentally retarded clients. Tr. 8/4/93 (Amado) at 4-5. Dr. Amado worked there as a building director with clinical accountability for four and a half years. Tr. 8/4/93 (Amado) at 5.

Since that time, Dr. Amado has worked as a consultant to many residential facilities for people with mental retardation, helping institutions better serve people with whom they have not had success, and helping institutions make the transition from the custodial care model to the active treatment model. Tr. 8/4/93 (Amado) at 5-6.

Dr. Amado is also a clinical faculty member of the University of Minnesota, where he trains third year psychiatry residents working with people with retardation and related disabilities regarding best practices in the area of mental retardation and non-medication treatment alternatives. Tr. 8/4/93 (Amado) at 6. Dr. Amado was invited by his peers to serve on a number of rule and policy making committees for the State of Minnesota. Tr. 8/4/93 (Amado) at 6-7. He has also given a number of workshops, training programs, and presentations around the country on a variety of behavior management topics. Tr. 8/4/93 (Amado) at 6-7. Most recently, Dr. Amado gave a presentation at the 1993 Annual Meeting of the American Association on Mental Retardation ("AAMR"). U.S. Exh. 2. Finally, Dr. Amado has published and edited in the field. Dr. Amado was the primary author of a state-wide staff training program in behavior analysis for the State of Minnesota. U.S. Exh. 2. Most recently, Dr. Amado was invited to be an editor for a new monograph series published by the AAMR called "Innovations: From Research to Practice." Tr. 8/4/93 (Amado) at 7.

Dr. Amado testified in the Welsch v. Likens right to treatment case. Tr. 8/4/93 (Amado) at 8.

Dr. Amado evaluated whether Ebensburg's behavior management services comported with accepted professional standards on two occasions -- in November 1990 and in August 1992. Tr. 8/4/93 (Amado) at 10, 11. To conduct his evaluation, during both tours he observed residents and staff, interviewed staff, with particular emphasis on the psychology staff during the 1992 tour, and reviewed at least 45-50 records and other facility documentation. Tr. 8/4/93 (Amado) at 10-11. After conducting each evaluation, Dr. Amado concluded that Ebensburg's behavior management services substantially departed from accepted standards in the field. Tr. 8/4/93 (Amado) at 10-11. More importantly, Dr. Amado found that the psychology services at Ebensburg had not improved between 1990 and 1992. Tr. 8/4/93 (Amado) at 12-13. In 1990, Dr. Amado found that Ebensburg's psychology services were deficient in eleven different respects, and, in 1992, Dr. Amado found that Ebensburg remained as deficient or more deficient in all eleven areas. Tr. 8/4/93 (Amado) at 99.

David Coulter, M.D., was accepted, without objection, as a medical expert qualified to testify about medical standards, standards in the care and treatment of neurological disorders, including status epilepticus, and issues surrounding neurological disorders among the developmentally disabled and those with mental retardation. Tr. 12/13/93 (Coulter) at 12-13.

Dr. Coulter is a neurologist specializing in pediatric neurology. Tr. 12/13/93 (Coulter) at 3. Dr. Coulter is currently licensed to practice medicine in the states of

Michigan, Texas and Massachusetts, although he only practices in Massachusetts at this time. Tr. 12/13/93 (Coulter) at 4.

Dr. Coulter currently works for Boston University School of Medicine as an associate professor in the Departments of Pediatrics and Neurology. Tr. 12/13/93 (Coulter) at 6. His principal work site is at the Boston City Hospital, a public hospital owned by the city serving the inner-city residents and the poor. Tr. 12/13/93 (Coulter) at 6. He is currently the Director of Pediatric Neurology at the Boston City Hospital. Tr. 12/13/93 (Coulter) at 6. The individuals he treats at the Boston City Hospital are all poor and come from largely minority, multi-ethnic backgrounds -- black, Hispanic, a number of Haitian families and Cambodian families -- all having the common denominator of poverty. Tr. 12/13/93 (Coulter) at 6-7. Dr. Coulter estimated that the vast majority of the individuals he treats have a developmental disability. Tr. 12/13/93 (Coulter) at 7. Approximately half of the individuals have mental retardation. Tr. 12/13/93 (Coulter) at 7.

Since 1979, Dr. Coulter has been board certified in neurology with a special competence in child neurology. Tr. 12/13/93 (Coulter) at 6. Dr. Coulter has also been board certified in pediatrics since 1981. Tr. 12/13/93 (Coulter) at 6. Since he has first been licensed to practice medicine in 1975, Dr. Coulter estimates that he has treated thousands of individuals with developmental disabilities and neurological problems. Tr. 12/13/93 (Coulter) at 6. He estimates that he has treated roughly five hundred patients a year. Tr. 12/13/93 (Coulter) at 6.

Dr. Coulter has received extensive pediatric and neurological training. Dr. Coulter began his training in neurology at Yale University Medical School (where he graduated in 1973) by researching and writing a thesis on the treatment of epilepsy, sponsored by the Epilepsy Foundation of America. Tr. 12/13/93 (Coulter) at 4. Dr. Coulter then moved on to Duke University Medical School where he received specialized pediatric training. Tr. 12/13/93 (Coulter) at 4. Dr. Coulter then completed a three year neurology residency at the University of Michigan. Tr. 12/13/93 (Coulter) at 4. In all, he received six years of neurological training at Michigan both as a resident and as a fellow. Tr. 12/13/93 (Coulter) at 4. Of the six total years, he spent two learning about adult neurology and another two years learning about pediatric neurology. Tr. 12/13/93 (Coulter) at 4-5. He received the bulk of his training under the tutelage of a doctor who had just served as President of the Child Neurology Society. Tr. 12/13/93 (Coulter) at 5. In his remaining years at Michigan, Dr. Coulter taught medical school students about epilepsy. Tr. 12/13/93 (Coulter) at 5. Virtually all of his professional time spent at the University of Michigan, involved work with individuals with developmental disabilities. Tr. 12/13/93 (Coulter) at 5. During his last two years at Michigan, Dr. Coulter was in charge of the Pediatric Epilepsy Clinic, so he was particularly and directly involved with individuals with seizures. Tr. 12/13/93 (Coulter) at 5-6.

Dr. Coulter has experience working with individuals with developmental disabilities who live in an institution. Tr. 12/13/93 (Coulter) at 7. Since 1981, he has provided regular

on-going neurological consultation to facilities or institutions serving individuals with mental retardation. Tr. 12/13/93 (Coulter) at 7. His consultation work with institutions began in Texas where he provided neurological consultation services once a month each for the Richland State School and for the Lufkin State School. Tr. 12/13/93 (Coulter) at 7-8. Specifically, he visited these institutions, saw patients, talked to staff physicians, helped them manage individuals with epilepsy and helped them diagnose difficult cases. Tr. 12/13/93 (Coulter) at 8. When he arrived in Massachusetts in 1986, Dr. Coulter began providing consult neurological services for the Perkins School for the Blind, an institutional facility housing individuals with multiple developmental disabilities, mental retardation, epilepsy, cerebral palsy, and blindness. Tr. 12/13/93 (Coulter) at 8. Dr. Coulter has served as the consult neurologist for Perkins for the past six or seven years. Tr. 12/13/93 (Coulter) at 8. His role is primarily to help make diagnoses of epilepsy and to help in the medical management of the individuals who live there. Tr. 12/13/93 (Coulter) at 8.

Dr. Coulter has been a member of the Epilepsy Foundation of America since he was a medical student on a research fellowship from the Foundation. Tr. 12/13/93 (Coulter) at 8. Dr. Coulter was elected to the Professional Advisory Board of the EFA in 1989. Tr. 12/13/93 (Coulter) at 9. The PAB asked Dr. Coulter to lead an effort to develop a document or manuscript that would deal specifically with the treatment of epilepsy and mental retardation. Tr. 12/13/93 (Coulter) at 9. The culmination of this effort is the American Journal of Mental Retardation's entire July 1993 special issue on epilepsy. Tr. 12/13/93 (Coulter) at 9. Dr. Coulter served as editor of this monograph and wrote the lead article which was an overview of all the issues involved. Tr. 12/13/93 (Coulter) at 9. In fact, opposing counsel cited to this monograph during his cross-examination of Dr. Alvarez. Tr. 9/13/93 (Kastner) at 164. While serving on the PAB, Dr. Coulter also participated on the Foundation's project on status epilepticus. Tr. 12/13/93 (Coulter) at 9-10. The EFA has also sponsored his continuing research over the years. Tr. 12/13/93 (Coulter) at 8. The EFA has asked Dr. Coulter to make a presentation at their national conference about mental retardation and epilepsy. Tr. 12/13/93 (Coulter) at 9. He testified that he has been instrumental in moving the EFA towards focusing more on mental retardation issues. Tr. 12/13/93 (Coulter) at 9.

Dr. Coulter has held positions in many other national medical organizations. Tr. 12/13/93 (Coulter) at 10. He was the president of the Academy on Mental Retardation, a group of research professionals in the field. Tr. 12/13/93 (Coulter) at 10. He has served as the head of the Medicine Division of the American Association on Mental Retardation. Tr. 12/13/93 (Coulter) at 10. He is currently serving on the national Board of Directors of the AAMR. Tr. 12/13/93 (Coulter) at 10. Dr. Coulter testified that he believes that he is the only doctor to have ever served on Boards of both the EFA and the AAMR. Tr. 12/13/93 (Coulter) at 10. He testified that he is not aware of any other individual who has ever been involved both at that level in the epilepsy field as well as in the mental retardation field. Tr. 12/13/93 (Coulter) at 10.

Dr. Coulter has held editorial positions on several medical publications. Tr. 12/13/93 (Coulter) at 10-1. He has been a member of the editorial board of the Journal of Child Neurology since that publication's inception. Tr. 12/13/93 (Coulter) at 11. He has also served on the editorial staff of the American Journal on Mental Retardation for a number of years. Tr. 12/13/93 (Coulter) at 11. He has served as an associate editor of the AJMR for the past four or five years where his role has been to elicit peer reviews of manuscripts that have been submitted for publication and to evaluate the reviews. Tr. 12/13/93 (Coulter) at 11. He also make recommendations to the editor regarding whether or not the article should be published. Tr. 12/13/93 (Coulter) at 11. The American Association on Mental Retardation has recently asked Dr. Coulter to develop a new journal which will be devoted specifically to health care for people with developmental disabilities. Tr. 12/13/93 (Coulter) at 11.

Dr. Coulter has published an extensive number of peer reviewed articles in national publications like the AMA Journal, the New England Journal of Medicine, and several other neurological journals. Tr. 12/13/93 (Coulter) at 11. He has also co-authored a book that was published last year by the AAMR which served as an update or current version of the definition and classification of mental retardation. Tr. 12/13/93 (Coulter) at 11. This book is entered in this case as U.S. Exh. 570. For further details about Dr. Coulter, see U.S. Exh. 1105.

In preparing for his testimony, Dr. Coulter reviewed the trial transcripts and the exhibits used in connection with the testimony of Drs. Kastner, Chamovitz, and Alvarez. Tr. 12/13/93 (Coulter) at 13.

Jeffrey J. Fahs, M.D., was accepted, without objection, as a medical expert qualified to testify about psychiatric issues concerning the mentally retarded. Tr. 8/3/93 (Fahs) at 58-59.

Dr. Fahs is a neuropsychiatrist specializing in the psychiatric care of mentally retarded individuals. Tr. 8/3/93 (Fahs) at 51. Dr. Fahs is licensed to practice medicine in North Carolina. Tr. 8/3/93 (Fahs) at 51-2. He has been board certified by the American Board of Psychiatry and Neurology since 1985. Tr. 8/3/93 (Fahs) at 52.

The bulk of the patients Dr. Fahs sees in his psychiatric practice are mentally retarded individuals. Tr. 8/3/93 (Fahs) at 53. Dr. Fahs is currently employed as a psychiatrist at the Murdoch Center, a large state-run psychiatric facility in North Carolina serving about 750 individuals. Tr. 8/3/93 (Fahs) at 54. Dr. Fahs is the Director of Psychiatric Services at Murdoch. Tr. 8/3/93 (Fahs) at 55. He provides psychiatric care and treatment to any individual who may need it, and he regularly follows all individuals who are receiving psychotropic medications. Tr. 8/3/93 (Fahs) at 55. The individuals at Murdoch are overwhelmingly functioning in the severe and profound range of mental retardation, and there is a relatively high frequency of people with severe behavioral difficulties. Tr. 8/3/93 (Fahs) at 55.

Dr. Fahs has had a great deal of experience providing psychiatric consult services to state-run facilities for individuals with mental retardation. Tr. 8/3/93 (Fahs) at 53-54. While he worked in Alabama, Dr. Fahs provided psychiatric services to four of the five large state-run facilities for mentally retarded individuals. Tr. 8/3/93 (Fahs) at 54. Dr. Fahs testified that the complexion of the populations at these facilities was indistinguishable from the population at Ebensburg. Tr. 8/3/93 (Fahs) at 54. The facilities each served several hundred profoundly and severely retarded individuals having a range of medical and psychiatric difficulties. Tr. 8/3/93 (Fahs) at 54. A large number of individuals had severe behavioral and psychiatric difficulties. Tr. 8/3/93 (Fahs) at 54.

Over the years, Dr. Fahs has been asked to help direct psychiatric consultations and provide training to a number of institutions across the country in many states, including Idaho, Colorado, Utah, Tennessee, West Virginia, Illinois and Virginia. Tr. 8/3/93 (Fahs) at 56.

Dr. Fahs is also currently helping the state of North Carolina devise protocols for the provision of psychiatric services. Tr. 8/3/93 (Fahs) at 56. He is also active in helping to train staff in the various North Carolina state institutions for individuals with developmental disabilities. Tr. 8/3/93 (Fahs) at 56.

Dr. Fahs currently serves on the national board of directors of the National Association for the Dually Diagnosed. Tr. 8/3/93 (Fahs) at 58. The NADD is a multi-disciplinary organization concerned with issues surrounding the severe behavioral and psychiatric difficulties of people with mental retardation. Tr. 8/3/93 (Fahs) at 58. He has also presented frequently at national meetings. Tr. 8/3/93 (Fahs) at 58.

In 1978, Dr. Fahs graduated from the University of Arizona College of Medicine, where he received a Ph.D. Tr. 8/3/93 (Fahs) at 52. He then completed a flexible internship at the Tucson Hospital's Medical Education Program. Tr. 8/3/93 (Fahs) at 52. He completed his psychiatry residency at the University of North Carolina in Chapel Hill. Tr. 8/3/93 (Fahs) at 52. Dr. Fahs next completed a neurology residency at the University of Arizona. Tr. 8/3/93 (Fahs) at 53. In the final year of his psychiatric training, Dr. Fahs concentrated on treating individuals with mental retardation. Tr. 8/3/93 (Fahs) at 52-3. In that year, Dr. Fahs trained under the mentorship of one of the faculty members at the University of North Carolina who was an expert in providing psychiatric care to individuals with mental retardation. Tr. 8/3/93 (Fahs) at 53. Dr. Fahs' training enabled him to provide psychiatric consultation services to a large state-run facility for the developmentally disabled called the Caswell Center. Tr. 8/3/93 (Fahs) at 53.

While at the University of Alabama, Dr. Fahs was an assistant professor of psychiatry at the medical school. Tr. 8/3/93 (Fahs) at 57. He served as the director of the consultation liaison service; provided consultation throughout the hospital; taught second year medical school students about medical interviewing, diagnostic assessments; supervised upperclass medical students in consultation psychiatry; and provided seminar training to residents,

fellows and co-faculty in consultation psychiatry, mental retardation, and neuropsychiatry. Tr. 8/3/93 (Fahs) at 57.

Dr. Fahs has published many peer reviewed articles that have appeared in journals such as the Journal of Developmental and Behavioral Pediatrics, the Journal of Clinical Psychiatry, the New England Journal of Medicine, the American Journal of Psychiatry and Contemporary Psychiatry, and the NADD Newsletter. Tr. 8/3/93 (Fahs) at 57. He also has had the opportunity to contribute to the American Psychiatric Association Treatment Manual on the treatment of psychiatric disorders. Tr. 8/3/93 (Fahs) at 57-58. Dr. Fahs contributed two chapters in this work: one on mental retardation and psychiatric illness and the other on the treatment of psychiatric illness in mentally retarded people. Tr. 8/3/93 (Fahs) at 58. (Dr. Kastner testified that Dr. Fahs is a "wonderful psychiatrist" and a "very skilled psychiatrist." Tr. 9/13/93 (Kastner) at 130, 132.) See also generally, U.S. Exh. 3.

Dr. Fahs was hired by the Justice Department to evaluate the provision of psychiatric services at Ebensburg. Tr. 8/3/93 (Fahs) at 59. Dr. Fahs visited Ebensburg on two separate occasions, in September 1992 and in February 1993. Tr. 8/3/93 (Fahs) at 59. Dr. Fahs toured the facility, observed a number of psychiatric consults conducted at the facility, and interviewed several members of the Ebensburg staff, administration and the consulting psychiatrist. Tr. 8/3/93 (Fahs) at 59-60. Dr. Fahs testified that he was able to see all of the living units of the facility, and the bulk, if not all, of the training areas. Tr. 8/3/93 (Fahs) at 60-61.

Dr. Fahs also reviewed about 30-40 medical records of Ebensburg individuals who were taking psychotropic medications. Tr. 8/3/93 (Fahs) at 60. The individuals selected were either randomly chosen or were looked at because Dr. Fahs had observed them during a consultation. Tr. 8/3/93 (Fahs) at 61. Dr. Fahs testified that he wanted to look at the medical records because they are an ongoing contemporaneous reflection of the care an individual is receiving. Tr. 8/3/93 (Fahs) at 61. He indicated that it also reveals the thinking process of the medical professionals. Tr. 8/3/93 (Fahs) at 61. The medical record serves as a treatment tool for the professionals in the facility, so it aided him in reviewing the quality of care the individuals had received and were receiving. Tr. 8/3/93 (Fahs) at 61-2. Dr. Fahs called the medical record the "keystone of medical evaluation." Tr. 8/3/93 (Fahs) at 62.

Susanne McAllister, M.S., R.P.T., was qualified as an expert in the areas of physical therapy, physical management services, and the therapeutic equipment needs of individuals with physical disabilities. Tr. 7/28/93 (McAllister) at 94. Ms. McAllister received her bachelor of science degree in psychology and biology at Dartmouth College and her masters of science degree in physical therapy at Boston University. Tr. 7/28/93 (Mcallister) at 85. In her two year training program for her master's degree, she completed courses in anatomy, physiology, chemistry, neurology, pathology, and developmental disabilities. Tr. 7/28/93 (McAllister) at 85. In addition, she completed a two year physical

therapy training program at the University Affiliated Program at the Eunice Kennedy Shriver Center in Boston. Tr. 7/28/93 (McAllister) at 85.

Since receiving her physical therapy degree, Ms. McAllister has specialized for the past fourteen years in developmental disabilities. Tr. 7/28/93 (McAllister) at 86. Between 1987 and 1993, she was a partner in Therapeutic Concepts, a company based in Orlando, Florida with six offices around the country with approximately one hundred employees and two hundred subcontractors providing services to individuals with developmental disabilities and physical disabilities. Tr. 7/28/93 (McAllister) at 86-87. She also was a partner in Therapeutic Design, which fabricated and marketed equipment and positioning devices for individuals with physical disabilities. Tr. 7/28/93 (McAllister) at 87. More recently, she has formed a new company in Jackson, Wyoming, called Therapeutic Lifestyles which focuses on individuals who have significant physical disabilities. Tr. 7/28/93 (McAllister) at 87-88.

During the course of her career, Ms. McAllister has been involved in assisting a number of state-operated mental retardation facilities across the country in the development and implementation of physical therapy and physical management programs. Tr. 7/28/93 (McAllister) at 88-91. Her work in state operated mental retardation facilities has had an impact on thousands of individuals with developmental and physical disabilities. Tr. 7/28/93 (McAllister) at 91. Frequently, her involvement in the facilities has been pursuant to consent decrees or institutional reform court orders. Tr. 7/28/93 (McAllister) at 88-91.[1]/ For example, in the early 1980's, Ms. McAllister was part of a court ordered physical therapy team that provided training and technical assistance in therapeutic positioning and handling and transfer programs in a state operated mental retardation facility in Sunland, Orlando. Tr. 7/28/93 (McAllister) at 88. During 1986-1987, Ms. McAllister served on a three person physical therapy task force in Lelsz v. Kavanaugh, where she was responsible for evaluating services at three state operated mental retardation facilities in Texas. Tr. 7/28/93 (McAllister) at 89. Between 1987 and 1992, Therapeutic Concepts was identified in the consent decree to develop and implement physical management programs at Hissom Memorial Center, a state operated mental retardation facility in Oklahoma. Tr. 7/28/93 (McAllister) at 88-89. From 1987-1992, Ms. McAllister was also hired by the State of Oregon to assist with the development of physical management services at Fairview Training Center pursuant to a consent decree. Tr. 7/28/93 (McAllister) at 90. In addition, between 1990-1993, she served as a member of an immediate needs assessment team created pursuant to litigation involving the Wyoming State Training Center. Tr. 7/28/93 (McAllister) at 90. The team was responsible for addressing the needs of physically challenged residents at the Center who were at greatest risk during the pendency of the litigation. Tr. 7/29/93 (McAllister) at 21-22. In other situations, state mental retardation facilities, such as the Coolidge Developmental Center in Arizona and the Hazelwood Developmental Center in

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[1]/ This is the first case, however, in which Ms. McAllister has worked as an expert consultant for the United States Department of Justice. Tr. 7/28/93 (McAllister) at 91.

Kentucky, sought her technical assistance in developing physical therapy and physical management programs. Tr. 7/28/93 (McAllister) at 89-90.

Ms. McAllister has also worked as a physical therapist at facilities for individuals with mental retardation and has published training materials for staff who work with individuals with significant physical disabilities, including Challenges in Physical Management and Physical Management for Professionals. Tr. 7/28/93 (McAllister) at 92-93; U.S. Exh. 71. She has taught courses on physical disabilities at Boston University and Lesley College in Massachusetts and has conducted a number of seminars nationwide on physical management. U.S. Exh. 4.

Ms. McAllister spent five days at Ebensburg Center between November 9 and 13, 1992, evaluating physical therapy and physical management services. Tr. 7/28/93 (McAllister) at 94-95. During the course of her tour, she spent approximately 43 hours at Ebensburg, including observing early morning and late evening activities. Id. at 94-95. Ms. McAllister visited each of the five living units at Ebensburg and the four living areas within each living unit. She spent most of her time (approximately 60 - 70%) in the Keystone unit, where the majority of individuals with significant disabilities reside. Tr. 7/28/93 (McAllister) at 98; Tr. 7/29/93 (McAllister) at 22. Ms. McAllister also spent time during her tour in program areas, the physical therapy and occupational therapy departments, the adaptive equipment shop, and the staff training department. Tr. 7/28/93 (McAllister) at 95. She additionally observed physical therapy programs, occupational therapy programs, active treatment programs, and how residents were transferred, handled, and positioned across different shifts, in different settings, and on different days. Id. at 95-96. Ms. McAllister further observed two complete meal times and worked with seven Ebensburg residents with significant physical disabilities. Id. at 96. Ms. McAllister also directed an FBI photographer to take pictures and videotapes of residents and residents' activities during the course of her tour. Id. at 96. Moreover, she interviewed direct care and professional staff, including the contract physical therapists, the occupational therapist, therapy aides, and the staff development trainer. Id. at 95, 161-162, 231. During her tour as well as following her tour, Ms. McAllister also reviewed individuals' records, Ebensburg documents and policies, staff training materials, and occurrence reports. Id. at 96, 231.

Karen Green McGowan, R.N., was qualified as an expert in the areas of nursing services and nutritional and physical management for individuals with developmental disabilities. Tr. 7/29/93 (McGowan) at 83. Ms. McGowan is a registered nurse who has specialized for the past twenty-eight years in services for individuals labeled as severely to profoundly retarded and medically fragile and complex. Id. at 75. Her specialty includes individuals who are immobile and have associated health problems such as swallowing disorders and gastrointestinal disorders, including gastroesophageal reflux. Id.

Ms. McGowan has been qualified by a federal court as an expert in the areas of physical and nutritional management for mentally retarded people with significant disabilities in a number of states, including Florida, Kentucky, Louisiana, New Hampshire, New York,

North Dakota, Minnesota, and Oklahoma. Id. at 76-77; U.S. Exh. 5. She has held several court-appointed positions in mental retardation institutional reform litigation, including her recent appointment as the physical and nutritional management expert on a three person expert panel to assist the federal district court of Oklahoma with monitoring implementation of the decree involving the Hissom Center. Tr. 7/29/93 (McGowan) at 77.

Over the years, Ms. McGowan has provided consultation to the Willowbrook Review Panel, the Pennhurst Special Master, and the office of the Special Master in the Gary W. case. U.S. Exh. 5 at 2, 7. In addition, she was recently retained by the State of Michigan to provide training and clinical consultation to specialized nursing care facilities in the areas of safe eating, functional positioning, and safe transferring and handling. Id. at 2. For three years, Ms. McGowan served as part of a court appointed interdisciplinary nutrition team to assess and devise plans for five hundred class members of a lawsuit involving Sunland, Orlando, a mental retardation facility in Florida. Id. at 82-83. Between 1989 and 1991 she was responsible for conducting training to prepare clinicians for court certification to participate on the nutrition team. U.S. Exh. 5 at 3. Ms. McGowan has also served as a consultant in the development of the training manual for ICF/MR surveyors. Id. at 6.

For the past seventeen years, Ms. McGowan has had a private practice in which she has provided consultation primarily to state agencies and private organizations regarding services for individuals with complex physical and nutritional needs. Tr. 7/29/93 (McGowan) at 75. In particular, she has been retained by a number of states, including Connecticut, Florida, Louisiana, Michigan, Minnesota, New Jersey, New York, North Carolina, and Pennsylvania to assist in her areas of expertise by developing and implementing services and training staff in facilities, including multiple state-operated institutions involved in institutional reform litigation. Id. at 78-80. Ms. McGowan estimates that over the course of her career she has provided nutritional and physical management services, either directly or indirectly, to several thousand people. Id. at 83.

Ms. McGowan has published in the area of individuals who are medically complex, including several book chapters and a number of training manuals on physical and nutritional management and health care services for developmentally disabled people with significant health care needs. Tr. 7/29/93 (McGowan) at 76; U.S. Exh. 5 at 8-10. She has also taught numerous seminars and training courses throughout the United States and Canada in physical and nutritional management as well as general health care for individuals with developmental disabilities. Tr. 7/29/93 (McGowan) at 79-80. She is an Associate of the National Institute on Mental Retardation and has conducted a four year series of training workshops in nine Canadian provinces on providing services to individuals with complex needs. U.S. Exh. 5 at 3. She has presented a number of seminars in Pennsylvania. For example, in the late 1970's, she provided training for four weeks throughout Pennsylvania in feeding, positioning, handling, and basic health issues in individuals with developmental disabilities. Tr. 7/29/93

(McGowan) at 80-81.[2]/ In the 1980's, she trained close to 200 people in Pennsylvania to provide training throughout the state on medications and related health care issues for people with developmental disabilities. U.S. Exh. 5 at 3.

Between 1987 and 1990, Ms. McGowan was the Director of Quality Assurance for Medical Services Corporation. U.S. Exh. 5 at 2. In this capacity, she was responsible for conducting quality assurance reviews and providing training to nursing and professional staff to meet federal and state standards in service delivery to people who are mentally retarded. Id.

Ms. McGowan has also had experience working for seven years at a state operated mental retardation facility. Between 1965 and 1972, she worked at Glenwood State School, a state operated mental retardation facility in Glenwood, Iowa. Tr. 7/29/93 (McGowan) at 81. During her employ at Glenwood she served as the nursing representative on the diagnostic and evaluation team. Id. at 81. She later became the administrator in charge of health care services and programming for 240 medically fragile residents at the facility. U.S. Exh. 5 at 4. Following her work at in institution, Ms. McGowan was responsible for running community residential programs in Nebraska. Id. at 3.

Ms. McGowan toured Ebensburg on three separate occasions during 1992 and 1993 for a total of 11 days: August 17-21, 1992, November 11 and 12, 1992, and February 22-25, 1993. Tr. 7/29/93 (McGowan) at 88. During the course of her three tours, Ms. McGowan spent approximately 90 hours at Ebensburg. Id. at 89. She observed twenty-one meals, including breakfast, lunch, and dinner in each of the five buildings in which individuals live at Ebensburg as well as in program areas. Id. at 90; U.S. Exh. 75. Approximately one-half of the meals that Ms. McGowan observed were at Keystone. Id. She directed videotaping of a variety of mealtimes during her 1992 tours. Tr. 7/29/93 (McGowan) at 108. In addition, Ms. McGowan toured all of the living units at Ebensburg, observed medication administration and handling of individuals with physical disabilities, and interviewed a number of staff, including the Director of Nurses and nursing supervisors. Tr. 7/29/93 (McGowan) at 89, 211. During her tours, as well as between and following her tours, Ms. McGowan spent approximately 400 hours reviewing the records of 74 Ebensburg residents. Id. at 170, 185. She additionally reviewed a number of related documents, including Ebensburg nursing protocols, memoranda prepared by Ebensburg administrators, mealtime feeding plans, occurrence reports, depositions, and medical assistance findings of deficiencies at Ebensburg involving meal times. Id. at 90, 140, 143, 148, 154, 186, 190.

Leslie Rubin, M.D., was qualified as a medical expert with special expertise in the provision of medical care and related services to people with developmental disabilities,

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[2]/ Spencer Hauenstein, one of the contract physical therapists at Ebensburg through December 1992 attended one of Ms. McGowan's training sessions. Tr. 7/29/93 (McGowan) at 81; Hauenstein Deposition Errata Sheet.

including the treatment of gastroesophageal reflux and feeding disorders, appropriate standards in medical care, and evaluations of the adequacy of medical services. Tr. 12/13/93 (Rubin) at 73.

Dr. Rubin is the Director of Pediatrics at the Developmental Evaluation Center at Children's Hospital in Boston, Massachusetts. Id. at 67. The Developmental Evaluation Center is one of fifty university affiliated programs around the country, created by federal law (the Developmental Disabilities Assistance and Bill of Rights Act), whose mandate is to provide clinical service, teaching, training, research, and technical assistance to individuals with developmental disabilities. Id. at 67-68. Dr. Rubin is also an Assistant Professor of Pediatrics at Harvard Medical School. Id. at 68. He has served on a number of local, regional, national, and international committees and associations dealing with health care issues for individuals with mental retardation. Id. at 68. He is on the Board of Directors of the American Association of University Affiliated Programs (AAUAP) and is chairperson on the Interdisciplinary Council. Id. at 68. As part of his responsibilities with AAUAP, he serves on a health care task force which is developing assessing the health care needs of people with mental retardation and developing policies for health care reform. Id. at 69.

Dr. Rubin has lectured both nationally and internationally on various topics related to health care for individuals with mental retardation. Id. He has published a number of articles and book chapters and has edited a seminal book on medical care for individuals with mental retardation, cited by defendants' experts during their testimony, entitled Developmental Disabilities: Delivery of Medical Care for Children and Adults. Dr. Rubin is a fellow of the American Academy of Cerebral Palsy and Developmental Medicine and is also an editor of a book on Comprehensive Management of Cerebral Palsy. Id. at 70; U.S. Exh. 1106. Dr. Rubin has also presented papers on esophagitis and nissen fundoplication at the Academy of Cerebral Palsy. Id. at 72-73; U.S. Exh. 1106 at 14.

Dr. Rubin has served as Medical Director and Director of Medical Education at state operated mental retardation facilities in Ohio and Massachusetts and has provided consultation services to a number of other facilities providing services to individuals with developmental disabilities. Tr. 12/13/93 (Rubin) at 66-67. He has diagnosed and treated mentally retarded people who have gastroesophageal reflux and feeding disorders, as well as having supervised medical students, residents, and fellows in this area. Id. at 72. He has evaluated medical care in mental retardation facilities on behalf of the Court Monitor in Lelsz v. Kavanaugh, Columbus Medical Services, which provides peer review around the country, and the Department of Justice. Tr. 12/13/93 (Rubin) at 69.

In preparation for his testimony in this case, Dr. Rubin reviewed the trial transcript of Dr. Kastner's and Dr. Sulkes' testimony, the United States' feeding videotape, and records related to Jeff K. Tr. 12/13/93 (Rubin) at 82, 85, 104-105.

Dennis Russo, Ph.D., was qualified as an expert in the provision of psychology services to individuals with mental retardation, with a particular expertise in behavior training programs for people with mental retardation. Tr. 8/2/93 (Russo) at 8.

Dr. Russo was awarded a Ph.D. in educational psychology in 1975. Dr. Russo started his career as a staff psychologist in a state-run institution for mentally retarded people in California. In 1975, Dr. Russo was appointed Director of Training and Clinical Services for the Department of Behavioral Psychology at the John F. Kennedy Institute in Baltimore, Maryland, a position he held for four years. During this time, Dr. Russo was also a behavioral psychology consultant and an assistant professor at the Johns Hopkins University School of Medicine.

In 1979, Dr. Russo became Chief of Behavioral Psychology in the Department of Psychiatry for The Children's Hospital in Boston, Massachusetts. From 1981 until 1989, Dr. Russo was the Director of the Behavioral Medicine Program at Children's Hospital. Dr. Russo is currently an associate professor of psychology at the Harvard Medical School. He is also currently vice-president of the health and rehabilitative services of the May Institute, a private not-for-profit corporation serving individuals with developmental disabilities.

Dr. Russo is a Diplomate of the American Board of Professional Psychology (the equivalent of board certification in the field of psychology) in the area of his specialization, behavioral psychology, and is a Diplomate of the American Board of Behavioral Psychology in Behavior Therapy. Dr. Russo is a member of and has held offices in many nationally recognized professional societies, including the office of President of the Association for Advancement of Behavior Therapy. Dr. Russo is currently on the Board of Directors of the American Board of Behavioral Psychology. Dr. Russo has published extensively in the field, and is currently on the editorial boards of six journals, including some of the major journals in the field. Dr. Russo has served on several national task forces in the field and given numerous presentations. Tr. 8/2/93 (Russo) at 2-7; U.S. Exh. 6.

Dr. Russo was a court-appointed expert in Lelsz v. Kavanaugh, where the court asked Dr. Russo to evaluate the adequacy of psychology services and protection from harm at a state institution for mentally retarded people in Texas. Tr. 8/2/93 (Russo) at 7-8.

Dr. Russo toured Ebensburg on three occasions between September 1992 and February 1993 to evaluate whether the psychology services at Ebensburg comport with generally accepted practices for psychology and to evaluate whether residents are being harmed as a result of Ebensburg's psychology services. Tr. 8/2/93 (Russo) at 9. During his tours of Ebensburg, Dr. Russo visited all of the living units and day programs at the institution at a variety of times of the day, including early morning and into the evening. Tr. 8/2/93 (Russo) at 9. Dr. Russo also interviewed a number of Ebensburg staff at both the direct care and professional level. Tr. 8/2/93 (Russo) at 9-10. Dr. Russo attended the September 23, 1992 Behavior Intervention Committee meeting. Tr. 10/15/93 (O'Brien) at 108; U.S. Exh. 42(c). Dr. Russo also directed an FBI photographer to take pictures and

videotapes of residents and residents' activities during the course of his tour. Both during his tours and afterwards, Dr. Russo evaluated resident records. He reviewed records of approximately 50 clients, more than a 10% sample of the residents at Ebensburg. Tr. 8/2/93 (Russo) at 9.

Jack A. Stark, Ph.D., was qualified as a general expert in the area of services for people with mental retardation. Tr. 7/26/93 (Stark) at 33. He has worked in the field of mental retardation for the past twenty-five years. Tr. 7/26/93 (Stark) at 27-28. Following a period of time in the seminary at Holy Cross College in LaCrosse, Wisconsin and then earning a bachelor of arts in philosophy from St. Francis College in Milwaukee, Wisconsin, he pursued his graduate work at the University of Nebraska in Lincoln. U.S. Exh. 7 at 1. Dr. Stark received a master's degree in rehabilitation psychology, specializing in individuals with developmental disabilities and a Ph.D. in counseling psychology with an emphasis on people with disabilities and a specialization in medical psychology. Id. at 27; U.S. Exh. 7 at 1. He is a board certified psychotherapist, is on the National Registry of Health Service Providers in Psychology, and is a licensed and certified clinical psychologist in the state of Nebraska. U.S. Exh. 7 at 2.

Dr. Stark's involvement in the field of mental retardation has included direct service, administration, teaching, presentations and technical assistance, publications, grant management, and activities in national associations and organizations. His years of professional service to the field have distinguished him as a national leader in the field. In terms of direct service, Dr. Stark has worked with individuals of all age levels from pre-school to the elderly. Tr. 7/26/93 (Stark) at 28. His involvement has spanned a variety of service settings from schools, community programs, vocational programs, and residential programs. Id.

For eight years between 1973 and 1981, Dr. Stark administered programs at the Meyer Children's Rehabilitation Institute in Omaha, Nebraska, a university affiliated program serving individuals with developmental disabilities, where he served at various times as Director of Adult Rehabilitation Programs and Director of the Center for Comprehensive Rehabilitation. U.S. Exh. 7 at 4. For the following eleven years he was the associate director and director of research and services for the National Center for Persons with Mental Retardation and Mental Illness (also called the Developmental Disabilities Program and National Research Center) in Omaha, Nebraska. Tr. 7/26/93 (Stark) at 28. In this capacity, he trained staff from eighty to one hundred mental retardation facilities around the country who brought their most challenging residents to the Center to learn appropriate treatment techniques. Id. at 29, 120.

Dr. Stark has been a faculty member at medical schools for the past twenty years and has taught physicians, psychiatrists, psychologists, occupational and physical therapists, and other professionals in the area of mental retardation. Id. In addition, Dr. Stark has conducted several hundred seminars across the nation, providing technical assistance to associations and facilities similar to Ebensburg. Id. His particular areas of expertise in

mental retardation are families, vocational services, individuals with a dual diagnosis of mental retardation and mental illness, and medical breakthroughs in treating people with mental retardation. Id. at 32-33.

Dr. Stark has been publishing in the field of mental retardation for the past 22 years. He has edited or authored nine books on the topic of mental retardation, has published more than 25 monographs and articles in journals, and has written chapters in an additional 25 books on various issues in the field. Tr. 7/26/93 (Stark) at 30; U.S. Exh. 7 at 11-16. He was one of the authors of the American Association of Mental Retardation's 1992 book entitled Mental Retardation, Definition, Classification, and Systems of Supports; U.S. Exh. 570. Dr. Stark has also served in editorial capacities for journals in the field, including serving as a consulting editor for Mental Retardation. U.S. Exh. 7 at 11. Moreover, Dr. Stark has 23 years of experience in writing and directing more than 55 grants in various areas of mental retardation services which have been funded by state and federal agencies. Tr. 7/26/93 (Stark) at 30.

Dr. Stark has consulted to federal agencies, including the Administration on Developmental Disabilities and the President's Committee on Mental Retardation. Tr. 7/26/93 (Stark) at 30. He is active in a number of national organizations involved with mental retardation issues. Dr. Stark is the immediate past president of the American Association on Mental Retardation (AAMR), the largest association in the world of interdisciplinary professionals involved in mental retardation, which sets standards in the field for people with mental retardation. Id. at 31. He has been actively involved in AAMR for many years and has been elected to a variety of offices in the Association, including being elected by the membership at large to be president in 1992.

Dr. Stark was also elected to serve a two year term as President of the National Academy on Mental Retardation between 1991 and 1993. Tr. 7/26/93 (Stark) at 31; U.S. Exh. 7 at 6. The Academy has 250 members who are the leading researchers and publishers in the field of mental retardation from around the world. The Academy is compromised of a wide variety of professionals, including physicians, psychologists, physical therapists, occupational therapists, and attorneys. Id. at 31. Dr. Stark has also served on a variety of committees of the National Association for Retarded Citizens and was elected as a fellow of the AAMR and the Mental Retardation Division of the American Psychological Association. Id.; U.S. Exh. 7 at 7.

In addition to his wide ranging professionals activities in the field of mental retardation, Dr. Stark has a son who is profoundly mentally retarded and physically disabled. Tr. 7/26/93 at 33. In Dr. Stark's words, he "know[s] what it's like to take care of someone twenty-four hours a day, seven days a week, for the last twenty-one years." Id.

Prior to this litigation, Dr. Stark was never involved with the Department of Justice or any other litigation involving the rights of people in institutions. Tr. 7/26/93 (Stark) at 31-32. He has served as a court appointed expert for the Social Security Administration in a number of worker's compensation cases. Id. at 32.

Dr. Stark toured Ebensburg on February 22 and 23, 1993. Tr. 7/26/93 (Stark) at 76-77. He toured each of the living and program areas at Ebensburg and spent approximately eighteen hours observing conditions, interviewing staff, interacting with residents, and reviewing documents. Id. at 77. He toured Ebensburg early in the morning as well as late at night. Id. at 77. Dr. Stark sat in on a drug review. Tr. 7/26/93 (Stark) at 229. He interviewed each of the top management staff at Ebensburg as well as direct care staff. Dr. Stark spent approximately twenty to twenty-five days, in addition to his on-site time at the facility, reviewing documents related to Ebensburg, including policies, memoranda, individual resident records, and thousands of occurrence reports. Id.

Stephen Sulkes, M.D. was accepted, without objection, as a medical expert qualified to testify about medical and health care issues present among individuals with developmental disabilities. Tr. 7/27/93 (Sulkes) at 80. Dr. Sulkes is a licensed pediatrician specializing in the care of people with developmental disabilities. Tr. 7/27/93 (Sulkes) at 72 He has been board certified in pediatrics by the American Board of Pediatrics for the past ten years. Tr. 7/27/93 (Sulkes) at 73. Since becoming a licensed physician, Dr. Sulkes has devoted one hundred percent of his clinical medical practice to the care, treatment and research needs of those individuals with developmental disabilities. Tr. 7/27/93 (Sulkes) at 75. Dr. Sulkes estimated that the total number of individuals with developmental disabilities he has treated over the years is "[t]oo numerous to count." Tr. 7/27/93 (Sulkes) at 76.

Currently, Dr. Sulkes works at the Strong Center for Developmental Disabilities which is a division of the Department of Pediatrics at the University of Rochester School of Medicine in New York. Tr. 7/27/93 (Sulkes) at 77, 78. The Strong Center program is a federally-funded, university-affiliated program whose goal is to provide exemplary service, training and medical care for people with developmental disabilities, to undertake research and to provide technical assistance to other agencies and individuals who work with people with developmental disabilities. Tr. 7/27/93 (Sulkes) at 78.

At the Strong Center, Dr. Sulkes is the Director of Services, providing medical care for the developmentally disabled individuals at the Center; he is the Pediatric Discipline Coordinator in charge of inter-disciplinary training of physicians; and he is the coordinator of a New York state-funded fellowship training program that trains physicians, dentists, psychiatrists, psychologists in the care of those with developmental disabilities. Tr. 7/27/93 (Sulkes) at 78.
Dr. Sulkes is also an Associate Professor of Pediatrics at the University of Rochester School of Medicine. Tr. 7/27/93 (Sulkes) at 79.

His work at the Strong Center keeps him in close collaboration with New York state run residential facilities for the developmentally disabled. Tr. 7/27/93 (Sulkes) at 78.
Dr. Sulkes is personally quite familiar with medical care at state-run institutions for the developmentally disabled. Tr. 7/27/93 (Sulkes) at 76. He first started working as a full-time doctor in New York at the Monroe Developmental Center, a New York state facility for people with developmental disabilities. Tr. 7/27/93 (Sulkes) at 76. At the time he worked

there, Monroe housed about the same number of people with roughly the same array of disabilities as those individuals who live currently at Ebensburg Center. Tr. 7/27/93 (Sulkes) at 76. Dr. Sulkes worked as a primary care physician for the individuals at Monroe. Tr. 7/27/93 (Sulkes) at 76. He was responsible for all the health care needs and the health care management for his residents at Monroe. Tr. 7/27/93 (Sulkes) at 77. He made daily rounds, sat in on inter-disciplinary team case reviews, addressed chronic and acute medical problems, and served as attending physician in the hospital when necessary. Tr. 7/27/93 (Sulkes) at 77.

In addition, during the time of his medical fellowship in Massachusetts, Dr. Sulkes worked as a primary care physician at the Wrentham State School, which is a Massachusetts state residential facility for people with developmental disabilities like Ebensburg Center. Tr. 7/27/93 (Sulkes) at 74. At the time he worked there, about 700 individuals lived at Wrentham and these individuals had roughly the same array of disabilities as the individuals living at Ebensburg Center. Tr. 7/27/93 (Sulkes) at 74. Also during his fellowship, Dr. Sulkes worked as a primary care physician at the Massachusetts Association for the Blind, which is a smaller Massachusetts residential facility housing about 25 individuals with mental retardation and multiple disabilities. Tr. 7/27/93 (Sulkes) at 75.

During his fellowship at the Developmental Evaluation Center (DEC) at Boston Children's Hospital, Dr. Sulkes was engaged in the practice of medicine exclusively with those individuals with developmental disabilities. Tr. 7/27/93 (Sulkes) at 75. At DEC, he received specialized clinical and didactic training in treating the developmentally disabled in both the medical and inter-disciplinary aspects of care. Tr. 7/27/93 (Sulkes) at 74. As part of his clinical training at DEC, he worked with a dysphagia or feeding team in evaluating swallowing problems, and he served as the coordinator of the Down's Syndrome program. Tr. 7/27/93 (Sulkes) at 74.

Dr. Sulkes has published a number of peer reviewed articles in such journals as the American Journal of Mental Deficiency, (now called Mental Retardation), Research in Developmental Disabilities and Pediatrics. Tr. 7/27/93 (Sulkes) at 79; U.S. Exh. 8. In the medical field specializing in the care and treatment of those with developmental disabilities, Dr. Sulkes has also engaged in a number of funded research projects, has given many regional and national presentations, and has written chapters in medical textbooks. U.S. Exh. 8. Dr. Sulkes has experience working with people with dysphagia. Tr. 7/28/93 (Sulkes) at 45. He provides consultations for people with feeding disorders and dysphagia in his current medical practice. Tr. 7/28/93 (Sulkes) at 45. He has given a presentation on interdisciplinary approaches to dysphagia to a national meeting. Tr. 7/28/93 (Sulkes) at 45. Most notably, Dr. Sulkes has published two chapters in the textbook entitled Developmental Disabilities, edited by Drs. Leslie Rubin and Allen Crocker. U.S. Exh. 8. This book was cited as an authoritative text by the defendant's feeding expert Dr. Sheppard. Tr. 10/18/93 (Sheppard) at 130.

In April 1989, Dr. Sulkes was first hired by the United States Department of Justice to assess and develop an opinion on the quality of medical and health care services provided to the residents of Ebensburg Center. Tr. 7/27/93 (Sulkes) at 80.
Dr. Sulkes testified that he did not go to Ebensburg Center with any preconceived notion of what he was going to find. Id. at 40. He visited Ebensburg Center on five separate occasions: April 1989, November 1990, January 1992, September 1992 and November 1992. Id. at 81. Dr. Sulkes spent about 80 total hours actually at the facility. Id. At one time or another, he testified that he had personally observed most if not all people who live at the facility. Id. at 83. He observed the residents both in their residential settings and in their day treatment programs. Id. at 81. Throughout his various tours, he visited all the living areas at Ebensburg Center. Id. During his tours, Dr. Sulkes interviewed many individuals working at Ebensburg Center including the facility director, Mr. Bellomo, the director of program services, Mr. O'Brien, all the physicians, the director of nursing, the head of the pharmacy, the dentist, the infection control nurse and some motor therapists. Id. at 85. In addition, Dr. Sulkes spent dozens of additional hours outside the facility further reviewing Ebensburg Center records and documents. Since 1989, Dr. Sulkes reviewed over one hundred Ebensburg Center resident medical records. Id. at 83. He selected the records he wanted to review based upon his own observations of residents while he toured the facility each time, based upon his discussions with Ebensburg staff, and based upon hard data about the residents provided him by the facility. Id. at 84.

EBENSBURG CLIENT SUMMARIES

OVERVIEW

The following summaries illustrate how the deficiencies set forth in the United States' Detailed Findings of Fact have had an impact on the lives of but a few of the people who live at Ebensburg. Inasmuch as evidence was presented on over 450 Ebensburg residents, the summaries are by no means an exhaustive listing. They demonstrate the common themes that underlie the deficient care at Ebensburg and the significant harm that has resulted to individual residents.

The following ten Ebensburg residents are highlighted:

ANN B.

1. Ebensburg Fails to Protect Ann B. from Harm -- Undue Restraint

a. Mechanical Restraint

Ann B. spends so much time restrained in her restraint chair that Defendants do not even include her time in restraint in their statistics. Def. Exh. Q. Mr. O'Brien explained that the reason Ann's time in restraint is not included in Defendants' time-in-restraint exhibit is that if it were included, "it would totally skew it." Tr. 10/15/93 (O'Brien) at 121.

In early 1986, Ebensburg was restraining Ann for her self-injurious behavior with a papoose board or helmet at a rate of less than two hours per month. Tr. 8/2/93 (Russo) at 65; U.S. Exh. 93. In April 1986, Ebensburg introduced the restraint chair as part of Ann's behavior program for self-injurious behavior, which resulted in an immediate and significant increase in Ann's rate of restraint. Tr. 8/2/93 (Russo) at 65; U.S. Exh. 93. Instead of making informed clinical judgments and recognizing that Ann was one of a whole class of individuals who self-injure in order to obtain restraint, for approximately a three year period after introducing the restraint chair to Ann, Ebensburg did not change her behavior program.

Ann has been spending increasing amounts of time in her chair and the rate of Ann's self-injurious behavior is increasing. Tr. 8/2/93 (Russo) at 65; U.S. Exh. 783. Except for a period of hospitalization in April 1993, Ann has been spending over 250 hours per month in her restraint chair since February 1991. U.S. Exh. 286, 783. In May 1993, Ann spent more time in her restraint chair (351 hours) than during any previous month at Ebensburg.

Id. Ann is shown being restrained in her chair at the end of Dr. Russo's videotape. Tr. 8/2/93 (Russo) at 91-93; U.S. Exh. 260.

b. Chemical Restraint and Inadequate Psychiatric Care

Ann experiences side effects from taking psychotropic medication for her self-injurious behaviors. U.S. Exh. 640 (Stratton Dep.) Exh. 2. Dr. Goldschmidt observed in November 1992 that Ann's tongue is protruding. Id. Ann is taking Cogentin for the treatment of extra-pyramidal symptoms ("EPS"). Id. EPS is a common side effect of psychotropic medication. Tr. 8/3/93 (Fahs) at 67-68. In spite of the fact that Ann took psychotropic medications for her self-injurious behavior for many years, Dr. Goldschmidt only saw Ann five times between April 1986 and January 1992. U.S. Exh. 640 (Stratton Dep.) Exh 2.

2. Ebensburg Fails to Protect Ann from Harm -- Inadequate Behavior Program

Ann's behavior program has not been revised since April 1990. U.S. Exh. 93. Dr. Russo testified that Ann's behavior program is not effective. Tr. 8/2/93 (Russo) at 65-66; U.S. Exh. 783. As the regression analyses in U.S. Exh. 783 relating to Ann show, Ebensburg's behavior program to reduce Ann's self-injurious behavior and to reduce the time that Ann spends in her chair is not working. Ann is an example of an Ebensburg resident on a behavior program whose behaviors are getting worse. U.S. Exh. 783.

Ebensburg's failure to revise Ann's behavior program in a timely manner has caused tremendous harm to Ann. Tr. 8/2/93 (Russo) at 65-66. Ebensburg's failure to revise her program has created Ann's enormous dependence on the chair and, as discussed above, a

case of chronic restraint. Tr. 8/2/93 (Russo) at 65-66. More importantly, Ebensburg has perpetuated Ann's self-injurious behavior by not adequately addressing it. Tr. 8/2/93 (Russo) at 65-66.

Ann suffers many injuries from her self-injurious behaviors. U.S. Exh. 135, 958. Between May and mid-August 1993 alone, Ann hurt herself four times through self-abuse. U.S. Exh. 958. Dr. Goldschmidt concluded that Ann's behavior is deteriorating because of the brain injuries she is sustaining due to her head banging. U.S. Exh. 640 (Stratton Dep.) Exh. 2.

The significant amount of time that Ann spends in her restraint chair is also causing Ann much harm. While in restraint, she is not receiving needed positive habilitation and skills development training. Tr. 8/2/93 (Russo) at 66, 92.

3. Ebensburg Has Failed to Obtain Outside Expertise

Defendants' psychology expert, Dr. Reid, thought that Ebensburg should be doing more for Ann, and he is not satisfied with her case. Tr. 9/16/93 (Reid) at 117. Dr. Reid relied on Ebensburg's representations that they had sought outside consultation from the Kennedy Institute, but he was not aware that the Kennedy Institute consultation occurred five years ago. Tr. 9/16/93 (Reid) at 159. At the time Ann received a consultation from the Kennedy Institute in 1988, she had been in her chair for about two years. The Kennedy Institute recognized that Ann's chair was serving a protective function, but cautioned that the chair must be considered as only a way station, and not as a final goal for Ann. Tr. 8/2/93 (Russo) at 101. The Kennedy Institute provided valuable information to Ebensburg concerning Ann's motivation for her self-injury, but Ebensburg failed to use that information

to change its treatment for her. Tr. 8/2/93 (Russo) at 101, 103-104. Ebensburg did not do its own functional analysis of Ann's behavior until March 9, 1993. U.S. Exh. 964.

4. Ebensburg Fails to Provide Ann with Adequate Nursing Care

Ann required emergency hospitalization for a bowel obstruction on September 16, 1991. Tr. 7/29/93 (McGowan) at 181. While in the emergency room, she went into respiratory arrest and had to have part of her bowel removed. Tr. 7/29/93 (McGowan) at 181. There is an indication in Ann's chart that she has suffered the bowel obstruction and has had a colostomy as a result of prolonged inactivity in her chair. Tr. 8/2/93 (Russo) at 66, 92.

Ebensburg nurses did not chart any vital signs prior to her hospitalization. Tr. 7/29/93 (McGowan) at 182. Contrary to accepted nursing practice, Ebensburg nurses treated her with Tylenol and fleet enemas despite the fact that there were clear signs and symptoms of an acute abdominal condition. Tr. 7/29/93 (McGowan) at 182.

FRANKLIN B.

1. Ebensburg Fails to Protect Franklin B. from Harm -- Undue Restraint

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

Franklin has been injured several times while being restrained. For instance, on October 20, 1992, Franklin banged his face on the floor during floor control procedures. As a result of the trauma, Franklin's right upper central incisor became loosened and was bleeding. U.S. Exh. 992. On May 27, 1993, Donald P. tried to bite Franklin. Franklin ran away, hitting others. Floor control was used, causing an abrasion to Franklin's back. U.S. Exh. 992. And on June 3, 1993, Franklin was tearing his clothing. Staff used floor control on Franklin. During floor control, Franklin's lower lip was injured and there were two open areas on Franklin's right forearm. Franklin also had blood all over his face. U.S. Exh. 992.

2. Ebensburg Fails to Intervene to Protect Franklin and Others from Injuries due to Franklin's Behaviors

Franklin has caused many injuries to himself and others, due, in part, to the fact that there are not enough staff at Ebensburg to protect Franklin and his peers from harm due to

Franklin's behaviors. For example, on January 15, 1992, at 8:15 a.m. in Horizon House, in the words of one of the two supervisors who reported to work there that morning, "the staff pattern was a mess." U.S. Exh. 132 at 40544. In West II, where Ibrahim D. was fighting with Franklin, "there was total chaos." Id. Ibrahim was restrained in a papoose board. As Ibrahim was completely immobilized in the papoose board, Franklin continued aggressing toward Ibrahim and kicked him in the face, in spite of staff monitoring during the restraint use. Ibrahim suffered a lacerated lip and a "foot print on the bridge of his nose." For the next fifteen minutes, while Ibrahim remained in the papoose board, Franklin stayed in the room with Ibrahim, and Franklin kept lunging at the staff guarding Ibrahim. Staff could not remove Franklin from the area due to lack of staff. Id. at 40544(a). On February 15, 1993, staff saw Franklin slapping his face and banging his head against the wall. Staff's response was to notify the nurse, who found Franklin still actively slapping his face and banging his head when she arrived. In March 1993, Franklin became uncontrollable at his day programming site. He was throwing large wooden boxes, flipping tables, attempting to smash his chair and hit other clients, and eventually ended up breaking the loading dock door with his head. Staff requested that a psychologist intervene, but none was available. U.S. Exh. 105; Tr. 8/2/93 (Russo) at 16-18. Ebensburg rates this incident as resulting in no injury to Franklin. Id.

Between May and August 1993, Franklin caused 11 injuries to himself or others, including causing Dennis B.'s temple to bleed; slapping Eric S. in the mouth, resulting in the extraction of Eric's front tooth; and biting Elliot G. twice. In spite of the fact that

Ebensburg acknowledged that Franklin was presenting a severe behavior disruption, his behavior program was not modified and only his medications were adjusted.

3. Ebensburg Fails to Provide Franklin with Adequate Psychiatric Care

Ebensburg fails to provide Franklin was adequate psychiatric care. In particular, Ebensburg has not done a proper psychiatric assessment for Franklin, leading to a delay in treatment while his aggression and severe agitation continue. Tr. 8/3/93 (Fahs) at 110. If Franklin had received an adequate and appropriate assessment and diagnosis, it is less likely that his aggression would have increased. Id. Overall, the psychiatric services provided to Franklin are inadequate because they are being rendered without data and they are not sufficiently coordinated with the psychiatrist, all leading to harm and injury for Franklin and his peers from continued agitation and aggression. Tr. 8/3/93 (Fahs) at 117.

At the end of the psychiatric consult provided to Franklin in June 1993, Defendants' psychiatric expert, Dr. Lubetsky, indicated that the team had still not completed a differential diagnosis on him. Tr. 9/14/93 (Lubetsky) at 181-182. Dr. Lubetsky admitted that it would have been helpful if the team had explored the precipitant of Franklin's behavior and the consequences of his behavior, but these topics had not been discussed. Tr. 9/14/93 (Lubetsky) at 182. Dr. Lubetsky indicated that it would also have been helpful to have more information about Franklin's target behaviors presented at the consult. Tr. 9/14/93 (Lubetsky) at 182-4. Dr. Lubetsky indicated that hard data and functional analysis of Franklin's behavior would help the psychiatrist appropriately treat the individual's target behavior. Tr. 9/14/93 (Lubetsky) at 185.

The diagnoses provided for Franklin changed over the years for reasons that were not entirely clear because the reasons for the changes were not articulated in the record. Tr. 8/3/93 (Fahs) at 111. At one point his Haldol was increased presumably because his behavior had worsened. Id. However, it was difficult for Dr. Fahs to tell if his behavior actually worsened because there was no intensity behavioral data or information in the record. Id. Dr. Fahs testified that the intensity data was "conspicuous by its absence;" "there was no measure of intensity." Tr. 8/3/93 (Fahs) at 111-112. The only information on which to proceed is anecdotal. Tr. 8/3/93 (Fahs) at 112. At another time, it was problematic for Dr. Fahs that Franklin was subjected to a "major medication change and a major environmental change occurring within two days of each other." Id. Dr. Fahs testified that that is something to be avoided. Id.

The psychiatrist made several recommendations to discontinue or decrease Franklin's psychotropic drugs, but none of her recommendations were implemented. Tr. 8/3/93 (Fahs) at 114-115. Dr. Fahs was perplexed why the changes had not been made since Franklin's behaviors had worsened. Tr. 8/3/93 (Fahs) at 115. Dr. Fahs stressed the need for follow-up of recommendations from the psychiatrist. Id. There was also a recommendation to decrease one of his psychotropic medications, and yet this was never done and it was not clear why it had not been done. Id.

Franklin was scheduled to be reviewed by Ebensburg's Behavior Intervention Committee in December 1992 when Dr. Fahs was present at the facility. Tr. 8/3/93 (Fahs) at 115-116. Dr. Fahs testified that he was "anxious to see how deliberations went for consideration of a new drug." Tr. 8/3/93 (Fahs) at 116. However, at the time, Dr. Fahs

was told that Franklin could not be reviewed that day because there was no data on him. Id. Dr. Fahs testified "in my mind, what I thought was, well, so now they're going to go back and do the things that I've been mentioning earlier, provide good baseline data or whatever, and it will be reviewed again. That's the purpose of those kinds of reviews." Id. However, when Dr. Fahs was finally able to review Franklin's record after the fact, he discovered that the medication was started five days after that behavior management meeting was scheduled to have taken place. Id. This indicated to Dr. Fahs that the kind of review Franklin had been provided was not useful. Id. Dr. Fahs found it hard to imagine that an adequate amount of information could have been retroactively put together in five days to support the proposed action. Tr. 8/3/93 (Fahs) at 136. In fact, Franklin worsened a lot after the medication was started, and it was discontinued about a month later. Tr. 8/3/93 (Fahs) at 116. He continues to be agitated. Id.

4. Ebensburg Physicians Fail to Implement the Recommendations of Outside Consultants, Causing Franklin Harm

Ebensburg's consultant neurologist and consultant psychiatrist each had recommended that Franklin's anticonvulsant and psychotropic medications be tapered. However, two years passed and the tapers did not occur. Tr. 7/28/93 (Sulkes) at 8-9. There was no indication that the primary care physician ever paid any attention to the recommendations or documented any justification for not following the recommendations. Tr. 7/28/93 (Sulkes) at 18. Franklin's sixty day notes did not mention this proposed taper or any reason why he should not be given a taper in his medications. Tr. 7/28/93 (Sulkes) at 9. In addition, this proposed taper was not mentioned in Franklin's annual review. Tr. 7/28/93 (Sulkes) at 9.

SAM B.

1. Ebensburg Failed to Provide Sam B. with Adequate Medical and Nursing Care

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

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

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

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

Nurses did not conduct assessments of his health condition in the months prior to his death when he was vomiting, having difficulty swallowing, refusing meals, and had an elevated temperature. Tr. 7/29/93 (McGowan) at 177-178.

2. Ebensburg Failed to Feed Sam in a Safe Manner

Dr. Sulkes watched Sam being fed at Ebensburg, in November 1992, about five months before Sam died. Tr. 7/27/93 (Sulkes) at 99, 101, 133. At that time, Dr. Sulkes observed that Sam had been provided with no head control, there was no head control suggested in his program, and staff fed Sam while he was coughing. Tr. 7/27/93 (Sulkes) at 133.

Ms. McGowan also observed Sam being fed in a unsafe position. In particular, she saw Sam being fed with his head in extension and rotated. Tr. 7/29/93 (McGowan) at 94, 116-123. Sam is shown on the feeding videotape, entered into evidence as U.S. Exh. 258, being fed with his neck and head in extension and rotated. Tr. 7/29/93 (McGowan) at 116-123. Sam is also pictured in United States' Exhibits 242 and 243.

RON E.

1. Ebensburg Fails to Provide Ron E. with Adequate Physical Management

Ron E. lives in a cart at Ebensburg. Ron's orthopedic notes indicate that the curvature from his scoliosis increased during a two year period of time while under Ebensburg's care from approximately forty-five degrees to one hundred ten degrees. Tr. 7/28/93 (McAllister) at 115-116. This has resulted in a deformity pattern where his head and legs are bowed backwards. Tr. 7/28/93 (McAllister) at 115-116. A picture of Ron appears as United States' Exhibit 687. His deformity pattern is currently so severe that he sometimes assumes a bowed position where his head reaches his feet. Tr. 7/28/93 (McAllister) at 116. Ron's deformity pattern is similar to the deformity pattern exhibited by Kent, a client with whom Ms. McAllister worked in the early 1980's. Id. at 115, 117. When Ms. McAllister first started working with Kent, he lived in a cart, similar to the cart in which Ron currently lives. Id. at 116, 118; U.S. Exh. 686. By placing Kent in various therapeutic positioning devices, his trunk was straightened and his hip flexion increased to the point where he was able to be placed in a customized powered wheelchair. Tr. 7/28/93 (McAllister) at 117; U.S. Exh. 688. Within a year and a half, Kent progressed from being immobile and confined to a cart to independent mobility. Tr. 7/28/93 (McAllister) at 117-118.

Ebensburg staff fail to handle, lift, and transfer Ron in a safe fashion. Tr. 7/28/93 (McAllister) at 222-223. Videotape footage of staff transferring Ron from a mat on the floor to an air mattress appears in United States' Exhibit 261. Ms. McAllister was concerned that staff plopped him on the air mattress and then pulled Ron by his arms and legs to turn him over. Tr. 7/28/93 (McAllister) at 222. This places a lot of pressure on shoulder and knee

joints and places Ron at risk of injury to the joints. Id. Staff did not make any effort to place Ron in proper alignment once they turned him over. Id.

The only physical therapy related services that Ron receives is percussion, which Ebensburg did not start until late 1992. U.S. Exh. 343. The percussion is provided by a physical therapy aide, not a physical therapist. Between December 1992 and March 1993, Ron was only scheduled for 29 percussion sessions. Id. He only actually received 22 sessions because he was hospitalized for part of the time. Id. As of April 27, 1993, the last time a physical therapist had actually reviewed the physical therapy aide's quarterly progress notes was 4 months earlier, on December 18, 1992. Tr. 10/13/93 (Arnall) at 94; U.S. Exh. 343.

Neither a physical therapist nor a physical therapy aide attended Ron's annual review in either 1992 or 1993, despite the fact that he receives percussion by a physical therapy aide and also has had a serious skin breakdown that lasted for more than a year. Tr. 10/13/93 (Arnall) at 25-28; U.S. Exh. 343. At his 1992 annual review, Ron's interdisciplinary team identified the need for a physical therapist to evaluate his lower extremities to facilitate their separation. U.S. Exh. 343 at 00082563.

An orthopedic evaluation of Ron in 1990 specifically recommended that "[a]t this point care should be taken in the positioning of the patient so that we do not have skin breakdown." Tr. 10/13/93 (Arnall) at 21; U.S. Exh. 1005. Beginning November 1990, shortly after the orthopedist made this recommendation, Ron began having a skin breakdown that continued to worsen through at least January 1992. Tr. 10/13/93 (Arnall) at 21-24; U.S.

Exh. 343. Between May 1991 and January 1992, the skin breakdown prevented Ron from being positioned at all on his side. Id.

2. Ebensburg Fails to Provide Ron with Adequate Nutritional Management and Safe Feeding Practices

Ron is fed in his cart. Tr. 7/29/93 (McGowan) at 111; U.S. Exh. 228. He is shown on two segments in United States' Exhibit 258 being fed in his cart and, in one segment, immediately after his meal. Tr. 7/29/93 (McGowan) at 111, 112, 128. Ron is coughing and experiencing distress in all three of the segments. Id. Dr. Sheppard agreed that Ron was experiencing difficulty on the videotape. Tr. 10/12/93 (Sheppard) at 47. Ms. McGowan repeatedly observed Ron experiencing distress during mealtimes during her many mealtime observations. For example, on August 18, 1992, Ron was coughing with almost every swallow and having difficulty breathing. Tr. 7/29/93 (McGowan) at 99-100. Tr. 7/29/93 (McGowan) at 100. On August 20, 1992, Ron was coughing and spurting out food during the mealtime. Immediately after the meal, he was kept flat on his back in his living unit and continued coughing in an attempt to expel what was trapped in his airway. Id. at 112, 113, 128; U.S. Exhs. 229, 258. Three months later, in November 1992, Ebensburg's Director of Occupational Therapy noted that Ron was having difficulty during mealtimes and thought that until Ebensburg got an expert in to assist with Ron, all staff can do is "trial and error." U.S. Exh. 617 (Graham Dep.) at 179. The head of Ebensburg's Dysphagia Team has also observed Ron frequently coughing and possibly choking during meals. U.S. Exh. 641 (Wagner Dep.) at 60, 61.

Ron has a history of choking, emesis, and hospitalizations for aspiration pneumonia and bowel obstruction. Tr. 7/29/93 (McGowan) at 111; U.S. Exh. 144. He is frequently

constipated and Ebensburg acknowledges that his inactivity and diet contribute to his constipation. U.S. Exh. 343 (5/26/93 annual review) at 6; Tr. 7/29/93 (McGowan) at 180. His body mass index (a way of calculating his nutritional health) is only 16.92 -- significantly below the lowest limit of the normal range of 21-27. U.S. Exh. 970.

Ms. McGowan has observed Ron being fed in an unsafe manner and in an unsafe position. For example, on one occasion during her tours, Ms. McGowan observed Ron being fed his entire meal in ten minutes. Tr. 7/29/93 (McGowan) at 100. Although Ron's cart is slightly elevated during the feeding process, he is fed in a position that is the equivalent of being flat because he is head is parallel to the ceiling. Tr. 7/28/93 (McGowan) at 94, 111; U.S. Exhs. 228, 258. Ms. McAllister also had concerns about the position in which Ron was fed during mealtimes. Tr. 7/28/93 (McAllister) at 199; U.S. Exhs. 228, 761.

On January 11, 1993, Mr. Bellomo wrote a memo to Mr. Bonfanti, Keystone's Unit Manager requesting a review of Ron's "specific needs in eating." U.S. Exh. 434(aaa). In particular, he queried whether a referral to the Dysphagia Team should be made. Despite Mr. Bellomo's involvement, the Dysphagia Team did not provide Ron with a comprehensive assessment until eight months later. Tr. 10/19/93 (O'Brien) at 95.[1] Despite the fact that Ebensburg developed the aspiration screening tool in November 1992 and Keystone was directed to screen every resident expeditiously, Ron was not screened using this tool until

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

May 24, 1993 -- two days before his annual review. U.S. Exh. 353 at 6; U.S. Exh. 637 (Sponsky Dep.) at 50.

3. Ebensburg Fails to Provide Ron with Meaningful Training Programs

During her November 1992 observations of what was supposed to be Ron's one hour of day programming, Ms. McAllister only witnessed a sum total of twenty seconds of staff interaction with him. Tr. 7/28/93 (McAllister) at 208-209. Ron's recreational assessment for his annual review held on May 26, 1993, indicates that his recreational activities for the entire year only included one birthday party, unit dances, VCR movies, and living area parties. U.S. Exh. 343. Ron's interdisciplinary team specifically noted during his annual review that his "ability to attend out of unit recreational activities was severely limited by the fact that he is in an orthopedic cart." U.S. Exh. 343 at 5.

FRANK H.

1. Ebensburg Fails to Provide Frank H. with Adequate Physical Management

Frank H. is an example of an Ebensburg resident whose deformity patterns have developed due to inadequate intervention and this has caused him to suffer serious health problems. Ms. McAllister worked with Frank during her tour of Ebensburg and provided the Court with a videotape during her direct testimony of her interactions with Frank. U.S. Exh. 261; see also U.S. Exh. 679 for a picture of Frank.

Frank has severe scoliosis, where his pelvis is up under his rib cage. Tr. 7/28/93 (McAllister) at 111. His intrathoracic structures are distorted and he has restrictive lung capacity due to his scoliosis. Id. at 112. As a result, he has to rely on abdominal breathing. Id. at 139. He has limited flexibility in many of his joints and skin breakdown is starting to occur in the crease inside of his elbow where his arm is tightly bent. Id. at 139-140. His scoliosis has also affected his skin integrity in the side where his body is curved. Throughout 1992, the progress notes in his record reflect that his skin integrity in this area was "fair to poor." Id. at 112. During this time, Frank did not receive any physical therapy services. Id. at 112. In addition, Frank has developed the following deformity patterns: his neck is in hyperextension, his arms are in flexion, he has severe deformities of his wrist, and his legs are wind swept. Id. at 111; U.S. Exh. 679. Frank is confined to a cart. In Ms. McAllister's professional opinion, Frank does not need to live in a cart. Tr. 7/28/93 (McAllister) at 141.

The only physical therapy related service that Frank receives is percussion by a physical therapy aide. The aide only writes a quarterly progress note in Frank's record

about his percussion treatment. No physical therapist had reviewed and countersigned those notes in the six month period between December 1992 and June 1993. Tr. 10/13/93 (Arnall) at 93; U.S. Exh. 975. State regulations promulgated by the Pennsylvania State Board of Physical Therapy specifically prohibit a physical therapist from permitting supportive personnel to "assume responsibility for patient care or document physical therapy treatment." U.S. Exh. 952; 49 Pa. Code Ch. 40.32(c).[2]

No physical therapist serves on Frank's interdisciplinary team, even though the team membership was updated as recently as May 1993. Tr. 9/17/93 (Arnall) at 121, 122; U.S. Exh. 975. No physical therapist attended Frank's annual review in either 1992 or 1993. Tr. 9/17/93 (Arnall) at 121, 122. At both Frank's 1992 and 1993 annual review, the team agreed that a physical therapist needed to re-evaluate his cart to determine whether it was the most appropriate mode of mobility available to him. Tr. 9/17/93 (Arnall) at 122; U.S. Exh. 975. Mr. Arnall did not know whether a physical therapist had responded to the requests and could find no indication in the progress notes of Frank's record that a physical therapist responded. Tr. 9/17/93 (Arnall) at 123-125.[3]

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[2] Despite this prohibition in State regulation and the fact that reviewing and countersigning notes is a contract objective, Mr. Arnall, one of Ebensburg's consulting physical therapists, does not, in fact, view the clear failure to do this in Frank's case as a "failure to countersign the notes" because "they probably are going to be signed." Tr. 10/13/93 (Arnall) at 94.

[3] Although Mr. Arnall testified in September 1993 that if a response was written, it would be contained in the progress notes, during redirect testimony one month later, Mr Arnall was able to produce a "speed message" which is not contained in Frank's record and which consisted of a two sentence response from a physical therapist to the team's 1993 request for assistance with Frank. Tr. 9/17/93 (Arnall) at 130; Tr. 10/13/93 (Arnall) at 113, 117.

2. Ebensburg Fails to Provide Frank with Adequate Medical and Nutritional Management of his Serious Health Condition

a. Inadequate Medical Management

Frank has been hospitalized numerous times: twice in 1989 for right lower lobe pneumonia and aspiration pneumonia, in 1991 for aspiration pneumonia, and in 1992 for acute bronchitis. Tr. 7/27/93 (Sulkes) at 138, U.S. Exh. 144, 788. He also has a history of gastrointestinal bleeding from the lower esophagus. Tr. 7/28/93 (McAllister) at 112; Tr. 7/29/93 (McGowan) at 113. In spite of the fact that Frank continues to have aspiration episodes and it is clear that they are not isolated events, Dr. Sulkes found that no one at Ebensburg has taken the time and effort to figure out why Frank continues to suffer from aspiration pneumonia. Tr. 7/27/93 (Sulkes) at 138. The annual medical evaluation notes in Frank's chart at Ebensburg indicate that the physician's only medical plan for him is "to observe" -- not to diagnose or intervene. Tr. 7/27/93 (Sulkes) at 138, lines 21-22. Dr. Rosenthal testified that if the symptoms of gastroesophageal reflux are serious, it is important to take more aggressive action than just observing. Tr. 12/13/93 (Rosenthal) at 163-4.

b. Inadequate Nutritional Management

Frank's body mass index is only 13.34. This is more than 25% below the lowest limit of the accepted range of body mass, which Dr. Sheppard has found bears a significant relationship to abnormal stool, gastroesophageal reflux, vomiting, and respiratory illness. Tr. 10/18/93 (Sheppard) at 64. Dr. Sheppard agrees that a body mass index as low as Frank's places him significantly at risk due to his low body weight and compromised nutritional status. Tr. 10/18/93 (Sheppard) at 67-68.

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

c. Unsafe Feeding Practices

Frank is fed in a cart in a reclined position. Tr. 7/28/93 (McAllister) at 112. Although according to his feeding plan his cart is supposed to be elevated to at least a forty-five to sixty degree angle during feeding, when Ms. McGowan observed him during mealtimes, his cart was elevated less than thirty degrees. Tr. 7/29/93 (McGowan) at 98, 113-114. Frank has had problems with constipation and has had urinary tract infections, both of which can be caused by dehydration. Tr. 7/28/93 (McAllister) at 112. Frank has difficulty handling liquids, but special techniques needed to assist him in being able to manage liquids are not used with him. Tr. 7/29/93 (McGowan) at 114.

Everyone who testified in this case about Frank's experiences during mealtimes at Ebensburg observed that he experienced distress while being fed. Ms. McGowan saw Frank coughing significantly and drooling out of both sides of his mouth as he was being fed fluids. Tr. 7/29/93 (McGowan) at 98. The head of Ebensburg's Dysphagia Team admits that she has observed Frank frequently coughing and possibly choking during meals. U.S. Exh. 641 (Wagner Dep.) at 60, 61. Dr. Sheppard observed Frank as recently as July 1993 "distressed" and "ejecting food" -- almost one year after Ms. McGowan's similar observations. Tr. 10/18/93 (Sheppard) at 92. In light of Frank's history of hospitalizations

for lung related problems, Dr. Sulkes also had concerns about Frank's position in his cart when he observed Frank being fed. Tr. 7/27/93 (Sulkes) at 105.

Frank is shown on the videotape that has been entered into evidence in this case as U.S. Exh. 258, being fed spoonfuls that are mounded high with food. Tr. 7/29/03 (McGowan) at 114. Frank is unable to swallow the amount of food and is forced to eject excess food and fluid that staff is attempting to feed him. Tr. 7/29/93 (McGowan) at 114; U.S. Exhs. 231, 232. At one point, the piece of food that staff tries to feed him is so large that it fell off the spoon and landed on Frank's chest before it even gets to his mouth. Frank is also unable to manage the amount of fluids that he is being fed and it dribbles out of both sides of his mouth. Tr. 7/29/93 (McGowan) at 114; U.S. Exh. 258.[4] The Commonwealth's sur-rebuttal feeding expert does not think it is "acceptable" to just continue to allow a person to eject food. Tr. 12/16/93 (Hinkle) at 27. He thinks that it is important that the amount of food that a person is fed in each spoonful is an appropriate size so that the food remains in the mouth. Tr. 12/16/93 (Hinkle) at 24. When Dr. Hinkle was presented with a description of Frank's history during his testimony (including the fact that he had been hospitalized for aspiration pneumonia), Dr. Hinkle agreed that he would have concerns if Frank was ejecting food while being fed. Tr. 12/16/93 (Hinkle) at 30. Dr. Hinkle did not think it would be appropriate to continue feeding Frank in this fashion without an assessment by a qualified professional. Tr. 12/16/93 (Hinkle) at 30. Frank was not assessed by the Dysphagia Team

[4] Despite the obvious difficulties that Frank was experiencing, the Commonwealth's expert characterized this sequence in the United States' videotape as Frank appearing "fairly comfortable in terms of ease of eating." Tr. 10/12/93 (Sheppard) at 49.

until July 6, 1993 -- eleven months after the feeding videotape in which he was ejecting food. Tr. 10/18/93 (Sheppard) at 119.

Ms. McGowan also has concerns about Frank's position in his cart while he is being fed. Tr. 7/29/93 (McGowan) at 98, 113-114. She repeatedly viewed him being fed at an elevation lower than what was required by his feeding plan. Id. Dr. Sulkes has had concerns, as well, about Frank's position in his cart while he is being fed. Tr. 7/27/93 (Sulkes) at 105. Claire Domino, a supervisor at Keystone, admits that there have been problems keeping Frank adequately elevated and positioned during mealtimes. U.S. Exh. 609 (Domino Dep.) at 55. Ms. McGowan has also observed staff using other poor feeding practices with Frank, including scraping food off of his face and standing above him while feeding him. Tr. 7/29/93 (McGowan) at 118.

3. Ebensburg Fails to Provide Frank with Adequate Training Programs

Frank's interdisciplinary team notes that he displays emotions, responds to his name, recognizes staff, and "appears to have a high level of awareness." U.S. Exh. 975 (4/23/93 annual review at 2). He is being denied the opportunity to develop the ability to identify objects through a head pointer, however, because his position in his cart does not allow this. U.S. Exh. 975 (4/23/93 annual review at 3). He had a skills training program that began in August 1992 to identify a picture by pointing to it with a head pointer. Because of his positioning, however, he was unable to accomplish this skill. Id. Moreover, although he needs glasses and his team feels that they would be beneficial to Frank, he is unable to wear them because his "head positioning in his reclining chair was not conducive to wearing the glasses successfully." Id.

JEFF K.

Jeff K. died of aspiration pneumonia during the course of this trial on September 30, 1993. U.S. Exh. 1108. Jeff also had gastroesphageal reflux. U.S. Exh. 1108 at 3. Dr. Rubin describes the story of his life and death as a "sad one" which is illustrative of systemic interdisciplinary issues, including "issues of seizure management, issues of nutrition, issues of feeding, issues in the evaluation of gastroesophageal reflux, issues in the monitoring of health and well-being, in the securing of consultants, on a regular basis, in working with it and working closely with the regional hospitals to adequately deal with the patients who are referred to them." Tr. 12/13/93 (Rubin) at 110.

1. Ebensburg Failed to Provide Jeff with Adequate Seizure Management

Jeff was directly harmed by Ebensburg's actions and inactions. He was harmed due to Ebensburg's overmedication of him; Ebensburg's inability to detect side effects; Ebensburg's failure to recognize that the medications it was using to treat Jeff were, in fact, increasing his number of seizures; Ebensburg's repeated rejection of advice of its consultant neurologist; and Ebensburg's lack of diagnostic techniques, such as the EEG. Tr. 7/30/93 (Alvarez) at 123-125. Jeff also did not receive an adequate amount of neurology consultation. Tr. 7/30/93 (Alvarez) at 136.

In January 1991, Jeff was being given five thousand milligrams of Depakote for his seizures. Tr. 7/30/93 (Alvarez) at 120. Dr. Alvarez labelled this as an "inordinately high" amount of this medication. Id. at 124.[5] Dr. Chamovitz agreed in a January 1991 consult

[5] Dr. Alvarez testified that he rarely goes over three thousand milligrams and never goes over three thousand five hundred. Tr. 7/30/93 (Alvarez) at 121.

that this dosage is "an unusually large amount" of Depakote for a person Jeff's size. Tr. 7/30/93 (Alvarez) at 121; U.S. Exh. 393A. Although Dr. Chamovitz showed concern about this, Jeff's primary care physicians did not take any action. Tr. 7/30/93 (Alvarez) at 121. The use of this extremely high amount of medication did not result in any better control of Jeff's seizures and, in fact, the seizures increased. Id. Twelve months later, Dr. Chamovitz again raised a concern in a December 19, 1991 consult. Tr. 7/30/93 (Alvarez) at 121; U.S. Exh. 393B. He wrote that in using this high amount of Depakote, "there has not been better control of his convulsions; and actually so far, there seems to have been an increase in his convulsions." U.S. Exh. 393B.

On February 27, 1992, Jeff was admitted to Mercy Hospital for a seizure disorder. Tr. 7/30/93 (Alvarez) at 122; U.S. Exh. 393C. Dr. Chamovitz admitted that Jeff had to be admitted to the hospital because he had high blood levels which made him sedated and lethargic. Tr. 9/15/93 (Chamovitz) at 203. Dr. Chamovitz acknowledged: "The medication was not doing him any good, and he was having side effects." Tr. 9/15/93 (Chamovitz) at 203. At Mercy, the hospital staff realized that the blood level of this medication was too high so they stopped this medication completely. Tr. 7/30/93 (Alvarez) at 122; U.S. Exh. 393C. After the Depakote was stopped, Jeff improved. Tr. 7/30/93 (Alvarez) at 123. He returned to Ebensburg from the hospital on Tegretol; the Ebensburg nursing notes indicated that he ate well for supper later that week, and that the next week he was "alert, active, seems his usual self." Id. Dr. Chamovitz acknowledged that once the hospital had stopped the Depakote, "lo and behold, as Dr. Alvarez points out, he stopped having spells." Tr. 9/15/93 (Chamovitz) at 203. Dr. Chamovitz agreed that "It was not a good medicine for

him, and the level didn't make any difference." Id. He added that "We just guessed wrong." Id.

When Jeff's medications were changed, he was started on Tegretol, even though he had been on Tegretol previously and it was relatively unsatisfactory. Tr. 12/13/93 (Rubin) at 106. When he began taking Tegretol, Jeff developed "petit mal seizures." Another anti-convulsant, Klonopin[6], was added to treat these. Id. at 106-107. In the months before his death, a third and fourth anti-convulsant were added to Jeff's medication regimen. Id. at 107. Coincidental with the addition of the fourth anti-convulsant, Jeff's health rapidly declined. Id.

2. Ebensburg's Treatment of Jeff Is Illustrative of Medical and Nutritional Management Issues.

One of the factors contributing to Jeff's death identified by Ebensburg is "underweight compounded by his poor eating ability and dysphagia" which was "complicated by muscle relaxation from high dose Klonopin in attempt to relieve his absence seizures." U.S. Exh. 1108, Death/Discharge Summary at 10. Jeff was on Klonopin for the eleven months leading up to his death. U.S. Exh. 1108, Death/Discharge Summary at 6. In Ebensburg's review of Jeff's death, the Mortality and Morbidity Committee notes that one of the side effects of Klonopin is increased secretions, a weakening of the swallowing muscle, and dysphagia. U.S. Exh. 1108, M. & M. Comm. Mtg. Minutes at 5. In the eight months prior to his death while he was on Klonopin, Jeff went from an "independent feeder, to the staff having to feed him, to the staff being afraid to feed him, to supervisors feeding him, then to a G-tube." Id.

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[6] This is transcribed as "Clonopin" in the transcript.

During the summer before Jeff died, Ebensburg "let the staff feed him again. He started to develop more aspiration." Id. In fact, during her tour of Ebensburg in July 1993, Dr. Sheppard observed a direct care staff person feeding Jeff thin liquids despite the fact that his feeding procedure states in big capital letters "No THIN LIQUIDS" and specifically instructs staff to thicken his liquids to a "pudding consistency." Tr. 10/18/93 (Sheppard) 88-89; U.S. Exh. 1002.[7]

Ebensburg's physician acknowledges that Jeff's dysphagia problems "at the end were due to the Klonopin." Id. Despite the difficulties that Jeff was having, he was not screened by the Dysphagia Team until May 14, 1993. The Dysphagia Team determined that he had severe dysphagia and observed him coughing more than forty-four times during the mealtime. U.S. Exh. 970. The Team did not note that he was on Klonopin, despite the fact such an evaluation should "critically look at the impact of medications," particularly anticonvulsants, on the ability of residents to swallow. Tr. 7/29/93 at 161-162. No one on the Dysphagia Team, however, is responsible for reviewing medications when evaluating a resident for potential dysphagia. U.S. Exh. 641 (Wagner Dep.) at 106. The Team never directly consults with Ebensburg's pharmacist. U.S. Exh. 641 (Wagner Dep.) at 107. At most, the Team only refers to the pharmacist's annual report in the resident's chart. U.S. Exh. 641 (Wagner Dep.) at 107. Although Ms. Wagner is aware that seizure medications and anti-psychotics can cause dysphagia and use of these medications is one of the most common reasons that dysphagia occurs in Ebensburg residents, she is unaware of the specific

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

types of seizure medications and anti-psychotics that are more likely to cause dysphagia. U.S. Exh. 641 (Wagner Dep.) at 14.

At the time of his dysphagia evaluation, Jeff's body mass index (BMI) was 15.21, this is more than 25% below the lowest number of the acceptable BMI range of 21-27. U.S. Exh. 970. Dr. Sheppard believes that an individual with this low a body weight is at significant risk due to their low body weight and compromised nutritional status. Tr. 10/18/93 (Sheppard) at 67-68.

During his review of the Mortality and Morbidity Committee review of Jeff's death, Dr. Rubin was "frustrated" that the clinical management issues discussed during the review had not been explored by the group prior to Jeff's death. Tr. 12/13/93 (Rubin) at 106. For example, during the Mortality and Morbidity Committee review of Jeff's death, Mr. Bellomo determined that it was important that Ebensburg's pharmacist provide the Dysphagia Team with a list of medications that can cause dysphagia. U.S. Exh. 1108, M. & M. Comm. Mt. Minutes at 5. This same issue had previously been raised by the United States during the deposition of John Fris, Ebensburg's pharmacist some eleven months earlier. During his deposition, Mr. Fris admitted that the Ebensburg pharmacy does not keep a list of the individuals who are prone to aspiration. U.S. Exh. 612 (Fris Dep.) at 89-90. Although he agreed that there are a number of medications that can contribute to chewing or swallowing difficulties, he was not aware of those individuals with chewing or swallowing difficulties at Ebensburg. U.S. Exh. 612 (Fris Dep.) at 92. Moreover, he has never tried to find out which individuals have serious medical conditions that could be adversely affected by medications. U.S. Exh. 612 (Fris Dep.) at 93. Mr. Fris further admitted that it is important

to have a list of all of the presenting conditions of all of the individuals at Ebensburg, but there are not enough pharmacists to maintain such a list. U.S. Exh. 612 (Fris Dep.) at 90, 93. To not have such a list is "obvious risk." U.S. Exh. 612 (Fris Dep.) at 90, line 16.

3. Ebensburg Failed to Protect Jeff from Harm

Jeff was subjected to harm while at Ebensburg. Between April 1990 and November 1991, he suffered 21 injuries, including several lacerations that required sutures or ethistrips. U.S. Exh. 136 at 00003409. Almost half of these injuries were not observed by staff. Id.[8] In September 1992, Jeff lacerated his head from hitting it on a couch while he was down on the floor during mat time. U.S. Exh. 1023. In April 1993, he was self-abusive and suffered a bloody nose from his wheelchair tray. U.S. Exh. 136 at 00599893. On July 8, 1993, Jeff was found laying at the foot of his bed with a bleeding laceration on his head. In the recommendation section of his incident report, the supervisor writes "With Jeff's behaviors (throwing himself about, etc.), this small injury is within normal risk limits." U.S. Exh. 984.

Other injuries that Jeff has sustained have resulted from his behaviors, including head butting. Exh. 136 at 00003409. His aggressive behavior was treated with Haldol, a powerful psychotropic medication. U.S. Exh. 1108, Death/Discharge Summary at 9; Tr. 8/3/93 (Fahs) at 66-67; Tr. 9/14/93 (Lubetsky) at 152.

On February 13, 1992, a direct care trainee witnessed staff place a pillow case over Jeff's head while drawing blood, and when he asked why, staff replied that "we always do that." U.S. Exh. 133 at 6658. Jeff's behavior program did not permit such a procedure.

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[8] These are rated as a "17" in the column identified as causes.

Id. at 6679. An investigation revealed that of the four regular staff in Jeff's living area, only one had been inserviced on Jeff's behavior program. Id. at 6673.

Jeff appears on the videotape admitted into evidence as United States' Exhibit 262. He is shown in his day program on February 23, 1993. Jeff, who used to be able to walk, make sounds, and interact, is sitting alone, removed from the rest of the group, without any staff interaction, with nothing to do, and "very bored." Tr. 7/26/93 (Stark) at 160. He is banging on the lap board on his wheelchair. Tr. 7/26/93 (Stark) at 159. Dr. Stark was struck by Jeff and focused on him with his camera. As he narrated the videotape, Dr. Stark described Jeff's frustration from his boredom with nothing to do and concluded that he was "trapped in his body, not being able to do anything, yet being aware of what is going on." Tr. 7/26/93 (Stark) at 160.

TIM P.

1. Ebensburg Has Failed to Provide Tim P. with Adequate Physical Management and Physical Therapy and He Has Suffered Serious Deformities as a Result

Tim P. is thirty-three years old. He has been at Ebensburg since a month before he turned three. Tr. 7/28/93 (McAllister) at 103; U.S. Exh. 973. At the time of his admission to Ebensburg, he was able to walk on his toes with assistance and could babble. Tr. 10/15/93 (O'Brien) at 77-78; U.S. Exh. 973. Tim's parents noted on their application for his admission to Ebensburg that Tim could take a few steps with help. Tr. 10/15/93 (O'Brien) at 77-78. Mr. Arnall agrees that "if at this time some intervention had been made to try to prevent him from becoming scoliotic, it may have helped." Tr. 9/17/93 (Arnall) at 199, lines 7-8.

Tim is currently immobile and lives in a cart in Keystone. Tr. 7/28/93 (McAllister) at 103. His scoliosis has developed to the point where his hip is actually up underneath his rib cage. Tr. 7/28/93 (McAllister) at 103; U.S. Exh. 670. Tim does receive any physical therapy services. Tr. 7/28/93 (McAllister) at 105. Because he spends his day being "pancaked," or turned from his stomach to his back, his chest has been flattened and his muscles are very tight through his upper chest region. Tr. 7/28/93 (McAllister) at 104. As a result, it is difficult for Tim to breathe and he has become a shallow breather. Id.

Tim's physical therapy assessment is representative of the types of deficiencies that Ms. McAllister found to be "consistent across all the assessments." Tr. 7/28/93 (McAllister) at 123; U.S. Exh. 433 (a). Tim's assessment does not contain any information about his shoulder subluxation, neck hyperextension, wind swept legs, labored breathing, flat chest, the type of reflex or spasticity patterns he exhibits in different positions, the difference in tone

throughout different parts of his body, and how to help maintain him in better alignment. Tr. 7/28/93 (McAllister) at 121, 122; U.S. Exh. 433(a). His physical therapy assessment also does not include goals, any expectations for change, or any physical management plan, including the types of positions he should be in throughout his day and movement opportunities. Id. at 123.

The only positioning plan that Tim has is a nursing procedure. This is the exact same positioning plan that he has had for more than six years -- since March 1987. U.S. Exh. 973. The plan only calls for turning Tim from his stomach to his back. Tr. 7/28/93 (McAllister) at 103; Tr. 9/17/93 (Arnall) 196-197; U.S. Exh. 973. Even this is only done between the hours of 10:00 a.m. and 8:00 p.m. U.S. Exh. 973.[9] Tim is not maintained in proper alignment while in his cart. Tr. 7/28/93 (McAllister) at 103.

The last orthopedic evaluation that Tim had was in December 1981. Tr. 10/13/93 (Arnall) at 32, 35; U.S. Exh. 1005.[10] At that time, Tim was twenty-one years old.[11] Mr. Arnall agrees that people in their twenty's are within the age group where skeletal maturity may not have occurred. Tr. 9/17/93 (Arnall) at 36. At the time of his 1981 orthopedic

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[9] Mr. Hauenstein, a contract physical therapist at Keystone until December 1992, agrees that, at a minimum, staff should reposition individuals who can not reposition themselves every two hours. U.S. Exh. 619 (Hauenstein Dep.) at 100.

[10] Following Mr. Arnall's testimony on September 17, 1993 and before his cross examination in October 1993, Tim had an orthopedic evaluation on September 29, 1993. Mr. Arnall admits that Tim had had no orthopedic evaluation in the twelve year interim between his December 1981 evaluation and this most recent one. Tr. 10/13/93 (Arnall) at 35.

[11] Counsel for the United States incorrectly identified Tim's age as 24 at the time of the orthopedic evaluation. Tr. 10/13/93 (Arnall) at 32. Both Mr. Arnall and Ms. McAllister testified that Tim is currently 33, therefore he was 21, not 24 in 1989. Tr. 7/28/93 (McAllister) at 103; Tr. 9/17/93 (Arnall) at 28.

evaluation, Tim was able to sit in a wheelchair. Tr. 10/13/93 (Arnall) at 32; U.S. Exh. 1002. The orthopedist describes Tim's condition as "a mild scoliosis that appears to be not a clinical problem at this time." U.S. Exh. 1002. The orthopedist specifically recommends that Tim should go to physical therapy for stretching exercises. Tr. 10/13/93 (Arnall) at 32; U.S. Exh. 1002. The orthopedist also recommends evaluation and training to teach Tim "to use his upper extremities for purposeful movements, perhaps positioning the hands in a way they can be useful for him." U.S. Exh. 1002. Twelve years later, Tim can no longer sit in a wheelchair. Tr. 7/28/93 (McAllister) at 103. He can only move his hands "a little bit." Id.

The physical therapists at Ebensburg have not established any goals for Tim. Tr. 10/13/93 (Arnall) at 5. Mr. Arnall and the other physical therapists who contract with Ebensburg believe that "obviously . . [they] cannot provide anything for him." Tr. 9/17/93 (Arnall) at 197, lines 15-16. This attitude towards Tim and other Ebensburg residents is contrary to established literature in the field, including the treatise Physical Management of Multiple Handicaps. In this book, the authors set forth a number of therapeutic positions for people who have a C-shaped scoliosis and other fixed body deformities. Physical Management of Multiple Handicaps at 167-187.

The physical therapists' attitude towards Tim is also contrary to the attitude of Ebensburg staff who work with Tim. After observing demonstrations by Ms. McAllister with Tim, Ebensburg staff were excited about the possibility of doing something more for Tim. For example, Ms. Malloy, the nurse supervisor in his building, learned that Tim could be "relaxed," his legs could be straightened, and he "was so calm." U.S. Exh. 622

(Malloy Dep.) at 102, 103, lines 5-6. One of the occupational therapy aides (LOTA) in Tim's building was "quite impressed" with Ms. McAllister's demonstration with Tim. U.S. Exh. 610 (Fagan Dep.) at 36, line 25. She was particularly impressed with the fact that Ms. McAllister was able to relax Tim to the point that he "was straight in his cart as compared to having curvatures." U.S. Exh. 610 (Fagan Dep.) at 37, lines 4-5. The LOTA now believes that deformities, such as Tim's, could potentially be reversed if more time could be spent on positioning at Ebensburg. U.S. Exh. 610 (Fagan Dep.) at 95-96.

2. Ebensburg Has Failed to Provide Tim with Adequate Nutritional and Medical Management

When Dr. Sulkes observed Tim during his last tour of Ebensburg in November 1992, he had concerns about Tim and Ebensburg's failure to provide him with adequate medical care. Tr. 7/27/93 (Sulkes) at 139. Although Tim had had brown tinged vomitus and he is anemic, no one at Ebensburg had checked his stool. Tr. 7/27/93 (Sulkes) at 139; Tr. 7/29/93 (McGowan) at 115. No one had worked him up to determine where his bleeding was coming from. Tr. 7/27/93 (Sulkes) at 139. Further, Ebensburg had not provided him with a swallowing study or a barium swallow study. Tr. 7/27/93 (Sulkes) at 139. Although as of January 1993, Kathy Wagner, the head of the Dysphagia Team readily identified Tim as someone who frequently coughs and is possibly experiencing recurrent choking during meals, the Dysphagia Team had not evaluated him. U.S. Exh. 641 (Wagner Dep.) at 60, 61. In March 1993, Tim was hospitalized for pneumonia. U.S. Exh 144. Tim's body mass index (BMI) as of June 1993 was 12, which is almost 40 % below the lowest acceptable

number. U.S. Exh. 970.[12] As of the time of Dr. Sheppard's tour in July 1993, Tim's condition had deteriorated to the point that he was being fed by a gastrostomy tube. Tr. 10/18/93 (Sheppard) at 96; Tr. 7/29/93 (McGowan) at 115; Tr. 7/28/93 (McAllister) at 104.

3. Ebensburg Has Failed to Safely Feed Tim

Tim also has difficulty eating. He has an abnormal swallowing pattern. Tr. 7/29/93 (McGowan) 115. Although Tim is one of only three Keystone residents who is on an occupational therapy program for feeding, he is still being fed unsafely. U.S. Exh. 617 (Graham Dep.) at 117-118; Tr. 7/29/93 (McGowan) at 115. His program was written by an occupational therapy assistant (LOTA), instead of an occupational therapist. U.S. Exh. 617 (Graham Dep.) at 118. Tim is shown on the videotape admitted into evidence as U.S. Exh. 258 being fed by a LOTA and experiencing significant distress. The LOTA who is feeding Tim, attempts to continue feeding him additional food and fluid while his mouth is full of food that he is unable to swallow. Tr. 7/29/93 (McGowan) at 115; U.S. Exh. 258. The only training that the LOTA feeding him received in how to feed individuals with developmental disabilities and physical disabilities was in 1980 from an occupational therapist at Keystone. U.S. Exh. 610 (Fagan Dep.) at 25-26, 34. The LOTA has not had any courses outside of Ebensburg on how to feed individuals with physical disabilities. U.S. Exh. 610 (Fagan Dep.) at 34. When Dr. Sheppard viewed Tim being fed on the United States' feeding videotape she admitted that "certainly there is a problem here." Tr. 10/12/93 (Sheppard) at 51. Dr. Sheppard also agreed that given Tim's "marked" and "complex" problems, there

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[12] Dr. Sheppard has found that BMI bears a significant relationship to abnormal stool, gastroesophageal reflux, vomiting, and respiratory illness. Tr. 10/18/93 (Sheppard) at 64. She agrees that a body mass index as low as Tim's causes significant risk due to low body weight and compromised nutritional status. Tr. 10/18/93 (Sheppard) at 67-68.

should be an assessment to determine whether he was experiencing oral motor difficulties because another feeding technique might make his eating better. Tr. 10/12/93 (Sheppard) at 51, 52; Tr. 10/18/93 (Sheppard) at 7. Although the head of Ebensburg's Dysphagia Team agreed during her deposition in January 1993 that she had observed Tim frequently coughing and possibly choking during meals, Tim did not even have a screening by Ebensburg's Dysphagia Team until June 1993 -- 6 months later. U.S. Exh. 641 (Wagner Dep.) at 60, 61; U.S. Exh. 970. In between the time the videotape was taken and June 1993, Tim was placed on a feeding tube. Tr. 7/29/93 (McGowan) at 115. When Dr. Sheppard observed Tim being fed in July 1993, staff were still feeding him unsafely by not implementing the specific instructions in his feeding plan for positioning him by elevating his cart to a certain angle. Tr. 10/18/93 (Sheppard) at 96.

Dr. Sulkes also had concerns when he saw Tim being fed during both his September and November 1992 visits. Tr. 7/27/93 (Sulkes) at 100-101. In September 1992, Dr. Sulkes saw a LOTA feeding Tim by pouring fluid from a spouted cup into Tim's mouth without ensuring that Tim's mouth had closed. Tr. 7/27/93 (Sulkes) at 100-101. He has also observed Tim being fed while he was coughing. Tr. 7/27/93 (Sulkes) at 99, 101.

On July 17, 1990, Tim had a distressed look on his face. U.S. Exh. 160 (interdisciplinary notes). He vomited a large amount of dark brown material with a piece of what the nurse thought was rubber or plastic, perhaps from a rubber glove. Id.; Tr. 7/29/93 (McGowan) at 115. He subsequently experienced heart related problems resulting from the vomiting. U.S. Exh. 160 at 2. Tim is unable to move his hands to his mouth and

Ebensburg was unable to determine how he ingested this foreign body but recognized that staff need to be "more conscious of their feeding responsibilities." Id. at 1.

4. Ebensburg Fails to Provide Tim with Training Programs and Meaningful Activities

Tim appears several times in the videotape taken by Dr. Stark on February 23, 1993, that is in evidence as United States' Exhibit 262. The first time Tim appears, he is in his one hour of day programming off of his living unit. He is in his cart, staring at the ceiling, separated from the rest of the group, and there is no attempt to involve him in any activity. Tr. 7/26/93 (Stark) at 159, 160. Absent any interaction with other residents or staff, Tim spends his day staring at a fluorescent light. Tr. 7/26/93 (Stark) at 160. "That is his life, every day, is to look at that ceiling." Tr. 7/26/93 (Stark) at 160.[13] Dr. Stark found that Tim's "world is the ceiling." Tr. 7/26/93 (Stark) at 168. Dr. Stark has interacted with Tim and believes he is very much aware of his surroundings: "As soon as you [interact with him], he starts to smile. You can see the glimmer in his eyes." Tr. 7/26/93 (Stark) at 160.

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[13] Dr. Stark contrasted what he observed at Keystone with a videotape of John, his son. Tr. 7/26/93 (Stark) at 210; U.S. Exh. 262(a). Like Tim P., John had meningitis when he was a few months old and has significant physical disabilities along with his severe and profound mental retardation. Tr. 7/26/93 (Stark) at 210, 211. John has been through thirteen operations, has to be suctioned frequently, is dependent on a tube to be fed, has twenty to thirty seizures a day, and has spastic cerebral palsy. Unlike Tim, his limbs are not severely contractured because John has received adequate care over the years. In contrast to Tim, who spends his day staring at the ceiling, John is involved with other people in meaningful activities, such as cooking, swimming, and learning to operate a switch to activate a computer. Tr. 7/26/93 (Stark) at 211. Because John has only slight movement in his hands, the switch is attached to his jaw. By moving his jaw, he can activate the switch and control what is happening on the computer. Through use of the switch, John can communicate and has some control over his environment to gain some independence in his life. Tr. 7/26/93 (Stark) at 212. John has also learned to communicate by blinking his eyes and indicating "yes" or "no." This videotape of John demonstrates that even the most severely involved people with mental retardation and physical disabilities are "capable of learning and interacting with their environment." Tr. 7/26/93 (Stark) at 21.

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

JAMES S.

1. Ebensburg Fails to Protect James S. from Harm -- Inadequate Psychology Services and Training Programs

a. Failure to Revise Training Programs

James S. had the highest number of incidents at Ebensburg during the 50 month period between January 1989 and February 1993. Tr. 7/26/93 (Stark) at 130. During this time he sustained more than 200 injuries. U.S. Exh. 777. United States' Exhibit 479 is a compilation of some of James' more recent incident reports, along with Ebensburg's own summary chronicling its inaction in the face of continuing, significant injury and repetitive harm. Tr. 7/26/93 (Stark) at 131-132. For 40 injuries between March and October 1992, Ebensburg's only response is "no change to IHP (individual habilitation plan)" and "behavior plan to continue," with the exception of a recommendation to start a psychotropic medication, a recommendation to change his living area, and a notation that James was "counseled" after he ripped off his toenail. Tr. 7/26/93 (Stark) at 131; U.S. Exh. 479. There is no response to his injury on June 23, 1992, when he put his head through a glass window in the dining room. U.S. Exh. 479 at 00050469.

b. Failure to Provide James a Behavior Program for his Severe Self-Injurious Behavior

James does not have a behavior program for his severe self-injurious behavior. Tr. 8/2/93 (Russo) at 75. James's annual psychological evaluation identifies several behavior deficits, including aggression, punching, kicking, biting, scratching, or throwing objects, and aggression to the environment, and self-injurious behavior such as head banging, stabbing himself with a utensil, or falling backwards. U.S. Exh. 640 (Stratton Dep.) at 144. The

only target behaviors included in James' behavior program are for aggression, which is defined as "hitting, slapping, kicking, and spitting." U.S. Exh. 640 (Stratton Dep.) Exh. 3. Although James does have a behavior program for aggression that purports to also address his self-injurious behaviors, there is insufficient documentation in James' record to suggest that James' self-injurious behavior and his aggression are related and amenable to the same treatment. Tr. 8/2/93 (Russo) at 75, 112-113; Tr. 8/3/93 (Fahs) at 130-131 (James' self-injurious behaviors are inappropriately "lumped together" for treatment purposes with other distinct unrelated behaviors).

In November 1992, when Ebensburg approved the use of Sinequan on an emergency basis for treatment of James' depression, James' team was instructed to submit a behavior program addressing James' self-injurious behavior together with a restrictive procedure request to the Behavior Intervention Committee. U.S. Exh. 922. The December 1992 minutes of the Behavior Intervention Committee, when a restrictive procedure request for James (client #806) was submitted, reflect no discussion of a behavior program for James for his self-injurious behavior. U.S. Exh. 42(c) at 541414. One month later when the Psychology Discipline Coordinator, Dr. Stratton, was deposed, he admitted that James' behavior program could be expanded and may be confusing to staff about how to respond to James' self-injurious behavior. U.S. Exh. 640 (Stratton Dep.) at 153, 168. This aspect of James' behavior program is still the same. U.S. Exh. 856.

James has suffered many, many injuries due to his self-injurious behaviors. U.S. Exh. 479. James' injuries from self-abuse continued even at the time of trial. U.S. Exh. 958. For the period May through mid-August 1993, James engaged in self-injurious

behavior four times, including breaking two mirrors and using the glass to cut his head open, hitting his head on the door causing four cuts to his forehead, hitting his head on a metal desk and lacerating his scalp, and removing his toenail. No change was made in his behavior program. U.S. Exh. 958.

c. Failure to Conduct a Functional Analysis of James' Behaviors

At the time of Dr. Stratton's deposition in January 1993, James did not have an adequate functional analysis. U.S. Exh. 640 (Stratton Dep.) at 175. Dr. Stratton admitted that the seriousness of James' behavior warranted a comprehensive written functional analysis before 1993. U.S. Exh. 640 (Stratton Dep.) at 176.

It took Ebensburg another two and a half months to complete a functional analysis of James' behaviors. U.S. Exh. 964. During this time period, James tore off one of his toenails and one of his fingernails, hit his head on the wall hard enough to cause a scalp laceration, and hit another client on the head so hard it reopened a wound on James' hand. U.S. Exh. 479. The incident where James hit his head on the wall occurred on February 17, 1993 -- one month after Dr. Stratton's deposition. On the occurrence report documenting that injury, the supervisor in James' living area was unable to make any recommendations for prevention of recurrence of James' self-abuse because there was no knowledge of what causes James' behaviors, despite the fact that his behaviors seemed to be getting worse. U.S. Exh. 479. It still took Ebensburg another 6 weeks to perform a functional analysis for James.

d. Failure to Intervene to Prevent Injuries to James and Others due to James' Behaviors

James' case is also illustrative of Ebensburg's failure to intervene at an early stage to prevent self-injurious behavior, despite James' known history of inflicting wounds to his head with sharp objects. Tr. 7/26/93 (Stark) at 132. For example, on July 13, 1992, James came into the day room with blood on his hands and face. He showed staff that he had stabbed himself on the forehead with a pair of scissors. Tr. 7/26/93 (Stark) at 132. His occurrence report notes that he had been crying all day and was upset because his parents did not attend the family picnic. Tr. 7/26/93 (Stark) at 132; U.S. Exh. 479. According to Pennsylvania Office of Mental Retardation policy, leaving a resident who requires supervision unattended or allowing a resident access to harmful substances such as chemicals and sharp instruments constitutes neglect. Tr. 10/19/93 (O'Brien) at 61.

Staff also fails to intervene at an early stage to prevent injuries due to James' aggressive behaviors. For example, earlier in the day on January 19, 1992, James had been restrained in a papoose board due to his aggressiveness, but continued to disturb others after being released. At 10:30 a.m., James hit Ibrahim D., and Ibrahim kicked James about 10 times in the head and face before staff could separate them. U.S. Exh. 107. The Unit Manager at Villa, where the incident between James and Ibrahim took place, agrees that early intervention is the "key" to stopping aggressive behaviors. U.S. Exh. 607 (Degretto Dep.) at 163. She acknowledges that in order to intervene early, staff have to know the antecedents of the aggressive behaviors and have to know the resident. U.S. Exh. 607 (Degretto Dep.) at 163. She also identifies "positive approaches" and "communication" as big factors in early intervention. U.S. Exh. 607 (Degretto Dep.) at 163.

2. Ebensburg Fails to Protect James from Harm -- Undue Restraint

In spite of 106 episodes of restraint in a two year period, James's behavior program for aggression was continued without change by Ebensburg during the period January 1990 through February 1993, except to change his drugs and replace use of the papoose board with use of floor control in late 1992. U.S. Exh. 42(c) at 4863, 4891, 4910, 4825, 4830, 4937, 541441, 541426, 541416.

James' psychologist is also failing to consider non-medication alternatives for James behaviors. For instance, on March 22, 1993, James pulled his toenail off. James' psychologist states that "he continues to receive medication to address his depression. No changes are recommended to his current programming." U.S. Exh. 117.

3. Ebensburg Fails to Provide James with Adequate Psychiatric Care

Dr. Fahs concluded that James is being harmed by not receiving psychiatric treatment that is effective for him. Tr. 8/3/93 (Fahs) at 132. James continued to receive high doses of Haldol for three years without any evidence that it was helpful. Tr. 8/3/93 (Fahs) at 131. Dr. Fahs explained that this exposed James to real harm given that he must incur the significant risk of side effects from Haldol, and yet there was no evidence that it was helpful to treat his ill-defined behaviors. Id. He added that one simply needs to make the absolute best efforts possible to treat this kind of severe self-injurious behavior and James is not receiving that kind of treatment from Ebensburg. Tr. 8/3/93 (Fahs) at 132.

Dr. Fahs testified that there was a real problem with respect to the specificity and adequacy of the psychiatric assessment process given to James. Tr. 8/3/93 (Fahs) at 131. Dr. Fahs noted that James suffered a lot of injuries because of his self-injurious behavior.

Tr. 8/3/93 (Fahs) at 130. However, Dr. Fahs noted that James' self-injurious behavior had been lumped together for the sake of treatment with other distinct unrelated behaviors such as stealing, aggression, non-compliance and 'pesty-type' behavior. Tr. 8/3/93 (Fahs) at 130-1. Dr. Fahs indicated that "it just didn't make any sense to me at all" that Ebensburg would lump together head banging and stabbing yourself with a fork with non-compliance and pesty behavior. Tr. 8/3/93 (Fahs) at 131.

4. Ebensburg Fails to Intervene in James' Unsafe Eating Practices

On December 1, 1991, James choked on dinner by overstuffing his mouth and then drinking juice without pausing. U.S. Exh. 273. James choked, like other Ebensburg residents, because staff are not monitoring, moderating, and intervening when residents are overstuffing their mouths and/or eating too fast. Tr. 7/29/93 (McGowan) at 145; U.S. Exh. 273.

DENISE V.

1. Ebensburg Fails to Protect Denise V. from Harm -- Inadequate Behavior Programs

Denise V.'s mother was one of two parents of Ebensburg residents who testified at trial about the long-term harm that their children have suffered at Ebensburg. Denise's mother, Marian Dekowski, chronicled the injuries that her daughter has sustained under Ebensburg's care. Tr. 7/26/93 (Dekowski) at 171. Ms. Dekowski placed Denise at Ebensburg when Denise was five years old and Denise has lived at Ebensburg for the past 31 years, except for a very short stay at Somerset State Hospital. Tr. 7/26/93 (Dekowski) at 172. When Ms. Dekowski brought Denise to Ebensburg at age five, Denise was a happy, healthy, active child who had no scars or marks on her body and could walk freely and run. Tr. 7/26/93 (Dekowski) at 172. Denise had not suffered any head injuries before she was institutionalized at Ebensburg. Tr. 7/26/93 (Dekowski) at 172.

Denise now has several scars and marks on her body and "her head has an indented look on the skull." Tr. 7/26/93 (Dekowski) at 173, line 12. Denise's head is indented because she bangs it on walls and furniture. Tr. 7/26/93 (Dekowski) at 173; U.S. Exh. 493(aa). Denise now walks with a limp. Tr. 7/26/93 (Dekowski) at 174. Ebensburg has never informed Ms. Dekowski that Denise suffered a leg injury. Tr. 7/26/93 (Dekowski) at 174. Ms. Dekowski believes Denise limps due to head injuries. Tr. 7/26/93 (Dekowski) at 174; U.S. Exh. 493(cc). While visiting Denise, Ms. Dekowski has seen "many, many bite marks on her arms, and she has marks on her face, scars." Tr. 7/26/93 (Dekowski) at 175. During one of Ms. Dekowski's visits, Denise had a black eye and her shoulders were covered with claw marks. Tr. 7/26/93 (Dekowski) at 175; U.S. Exh. 493(bb). Two days

before Ms. Dekowski testified, Denise was found with multiple bruises on her upper thighs and an abrasion on her right knee. U.S. Exh. 958 (7/24/93 Inc. Rep.). Staff do not know "how, when, or where" Denise injured herself but note that she frequently throws herself to the ground and pounds her legs. Id. Several days after Ms. Dekowski testified, Denise was again found with a bruise on her leg. U.S. Exh. 958 (7/29/93 Inc. Rep.). This time staff note the injury was discovered immediately after Denise was self-abusive.

Denise does not have a behavior program for her severe self-injurious behavior, even though she has suffered serious and repeated injuries due to her behavior of banging her head on walls, floors, and windows. Tr. 8/2/93 (Russo) at 75. Between May and August 1993, Denise engaged in self-injurious behavior on at least four occasions, including lacerating her scalp from hitting her head on a wooden divider. Ebensburg recommended that no changes be made to Denise's current behavior program.

2. Ebensburg Fails to Protect Denise from Harm -- Undue Restraints

Between January 1990 and February 1993, even though Denise had been subject to continuing restraints, Ebensburg's Behavior Intervention Committee recommended that Denise's behavior program be continued except to change her drugs and replace use of the papoose board with use of floor control in late 1992. U.S. Exh. 42(c) at 4879, 4895, 4919, 4836, 541460, 541433, 541421-22. Since January 1, 1991, Denise has been restrained a number of times due to her aggression or her self-injurious behaviors. U.S. Exh. 993.

Ebensburg is treating Denise's behaviors with behavior-modifying medications instead of providing an adequate, effective behavior program. In addition, Denise's psychologist has failed to consider non-medication alternatives for Denise's behaviors. For instance, on

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

JAMES W.

1. Ebensburg Fails to Protect James W. from Harm

a. Ebensburg Staff Fail to Intervene to Protect James from his Peers' Aggression

The second parent to testify about Ebensburg's failure to protect her child from harm was James W.'s mother, Mrs. Weakland. Mrs. Weakland testified about repeated, significant harm to her son, James, who, within a three year period of living at Ebensburg, had three emergency hospitalizations for such severe injuries as a ruptured globe in his eye, a fractured jaw, and a ruptured spleen along with broken ribs. Tr. 7/26/93 (Weakland) at 190-196.

For the period January 1989 until February 1993, James suffered 57 injuries and incidents at Ebensburg. U.S. Exh. 777. James suffered three very serious injuries in that time period. In 1989, one of James' eyes was knocked out when he fell against a chair. Tr. 7/26/93 (Weakland) at 190-193. Ebensburg records indicate that the enucleation was not the result of an accident. U.S. Exh. 135.

On November 20, 1991, at 10:15 a.m., James' jaw was fractured during a fight with Alan G., another blind Ebensburg resident, at the JFK Learning Center at Ebensburg. Tr. 7/26/93 (Weakland) at 194; U.S. Exh. 501(aa). Before staff could intervene to break up the fight, a table was upset, chairs were thrown, a bench seat was three feet from the wall, and lockers were moved. U.S. Exh. 501(aa). An Ebensburg physician did not examine James until two days later, at which time he was found to have a fractured jaw. U.S. Exh. 501(bb). James required surgery for the fracture, and his jaw was wired shut. James could only drink through a straw while his jaw was wired shut. Tr. 7/26/93 (Weakland) at 195; U.S. Exh. 501(bb). Following surgery, the discharge report from Mercy Hospital

specifically recommended that James "is to be isolated from other combative residents at Ebensburg." U.S. Exh. 501(cc) at 338273.

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

James was finally sent to the hospital at 12:30 p.m. (four hours after the original injury) and found to have a ruptured spleen, pneumothorax, and two liters of blood in his abdominal cavity. He had to have emergency surgery to remove his spleen. Tr. 7/26/93 (Weakland) at 196; U.S. Exhs. 501(dd)(ee)(ff); U.S. Exh. 623(aa). James developed pneumonia following the September 1992 injuries. Tr. 7/26/93 (Weakland) at 199-200; U.S. Exh. 501(gg) (excerpts from James' medical record describing the pneumonia); U.S. Exh. 501(hh) (Mercy Hospital discharge report concerning the hospitalization for pneumonia). About four weeks before trial, Mrs. Weakland saw a big cut on the lower part of James' knee and now there is a scar. Tr. 7/26/93 (Weakland) at 200. On the day that Mrs. Weakland testified about Ebensburg's failure to protect James from harm, he suffered two additional injuries. U.S. Exh. 501. Staff found James that morning with a swollen and painful knuckle that was slightly discolored. Staff do not know how it happened but James stated that he punched the wall. Id. Later that day, James was pushed from behind by another resident and hit his head on the door frame, cutting his forehead.

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

b. Failure to Provide James a Behavior Program for his Inappropriate Sexual Behaviors

Dr. Stark found that James does not have a behavior program for his inappropriate sexual behavior. U.S. Exh. 780. Mr. Bellomo knew as far back as December 1991 that James was sexually aggressive. Tr. 10/14/93 (Bellomo) at 108. In spite of this knowledge, Mr. Bellomo placed James in Keystone House to recuperate from his fractured jaw. A few weeks later, in January 1992, James was found in a Keystone bathroom stall with Keystone resident Vincent V., Vincent's underwear was down, and James was straddling him. Following three more incidents in 1992 where James was engaged in a sexual activity with another client, James' team met on October 28, 1992. James' team decided to acquire a private bedroom for James and to contact a certified sex therapist for James. U.S. Exh. 501 (summary chart of Ebensburg's response to James's sexual behaviors). James' sexual behaviors continued. After six such incidents, on November 12, 1992, Mr. Bellomo issued a memo stating that James should be moved to a private bedroom "immediately." On Thursday, November 19 at 5:10 a.m., James was found in bed with another individual disrobed from the waist down. Later that same day, at 10:00 a.m., James was found in the bathroom on his living unit engaging in anal intercourse with Michael W., a Hepatitis B carrier. U.S. Exh. 501. James was not moved to a private bedroom until more than two

weeks after Mr. Bellomo's memo, on November 27, 1992, nearly a month after James' team recommended that he be moved to a private bedroom. Tr. 10/13/93 (Bellomo) at 169.

An evaluation of James' sexual behavior was not completed until February 22, 1993 and the evaluation was done by a certified sexuality therapist who is a member of the sexuality team at Selingsgrove Center. Tr. 10/14/93 (Bellomo) at 111-113. This was more than a year after Mr. Bellomo first knew of James' sexual aggressiveness and four months after James' interdisciplinary team issued a plea for help.

c. Failure to Provide James a Behavior Program for his Self-Injurious Behavior

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

2. Ebensburg Fails to Provide James Minimally Adequate Training

James' mother testified that before he was institutionalized, James bathed himself, combed his hair, and put on his shoes. He possessed all of his self-care skills. Tr. 7/26/93 (Weakland) at 187-188. Before being institutionalized, James could also speak in about three word sentences. Tr. 7/26/93 (Weakland) at 188. James was first institutionalized at Cresson Center in Pennsylvania. When Cresson closed in the early eighties, James was transferred to Ebensburg. At that time, James still possessed all of his self-care skills, could still talk, could still see, and was still active and healthy. Tr. 7/26/93 (Weakland) at 189. Since moving to Ebensburg only a decade ago, James has lost the ability to perform most self-care skills. Tr. 7/26/93 (Weakland) at 190. Since moving to Ebensburg, James has also lost his

ability to communicate with words. He now only speaks a "very few words." Tr. 7/26/93 (Weakland) at 190.

3. Ebensburg Fails to Provide Adequate Medical Care to James

Despite the fact that Ebensburg staff have an obligation to contact a nurse immediately whenever a resident hits or kicks another resident, they did not notify a nurse when a resident was found hitting and kicking James in late September 1992. U.S. Exh. 790, U.S. Exh. 501 (cc); U.S. Exh. 638 (Sponsky Dep.) at 108. Instead, staff waited one-and-a-half hours to report this incident to the nurse after James started complaining of chest pain. U.S. Exh. 790; U.S. Exh. 501 (cc). Even though the nurse documented that he had bruising on his rib cage and there was a "clicking" sound when touching his ribs, all the nurse did was to give him tylenol. U.S. Exh. 501 (cc). The nurse did not notify the doctor until more than an hour later. Id. James was finally sent to the hospital at 12:30 p.m. (four hours after the original injury) and found to have a ruptured spleen, pneumothorax, and two liters of blood in his abdominal cavity. He had to have emergency surgery to remove his spleen. Id.

Ebensburg's Director of Nursing admits that the seriousness of James' condition necessitated more immediate medical attention than waiting an hour and a half to transport him to the hospital. U.S. Exh. 638 (Sponsky Dep.) at 116. Despite the seriousness of this event, Ms. Sponsky did not even review the occurrence report until nine days later. U.S. Exh. 638 (Sponsky Dep.) at 109. As part her review, she did not investigate why the nurse was not notified for approximately 1 1/2 hours until after the incident occurred. Id. at 110. No one at Ebensburg has every evaluated whether direct care staff are reporting injuries to

nurses on a timely basis and the Nursing Director does not think that it is her responsibility to look at the circumstances surrounding James' injury to determine why there was a delay in notifying the nurse. Id. at 114-115. Ms. Sponsky also does not know if anyone investigated why there was an additional 1 1/2 hour delay between the time the nurse examined James and his emergency transport to the hospital. Id. at 115.

This was not an isolated incident at Ebensburg for James. One year earlier, in late November 1991, James was found fighting with another client at 10:15 a.m. U.S. Exh. 501 (aa); U.S. Exh. 790. Despite the fact that James had a bloody mouth, staff did not report his injury to the nurse until 5:30 that evening when he complained of mouth pain and refused supper. Id. at 00210934. Although he was seen at dental clinic the following day, an Ebensburg physician did not examine him until two days later, at which time he was found to have a fractured jaw. U.S. Exh. 501 (bb).

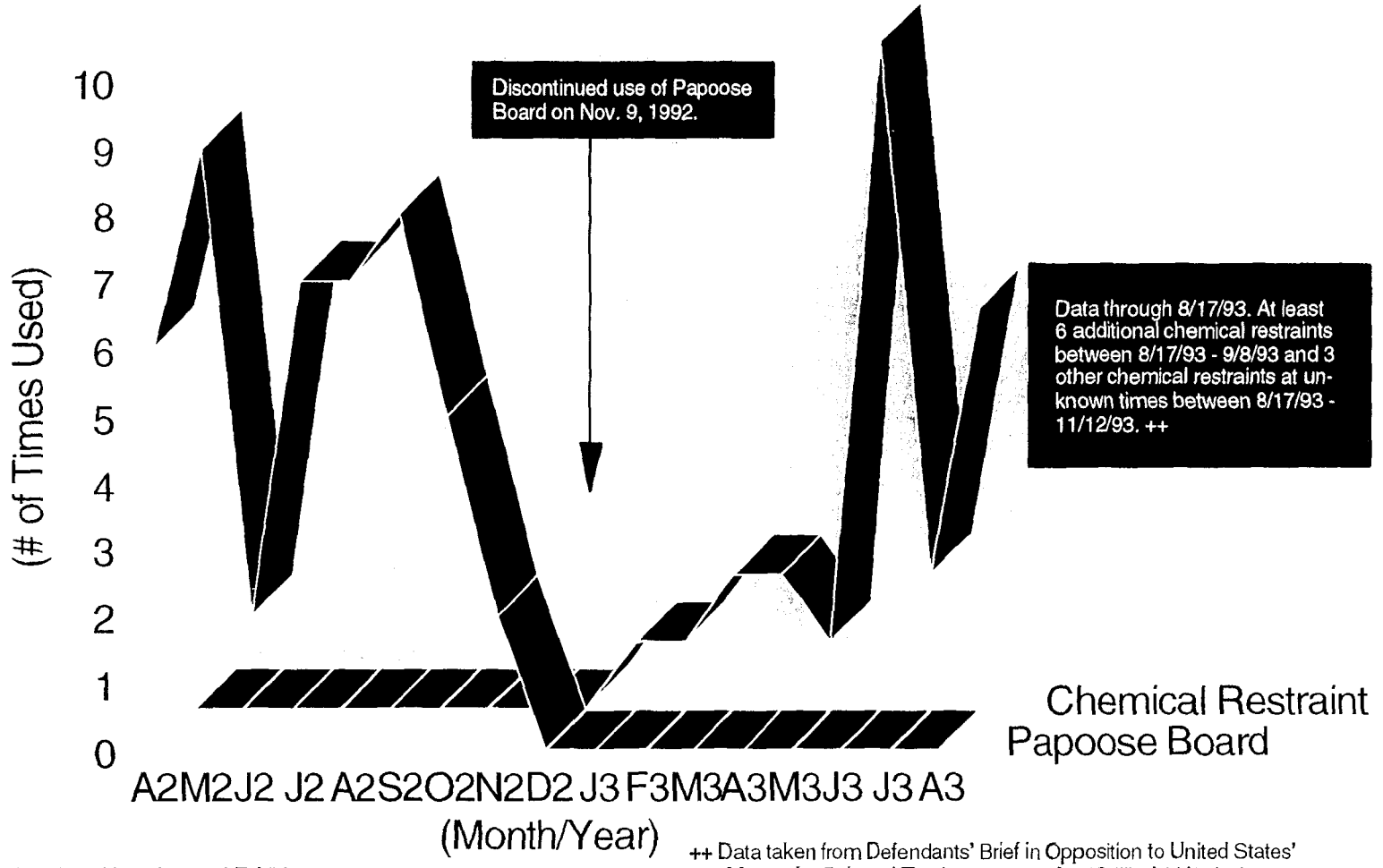
4. Ebensburg Fails to Find a Community Placement for James Even Though It Recognizes that Ebensburg Is Not a Safe Place for James

In September 1992, after James was severely injured by a peer, James' Unit Manager wrote a memo pursuant to his responsibility to "establish a safe living area for [James] and his peers." James' Unit Manager wrote that "[i]deally, a community placement in a small CLA would best serve to meet his many personal daily needs in the most quiet, unrestricted environment." U.S. Exh. 501(dd) at 200339.

However, James remains at Ebensburg. Tr. 7/26/93 (Weakland) at 186. Since September 1992, James has continued to suffer repeated injuries. U.S. Exhs. 135, 136.

United States v. Pennsylvania

Papoose Board/Emergency Chem. Restraint

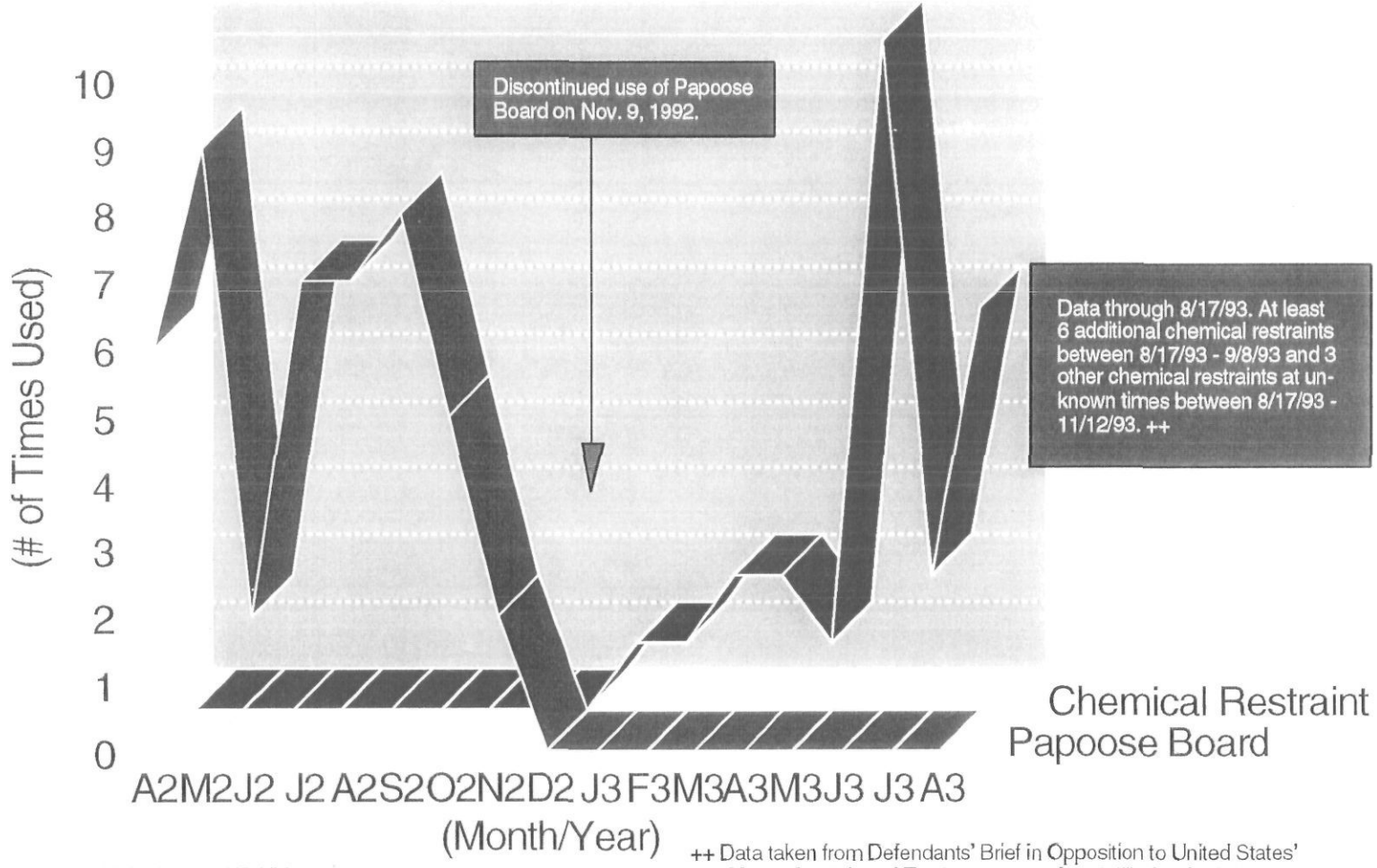


+ Data taken from United States' Exhibit 993.

++ Data taken from Defendants' Brief in Opposition to United States' Motion for Rebuttal Testimony at 35, fn. 13 (filed 11/12/93).

United States v. Pennsylvania

Papoose Board/Emergency Chem. Restraint

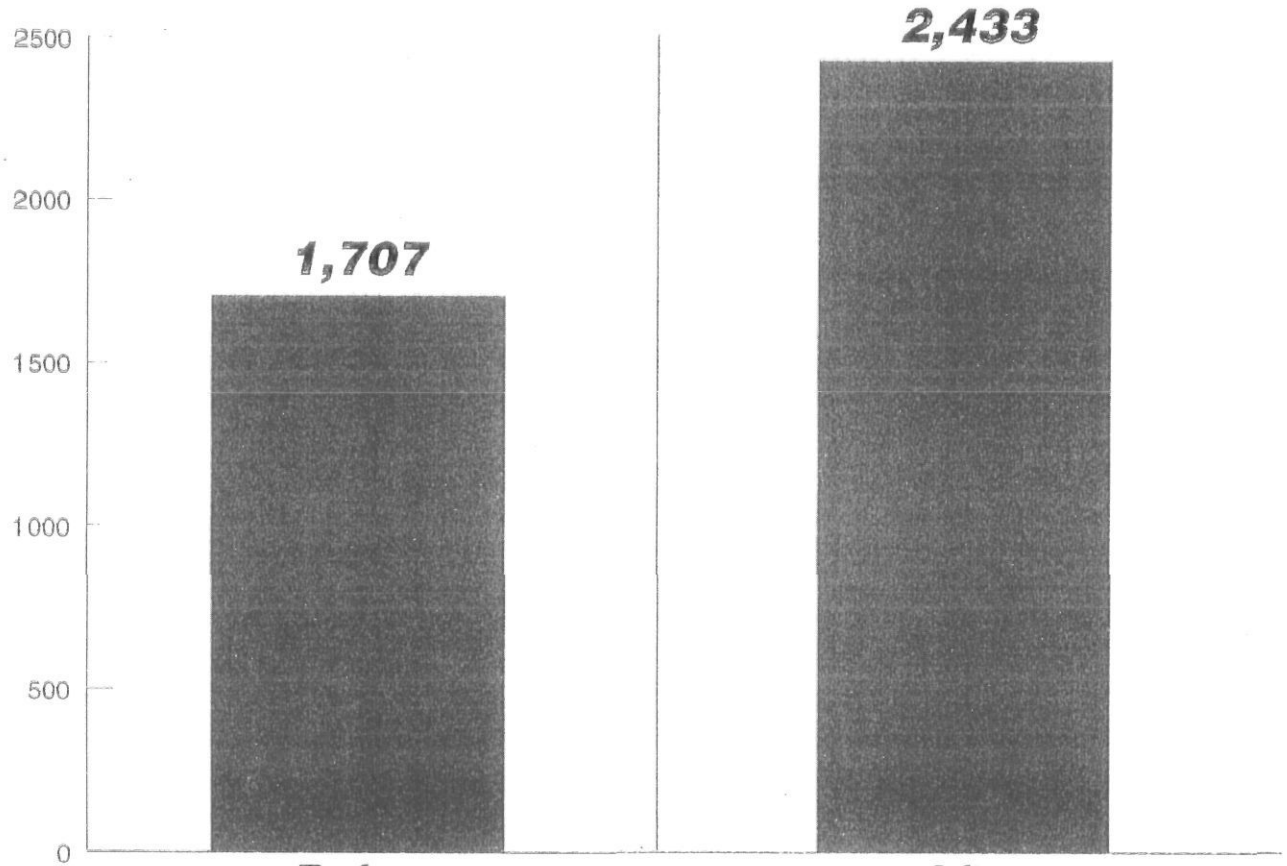


+ Data taken from United States' Exhibit 993.

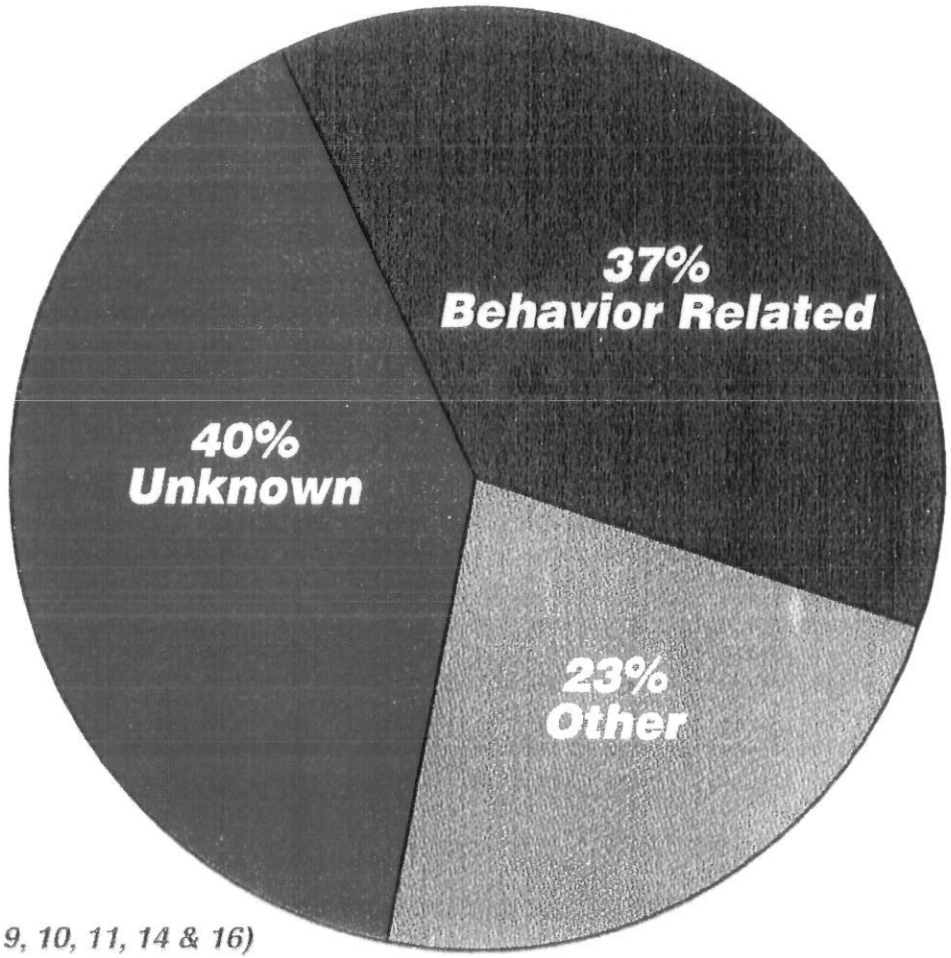
++ Data taken from Defendants' Brief in Opposition to United States' Motion for Rebuttal Testimony at 35, fn. 13 (filed 11/12/93).

Number of Reported Injuries at Ebensburg Center

Twelve Months Before and After the United States' Lawsuit



Causes of Injuries During 1992 at Ebensburg Center



Unknown (Cause 17)
= 964 incidents

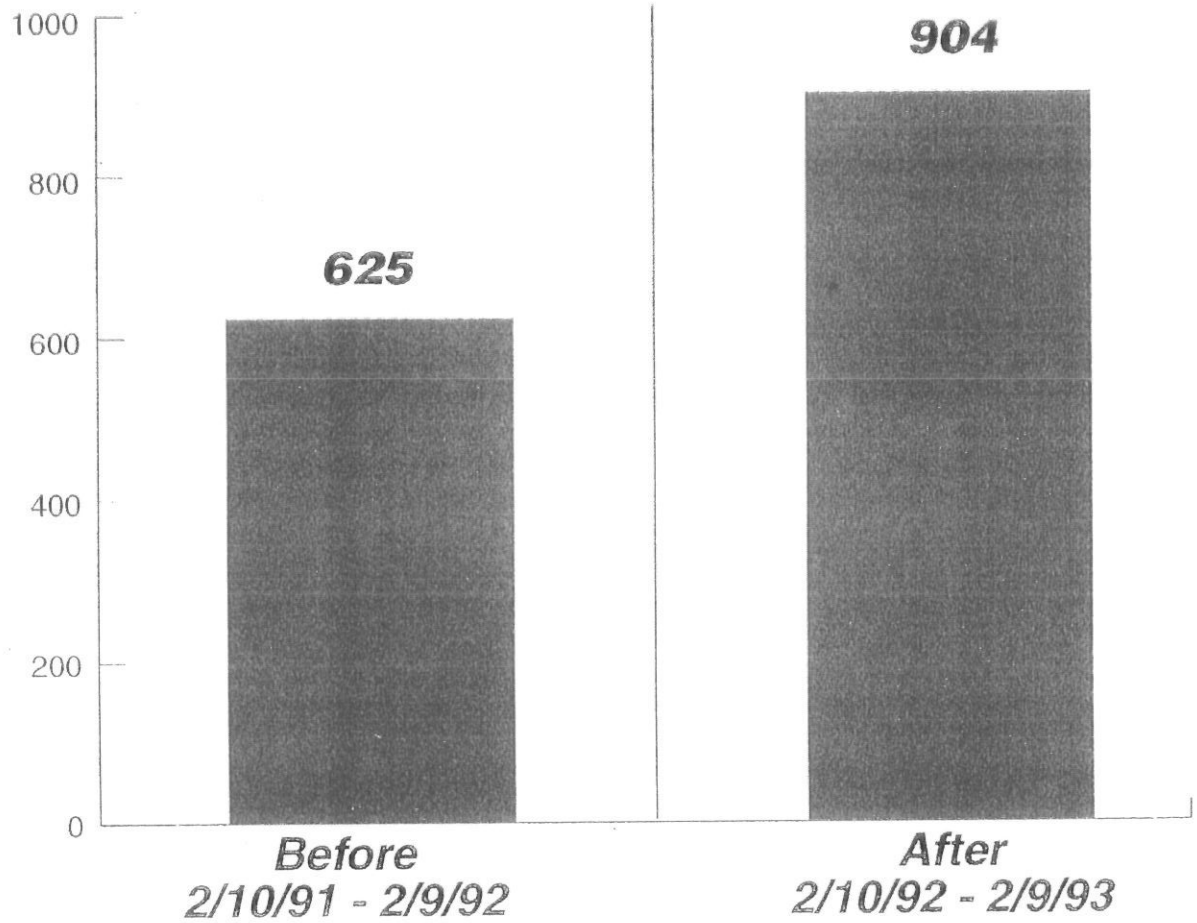
Behavior (Causes 4, 5, 9, 10, 11, 14 & 16)
= 886 incidents

Based on a total of 2,399 incidents

PENGAD-Bayonne, N. J.
PLAINTIFF'S EXHIBIT
90

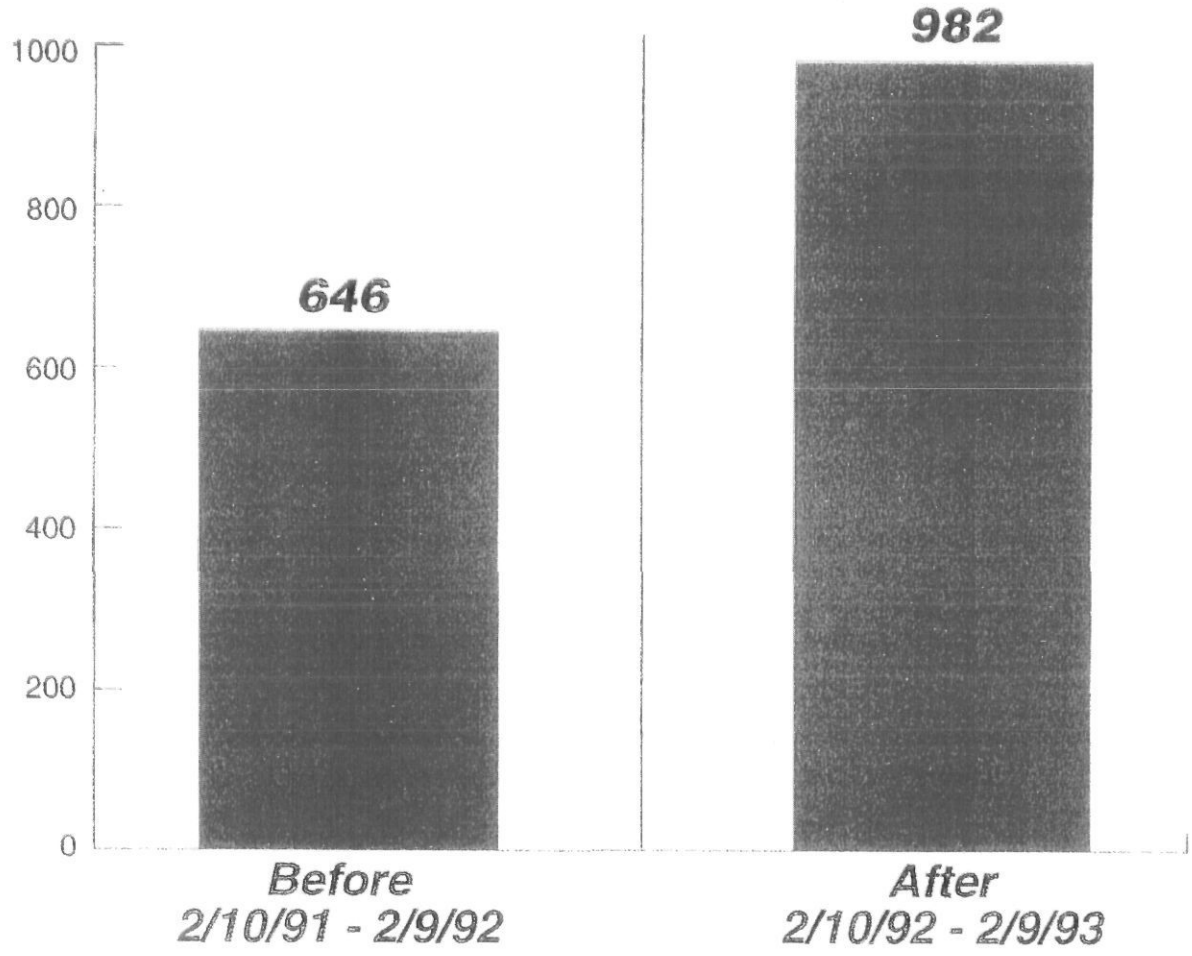
Number of Injuries Related to Behaviors at Ebensburg Center

Twelve Months Before and After the United States' Lawsuit



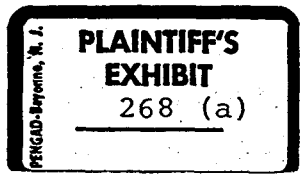
Number of Unknown Injuries at Ebensburg Center

Twelve Months Before and After the United States' Lawsuit



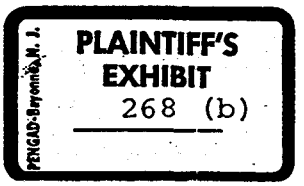
BARBARA K.

DATE	SAMPLE OF SEIZURE INJURIES
05/01/93	Fell face forward to floor re-opening old injury to elbow.
03/05/93	Fell to floor striking face on small toy causing puncture wound of left cheek.
11/23/92	Fell to floor re-opening wound on chin; sustained 1 1/2" deep laceration; required 4 sutures.
11/21/92	Fell, hitting forehead on chair; hematoma and swelling.
10/21/92	Fell hitting her chin; required 6 sutures.
09/02/92	Fell hitting her chin; sustained a very deep chin laceration; bleeding; required 6 sutures; days later admitted to hospital to x-ray for fracture.
08/08/92	Fell face forward to the floor re-opening old wound on chin.
08/01/92	Fell to floor re-opening old elbow injury.
02/25/92	Fell face forward to floor sustaining cut on chin; required 4 Ethistrips and a bandaid.
11/25/91	Fell with force on her face and arms in bath area; sustained deep laceration on chin requiring 7 sutures, superficial laceration on elbow.
11/01/91	Fell straight down on face; sustained laceration to lower lip requiring 2 inner and 3 outer sutures, re-opened old wound on chin.
10/23/91	Fell full force to bathroom floor; bleeding; re-opened old wounds on chin and right elbow.
10/11/91	Fell straight down to floor; re-opened laceration on chin and extended.
08/24/91	Fell forward onto face; re-opened chin wound; 9 sutures.
08/23/91	Fell to floor; sustained deep 2" laceration of chin requiring 9 sutures.
07/23/91	Fell to floor; sustained a 1 1/2" jagged laceration of chin requiring 4 sutures.
07/02/91	Fell striking side of head on bottom of bed; sustained 1 1/2" laceration of ear near temple extending to ear canal; required 4 sutures.



RONALD A.

DATE	SAMPLE OF SEIZURE INJURIES
01/03/93	Fell and hit mouth, cut lower lip.
08/26/92	Fell and sustained abrasions on elbow, knee, and shin.
08/13/92	Suffered 4 seizures; fell while running and hit head.
04/29/92	Fell backward and struck head on the floor; moderate amount of bleeding from laceration over old scar tissue; required 3 sutures.
04/05/92	Fell and re-opened old cut on occipital scalp; bleeding.
04/04/92	Fell and cut back of head.
11/03/91	Found with black and blue eye.
10/26/91	Fell and hit back of head; left occipital scalp bleeding.
09/11/91	Fell head first to floor; bleeding; abrupt loss of consciousness; sustained 1" laceration medial frontal region of head.
08/06/91	Fell off picnic bench and patio; bleeding from back of head; abrasions on back and head.



EXAMPLES OF CHOKINGS
EBENSBURG CENTER
01/21/91 TO 05/09/93

DATE	CLIENT	SUMMARY OF CHOKING EPISODE
5/9/93	MaryAnn R.	Grabbed piece of bread from another client's tray. Cyanotic. Took 7 abdominal thrusts to perform heimlich.
5/4/93	Chris W.	Choked while being fed beets. Heimlich performed.
4/29/93	Charles M.	Choked while eating grapes.
4/22/93	Edward S.	Gagging, cyanotic after stealing meat from another client's tray. Is on pureed diet. Sent to emergency room.
4/21/93	James R.	Choking and gagging at dinner. Had just been changed from pureed to chopped diet by Dysphagia Team.
4/16/93	Pamela R.	Choked on large piece of waffle. Cyanotic; Heimlich done. Is on chopped diet but waffle pieces were larger than bite size. "On-going problem."
4/13/93	Michael B.	Choked on doughnut in bath area; heimlich performed.
3/21/93	Charles M.	Partially obstructured airway from not chewing meatball pieces. Dentures floating in mouth.
3/17/93	Deborah S.	Choked on a piece of toast while being fed breakfast. Third choking episode in less than a year.
2/18/93	Griffith S.	Choked on 1" square piece of overly browned and crusty cheese strata.
2/12/93	John B.	Choked on whole pieces of chicken he stole from another client's tray.
2/6/93	Pamela R.	Choked on Pop Tart. Cyanotic, rales in chest.
2/4/93	Ronald A.	Choked on breakfast. Cyanotic, heimlich done; suctioned.
2/2/93	Jonathan L.	"Apparent choking." Eyes tearing, large emesis of undigested food.

EXAMPLES OF CHOKINGS
EBENSBURG CENTER
01/21/91 TO 05/09/93

DATE	CLIENT	SUMMARY OF CHOKING EPISODE
1/31/93	Alan G.	Choked on chunk of meat despite order for Pureed Meat. Expectorated meat 40 minutes after Heimlich.
1/13/93	Vickie W.	Choked on entire piece of cake; "limp & purplish. Two RN's to remove food; one doing heimlich, other finger sweeping. Oxygen used.
12/18/92	Jeffrey C.	Choked on chopped food at dinner.
11/25/92	Ivy W.	Cyanotic, not swallowing; potatoes found impacted on roof of mouth & back of throat. Taken to Emergency Room.
11/22/92	Elliot G.	Choked on piece of meat at lunch.
11/9/92	Charles M.	Airway partially obstructed by lettuce during dinner.
10/31/92	David F.	Choked on ice cream. Labored respirations, cyanotic.
10/1/92	Pamela R.	Choked on French Toast; Heimlich done.
9/27/92	Gary K.	Choked on piece of cheese. Heimlich done.
9/16/92	Estelle M.	Choked on hamburger.
9/12/92	Mary Lou F.	Gagged and choked by overstuffing mouth with ham/potato casserole.
9/5/92	George K.	Choked on chunks of fruit cocktail at breakfast.
8/28/92	Donald R.	Choked twice on large piece of fish at lunch. Mouth swept to remove food.
8/23/92	Fred G.	Choked on piece of meat at dinner. Is on a chopped diet.
7/26/92	Irvin B.	Choked on piece of chicken.
7/16/92	Deborah S.	Choked on scrambled eggs she was being fed; difficulty breathing and swallowing; Heimlich done. Is on pureed diet.

EXAMPLES OF CHOKINGS
EBENSBURG CENTER
01/21/91 TO 05/09/93

DATE	CLIENT	SUMMARY OF CHOKING EPISODE
7/12/92	Vincent P.	Choked on whole pieces of zucchini and chicken from overstuffing mouth and not chewing. Heimlich done.
6/23/92	Gary W.	Choked on toast at breakfast. Has history of choking.
5/6/92	Mary Ann R.	Choked after stuffing half bun into her mouth. Heimlich done.
5/5/92	Eileen G.	Difficulty breathing, trying to pull something from throat. After Heimlich, 2 cubes of meat dislodged from throat; is on chopped diet.
5/5/92	Joyce Y.	Choked on chunk of meat; is on chopped diet. Heimlich performed.
5/3/92	Alan G.	Choked on meat; Unable to swallow fluids. Ambulance called; canceled when meat expectorated 35 minutes later.
4/8/92	Deborah S.	Choked and gagged on food at lunch. Abdominal thrust.
4/5/92	Sylvia B.	Choked on 1" x 1" cube of meat; is on chopped diet.
3/21/92	Ibrahim D.	Unable to breathe from overstuffing mouth with food. Abdominal thrust.
3/16/92	Judith L.	Choked at dinner while being fed; food expelled later. Is on chopped diet; had whole lettuce on plate.
3/13/92	Fred G.	Choked after grabbing food from tray, stuffed food in mouth. Abdominal thrusts.
3/10/92	Mary Lou F.	To Emergency Room for possible aspiration: emitted cubed meat after dinner, is on chopped diet.
3/7/92	Glenn A.	Choked on meatball lodged in throat. Abdominal thrusts.
3/4/92	Harold H.	Coughing after lunch: piece of carrot, green bean and corn expelled.

EXAMPLES OF CHOKINGS
EBENSBURG CENTER
01/21/91 TO 05/09/93

DATE	CLIENT	SUMMARY OF CHOKING EPISODE
2/11/92	Albert K.	Choked on dry cake; should be moistened and cut up.
12/27/91	Sandra S.	Choked on pieces of candy.
12/14/91	Elliot G.	Choked after swallowing whole french fry kept in his closet.
12/1/91	James S.	Choked on dinner; overstuffed mouth & then drank juice without pausing.
10/25/91	Richard P.	Choked on large chunk of tuna; has chopped diet order.
9/20/91	Louis L.	Choked on dinner. Coughing, gagging, cyanotic lips.
8/8/91	Francis R.	Respiratory distress from choking on pepperoni pizza. Multiple heimlichs over railing. Is on pureed diet due to missing teeth.
7/29/91	Robert Y.	To Emergency Room for possible aspiration; acute respiratory distress. Lost consciousness. Choked on lima beans from peer's tray. Developed pneumonia.
7/2/91	Jacqueline H.	Obstructed airway due to chicken nugget size. Has no teeth and eats too fast.
5/25/91	Jeff B.	Choked on pieces of hamburger. Heimlich done.
5/2/91	Larry D.	Choked on pureed meat; overstuffs mouth.
4/10/91	Albert K.	Choked on chopped meat. Staff gave several blows to back to start regular breathing.
3/28/91	David G.	Choked on 5 candy pumpkins when he overstuffed mouth and took a drink; cyanotic. Heimlich done.
3/15/91	Linda S.	Choked while being fed. 3 tries of Heimlich to restore breathing.
3/14/91	Sylvia B.	Choked, face red, gasping for air. Heimlich done.
3/11/91	Alice W.	Choked, turned blue, gasping for air; eating fast and not chewing food. Abdominal thrusts used.

EXAMPLES OF CHOKINGS
EBENSBURG CENTER
01/21/91 TO 05/09/93

DATE	CLIENT	SUMMARY OF CHOKING EPISODE
2/25/91	Griffith S.	Choked; meat stuck in esophagus. To Emergency Room; esophagoscopy to push meat into stomach.
2/21/91	Benita B.	Aspiration; choked on large beef cubes; is on chopped diet.
1/21/91	Sandra S.	Found choking on apple; abdominal thrusts. Overstuffs her mouth.

GREG A.

DATE	INCIDENT	EBENSBURG'S RESPONSE
08/10/91	During med time, found with cut on eye.	Monitor.
08/25/91	Scratched on back of neck by client.	Staff will continue to monitor to prevent recurrence.
09/17/91	Hit in face by client; laceration on eyebrow; bleeding.	Aggressive behavior not common for individual who hit him; had recent med change.
10/21/91	Pulled sock out of client's hand; client kicked him in the mouth "very hard;". knocked out 2 teeth.	Behavior of both individuals currently addressed; will monitor for possible need for further interventions.
11/03/91	Pushed into playroom wall by another individual. Laceration on eyebrow and lip.	Client not usually aggressive; monitor client and modify behavior program if needed.
11/19/91	Found with lacerated ear in group of highly agitated clients in bath area who were pushing, shoving and hitting.	Escalation/chain reaction of behaviors not anticipated and unavoidable once started.
12/16/91	Pushed against couch; bleeding eyebrow and lip. Lip wound sutured.	Monitor behavior.
01/09/92	Scratched on nose by another individual.	Aggressor's behaviors are addressed; staff will continue to try and anticipate aggressive behavior and intervene immediately.
01/14/92	Client ran into him, knocking him into door. Head bleeding; area shaved and ethistripped.	Difficult to intervene or even anticipate this type of situation. Staff will continue to monitor.
01/17/92	Sitting on floor by door. Hit on head by another individual; head bleeding.	Staff must try to keep individuals off floor; both individuals are frequently involved in altercations resulting in injuries; they will have to be more closely monitored.
03/04/92	Bitten on thigh; 3 open areas; 2 swollen areas; bleeding.	Staff will continue to monitor individuals and prevent this type of behavior.
04/27/92	Pushed; face hit corner of table. Six sutures to close face wound.	Staff will continue to observe and try to intervene to prevent future injuries.

GREG A.

DATE	INCIDENT	EBENSBURG'S RESPONSE
06/10/92	Pushed; face hit chair. Laceration bleeding and swollen.	Staff will continue to prevent aggression between individuals. Client who pushed has behavior program for aggression.
08/9/92	Crawled off mat scraping knee on cement.	Staff will intervene in this type of behavior to prevent injury, providing proper seating and activity.
09/05/92	Found with scratches on cheek and nose.	Adequate Rx. No further recommendations at this time.
10/19/92	Found at med time with lacerations on eyebrow and below eye.	Has history of pushing and being pushed. Behavior plan to address aggression.
10/26/92	Found at med time with bleeding laceration over eye.	Head butts; intervene.
10/29/92	Scratches on neck from altercation.	Proper medical attention; no further recommendations at this time.
11/01/92	Grabbed around neck by another individual; scratches on face and neck; skin broken.	Necessary medical attention; no further recommendations at this time.
12/09/92	Found with blood on face and hands; puncture type wound on scalp. Had been head butting client.	Monitor and intervene in aggression. Has behavior plan for aggression; start Ativan.
12/22/92	Found with scratch on forehead.	No occurrence report.
01/12/93	Sitting by self in chair at program. When asked to come to the table for his program, staff noticed blood on cheek from open scratches.	Scratch should heal. Fingernails not excessively long. No change in treatment plan or programming necessary at this time.
02/28/93	Pushed by client during altercation; fell backwards onto floor and against wooden arm of sofa. Bleeding area on ear.	Expected response by client who doesn't like to be touched. Client has behavior program and medication.
04/20/93	Found during med time to have 2 1/2 inch scratch extending from eye to cheek.	Individual who is likely aggressor has acceptable nail length.

EBENSBURG'S RESPONSE TO WITNESSED AND SUSPECTED BITES INFLICTED BY GEORGE F.

DATE	NAME	DESCRIPTION	ACTION TAKEN BY EBENSBURG CENTER
02/09/91	James R.	Fractured toe from bite.	
02/11/91			**IDT Action: Increase Haldol-Staff must monitor George "very closely."**
02/27/91			**Sneed Memo to Bellomo: "Discuss program designed to limit/reduce the behavior of [George]" "If such a program doesn't exist, have staff outline how the program will be developed and implemented (including target date(s) for implementation." "Our concern is [George] will continue to bite (attack) other relatively defenseless individuals."**
03/30/91	Philip A.	Bitten on thumb.	
07/12/91	Timothy T.	Bitten on arm; skin broken & ecchymosed.	
07/31/91	Raymond H.	Bitten on foot while sitting at picnic table; skin broken.	
08/07/91	Timothy T.	Bitten on foot; teeth marks present; open area.	
10/~~31~~ 13/91	Elliot G.	Bitten on arm; skin broken & deeply abraded.	

12/04/91	Kenneth M.	Two separate sets of teeth marks on upper & lower back; claims that George bit him.	
01/07/92	Alan G.	Bitten on shoulder and arm.	
03/22/92	James S.	Hollered from bedroom, staff found that he had been bitten on toe; skin broken; claims that George bit him.	
06/08/92	James S.	Staff checked him when he yelled out and found George with James' foot in George's mouth; toe bleeding.	
07/12/92	Chris D.	Staff heard noise and walked into bedroom; found Chris with bite mark on ankle; ecchymosis & skin broken.	
07/17/92	Albert K.	Bitten while in bed; toe nail missing; open area.	
07/17/92	Albert K.	While being given injection, staff found bite on buttocks; skin broken; suspected to have occurred at same time George bit his toe.	

07/25/92	Charles R.	Found with blood on socks; both feet bleeding; missing toe nail; George, who was seen leaving bedroom, is suspected biter.	
08/11/92	Charles R.	Found with blood on sock; toe tip partially amputated and jagged, hanging, & cyanotic; sent to emergency room; possible that George bit him.	
08/12/92			**Data Collection Stated-- Ebensburg begins taking data on George's biting behavior.**
11/11/92	Chris D.	Found with toe nail completely off and black and blue; "very swollen and ecchymotic", team consensus that George bit him.	
11/21/92	Chris D.	Was found with toe severely bruised and the nail missing, team consensus that George bit him.	
12/02/92	Arthur S.	Found with blood on his sock; missing toe nail and abrasion on toe tip. Supervisor believes that George is "most likely causitive factor".	

01/23/93	Donald P.	Bitten on the toe while sleeping.	
03/08/93	Donald P.	Bitten on the arm; large bite mark with skin broken; claims that George bit him. PSA states: "will complete functional analysis to re-examine the behavior of [George] during the next three weeks."	
06/06/93			**Behavioral Evaluation-- Recommends: (1) Collect behavior data; continue Haldol therapy; (2) frequent visual monitoring; (3) redirection of behavior.**

EILEEN G.

DATE	INJURY
12/20/90	Up all night screaming and yelling.
12/27/90	Pushed into wall by another client, lacerating back of head.
2/13/91	Found with lacerated scalp at 7:30 a.m.; 5 sutures required.
5/11/91	Came out of bedroom with blood on face; laceration above eyebrow.
5/18/91	10:30 p.m., pushed by client and fell, hitting edge of TV; sustained laceration in corner of eye and bridge of nose; 5 sutures.
5/28/91	Reopened laceration on eyelid during programs; 2 sutures required.
6/6/91	10:40 p.m. pushed by another client; lacerated eyelid.
6/14/91	Pushed, hitting head on floor.
6/22/91	Pushed by another client, causing old wound on scalp to bleed.
6/23/91	Lacerated eyebrow as a result of aggression by another client.
6/29/91	Bitten on arm and shoulder.
7/9/91	In wheelchair due to swollen ankle; pushed over in wheelchair by 3 different individuals.
8/7/91 Moved to EII temporarily for 60 days or until injuries are caused by her. Team has concerns that Eileen may cause serious injuries to women in EII.	
8/8/91	Pulled arm of individual in a wheelchair until staff intervened; grabbed the back of the neck of another individual in a wheelchair, trying to pull her down on the floor; pulled an individual to floor and then sat on top of her until staff intervened.
8/13/91	Stripping until staff intervened, then became aggressive toward other individuals; punching them, pushing them off furniture, and sitting on top of them; pushed someone onto floor.
8/14/91	Scratching and pushing 3 clients off furniture.
8/15/91	Pushing and shoving individuals off furniture; agitating clients, making them scream; slapping heads of clients in wheelchairs.
8/16/91	Stripping; climbing over furniture and pushing other individuals.

EILEEN G.

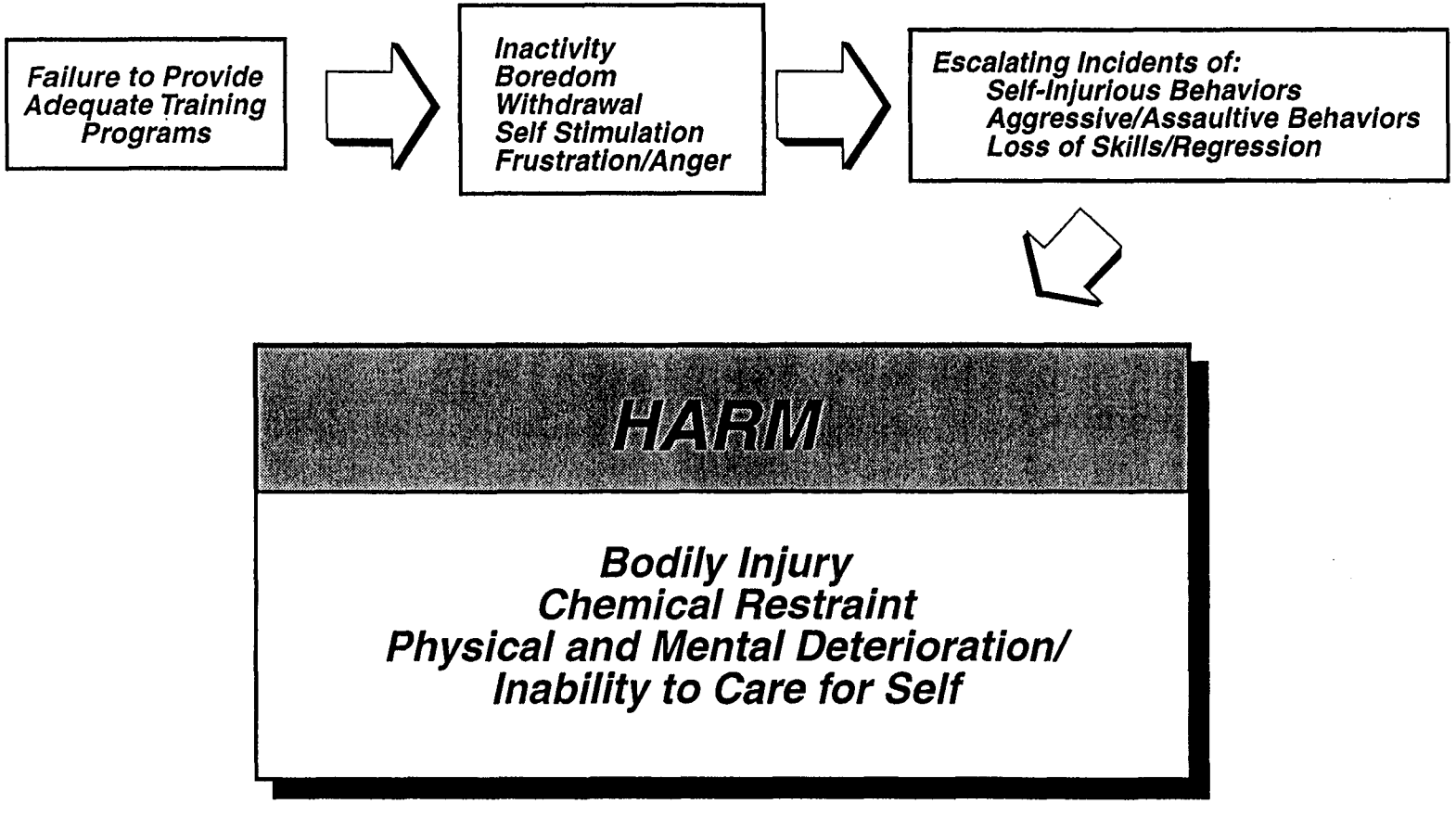
DATE	INJURY
8/23/91	Shoving clients; agitating clients in wheelchairs, making them scream and cry.
8/26/91	Pushing clients off chair; climbing on top of clients while trying to sit on couch.
9/7/91	Pushing clients; stepping on them while on floor.
9/8/91	Pushed client to the floor; pulling wheelchair clients' hair; hitting and pulling their arms; refusing to stay away.
9/10/91	Stripping and annoying other clients; pushing, grabbing, and hitting them.
9/19/91	Found with black and blue areas and abrasions on leg.
10/28/91	Climbing over furniture and pushing clients off chairs; pulling clients while sitting in wheelchairs.
10/31/91	Pulling clients off furniture and wheelchairs.
11/3/91	Pushing and pulling clients; stripping; pulling hair of clients in wheelchairs.
11/10/91	Refuses to leave wheelchairs alone; pulling hair, arms of clients; stepping and falling on clients on mats.
11/11/91	Pushing clients off furniture; pulling hair.
11/23/91	Pushing and pulling clients in wheelchairs; sitting on top of clients sitting in furniture; stripping.
12/3/91	Stripping and head butting; knocking client to the floor.
12/22/91	Banging head; pushing clients off chairs; stripping.
1/24/92	Stripping; pushing other clients off furniture.
2/22/92	Bitten on leg.
2/22/92	Pushing clients off couch; stripping; hitting other clients.
2/23/92	Pushing client to the floor; pulling hair and laying on top of other clients.
3/10/92	Found with black and blue, swollen left ear.

EILEEN G.

DATE	INJURY
3/15/92	Sitting on clients while on mats; pulling on arms; pushing clients off chairs.
4/24/92	Scratched by hepatitis B carrier on face and back of neck.
6/3/92	Noted at bath time to have scratch from thigh to knee and black and blue area on calf.
6/23/92	Scratched by peer, sustaining numerous open areas about face and neck.
8/4/92	Bitten on index finger; 2 open wounds.
8/17/92	Numerous superficial scratches on back between shoulders and right arm.
9/10/92	Found with bruised lip; bites her lip and hits her face; probably self-induced.

Pattern of Harm

For Ebensburg Residents



INJURIES OCCURRING WHILE STAFF ARE INVOLVED WITH MEALS, BATHING, TOILETING, MEDICATION ADMINISTRATION

DATE	CLIENT	DESCRIPTION OF INJURY	WHAT STAFF WERE DOING AT TIME OF INJURY
04/29/93	Albert K.	Staff took away recreational materials and placed them on top of closet. Albert attempted to reach materials and toppled sideways in wheelchair; bleeding from head.	Medication time; staff removed materials to assist with medications.
04/21/93	Albert B.	Pushed into table by individual who had been upset all morning. Lacerated area above eye; 6 sutures to close wound. Was in "wrong place at wrong time."	Morning care; 4 staff involved in a.m. care; 1 in quiet area/dayroom.
04/20/93	James S.	Found with blood on face and hands; reported that he took piece off record player and inflicted puncture wounds to his forehead.	Following lunch; 1 staff on break; 2 assisting individuals after lunch; 1 toileting.
04/19/93	Carol D.	Roaming around and bumped into dressers and beds. Reopened suture site.	All staff involved in a.m. care, changing and dressing clients.
04/18/93	Michael L.	Found with blood on head from laceration. Blind; possible that he hit head on gazebo or door jamb.	Lunchtime; injury discovered when staff came back to living area to take him to lunch.

INJURIES OCCURRING WHILE STAFF ARE INVOLVED WITH MEALS, BATHING, TOILETING, MEDICATION ADMINISTRATION

DATE	CLIENT	DESCRIPTION OF INJURY	WHAT STAFF WERE DOING AT TIME OF INJURY
04/15/93	Thomas H.	Found with bloodied ear from human bite. Ten sutures to repair wound.	Morning care; 1 staff returning after bloodwork who found injury; 3 involved in a.m. care.
04/14/93	Debra J.	Pushed by another individual; hit face on table. Laceration next to eye required sutures.	Medication administration.
04/08/93	Gary K.	Another client scratched him in the eye.	Medication administration.
03/26/93	Raymond K.	Kicked in the head by another individual; 4 sutures to close wound.	Getting ready to go to Learning Center. 2 staff in dayroom; 1 doing paper work; 1 in bath area.
03/08/93	James P.	Pushed by another individual into corner of door, bleeding scalp.	Bathing; 3 staff in bathroom; 1 on break; 1 in dayroom; 1 left to go to another living area to release staff on overtime.

INJURIES OCCURRING WHILE STAFF ARE INVOLVED WITH MEALS, BATHING, TOILETING, MEDICATION ADMINISTRATION

DATE	CLIENT	DESCRIPTION OF INJURY	WHAT STAFF WERE DOING AT TIME OF INJURY
03/06/93	Alan R.	Found on floor with face covered with blood. Lip required suturing. No one saw him fall and he was partially hidden by furniture arrangement in living room.	Weekend. 2 staff on break; 1 in chart room signing books; other staff circulating through day room and bathroom while weighing individuals.
02/28/93	Joseph C.	Smashed fist through window. Two inch laceration on hand requiring suturing.	One staff getting ready to sort clothes; 1 getting ready for break; 1 getting carts for clothes.
02/15/93	Jeffrey C.	Found choking individual who had bitten him so hard he had blood on his tooth. Need to retrain staff not to leave clients unobserved.	Dinner time; 1 staff on break, 2 in dining room; 2 in bathroom. Incident discovered by LPN walking through area.
02/07/93	John C.	Found with blood dripping from ear. Seven sutures to close wound.	Morning care. 1 staff doing a.m. care; 1 putting laundry in another room; 1 toileting.
01/29/93	Tracey M.	Pushed by another individual striking head on floor. Deep laceration on eyebrow sutured.	Lunch time. 1 staff in dayroom; 1 at door; 2 in dining room.

INJURIES OCCURRING WHILE STAFF ARE INVOLVED WITH MEALS, BATHING, TOILETING, MEDICATION ADMINISTRATION

DATE	CLIENT	DESCRIPTION OF INJURY	WHAT STAFF WERE DOING AT TIME OF INJURY
01/16/93	Robert W.	Found in bathroom "with blood coming out of his head." Deep laceration on eyebrow; sutured.	Dinner time. 1 staff in "ward area;" 1 returning from dining room; 2 in dining room.
12/03/92	Paul M.	Found with 1.5" deep laceration on forehead; sutured.	Evening care. 1 staff in quiet area; 3 in bath area. Recommendation to increase number of staff.
09/01/92	Albert K.	Another individual grabbed his wheelchair and tipped him backwards. Fell to floor, striking head; unconscious for 8-10 minutes. Sent to hospital emergency room. Need to include clients in more productive activities and decrease free time.	Breakfast; 2 staff in dining room; 1 in bathroom; 2 monitoring clients going to and coming from dining room; 1 monitoring day room; 1 in back area.
08/26/92	Robert W.	Found with blood on leg and 5" deep scratch on thigh. Staff need to be more alert and walking around monitoring individuals.	After dinner; 1 staff on break; 1 on 1:1, 1 pulled from another unit; 1 who found injury.

INJURIES OCCURRING WHILE STAFF ARE INVOLVED WITH MEALS, BATHING, TOILETING, MEDICATION ADMINISTRATION

DATE	CLIENT	DESCRIPTION OF INJURY	WHAT STAFF WERE DOING AT TIME OF INJURY
03/22/92	Edward S.	Found with multiple marks and abrasions on face. Apparently found a razor when left unattended. Has happened before. He is blind and is consistently bouncing off walls, door jambs and anything else that's in his way."	Sunday, 8:a.m.; 3 staff. Need more staff on weekends.
01/23/92	Sandra W.	Grabbed another individual and tried to bite her. Client pushed and shoved her against sofa. Fell, hitting her head, 11 sutures to close wound.	Lunchtime; 1 staff relieving for aide breaks; 1 in dining room; 1 on break; 1 at door; 1 involved in dentals and transport.
01/11/92	Adelbert G.	Multiple abrasions from cheek to chin from another individual kicking and slapping him.	Lunch time; 1 staff on break; 1 getting clients ready for lunch; 1 setting up dining room.
01/11/92	Winfield M.	Pushed by another individual into arm of chair; lacerated corner of his eye.	Evening care; staff doing charts; 1 bathing; 1 returning van after trip; 1 in quiet area.
01/09/92	Benita B.	Found coming out of bathroom with feces smeared on hands, face and feet. Eyelid and chin bleeding. Could be result of visual impairment or aggressive client.	Evening; 1 staff doing paper work; another logging clothes; 1 doing bed check in back bedroom.

INJURIES OCCURRING WHILE STAFF ARE INVOLVED WITH MEALS, BATHING, TOILETING, MEDICATION ADMINISTRATION

DATE	CLIENT	DESCRIPTION OF INJURY	WHAT STAFF WERE DOING AT TIME OF INJURY
12/02/91	Robert C.	Found with a broken leg. Probably fell and caught leg in gazebo which inhibits staff observations.	Lunch time; 1 staff on break; 1 preparing clients for lunch; 2 floating in and out of areas calling clients for bathroom.
03/23/91	Carol D.	Walked into door, lacerating nose. Sutured.	Dinner time; all staff involved in evening meal.

SAMPLE OF INCIDENTS AT EBENSBURG WHERE STAFF WERE UNAWARE OF PICA UNTIL INDIVIDUAL FOUND IN DISTRESS OR FOREIGN OBJECT FOUND IN FECES OR VOMIT

DATE	CLIENT	DESCRIPTION OF INCIDENT
02/22/93	Dale J.	Admitted to emergency room for GI bleed with possible bowel obstruction. X-ray of abdomen revealed multiple injested metallic objects.
02/04/93	Winfield M.	Trouble bending; x-ray found mass of metallic objects in right lower quadrant.
01/21/93	Dale J.	Vomit tested positive for occult blood. Sent to emergency room, x-ray revealed multiple ingested metallic foreign objects.
11/27/92	Ronnie B.	Two inch wooden peg found in her feces.
10/31/92	Brain B.	Refused to eat breakfast; was drooling and unable to swallow. Found to have a paper dixie cup in her throat.
09/01/92	Vincent P.	Vomited and staff found a cloth tag in it.
08/25/92	Vincent P.	Vomited food with yarn fibers.
08/22/92	Darlene F.	Vomited while coming down the hall from dining room and when back in living area. "Throughout this large amounts of emesis cigarette filters were seen."
07/25/92	Brain B.	Choked during lunch. Found to have a thermometer ear tip lodged in his throat.
07/09/92	Winfield M.	Vomitted clothing labels.
06/28/92	Winfield M.	Vomitted rubber bands, clothing labels and cigarette butts.
04/22/92	Margaret M.	Found coughing in bedroom. Pieces of artificial flowers pulled from her mouth.
04/13/92	Ivy W.	Unable to swallow during evening meal. Small bottle removed from her throat.
03/24/92	Winfield M.	Limping; x-ray revealed zipper and numerous screws in abdomen.

SAMPLE OF INCIDENTS AT EBENSBURG WHERE STAFF WERE UNAWARE OF PICA UNTIL INDIVIDUAL FOUND IN DISTRESS OR FOREIGN OBJECT FOUND IN FECES OR VOMIT

DATE	CLIENT	DESCRIPTION OF INCIDENT
02/14/92	Darlene F.	Again left living area and later vomited cigarette butts.
01/20/92	Darlene F.	Left living area early in the morning and found with mouth full of cigarette butts. Later vomited the butts along with blood. Direct care staff was involved with morning care and requested permission to lock doors or more staff to supervise.
11/01/91	Brain B.	Choked during supper. Emergency transport to hospital where he threw up a piece of wood that he had ingested (1 1/2-2" x 1/2").
08/20/91	Vincent V.	Vomited white plastic material; sent to hospital, fecal impaction.
08/14/91	Vincent V.	While flushing toilet, staff saw 3" x 1" white plastic material in B.M.
04/19/91	Vincent V.	Emesis of piece of attends.
11/16/90	Vincent V.	Vomited large amount of food, liquid, and foreign objects.
10/22/90	Kathleen P.	4 metal nuts and snap top from soda can found in B.M.
10/21/90	Kathleen P.	8 nuts found in B.M.
10/20/90	Kathleen P.	18 nuts and soda can tab found in B.M.
09/28/90	Kathleen P.	9 metal bolts discovered in toilet with feces.
9/19/90	Ronnie B.	Passed 2" machine screw in B.M.

HUMAN BITES SUFFERED BY MARYANN R.

DATE	BITE
7/7/92	Attacked by client in the dayroom who bit her on the back and shoved her to the floor.
7/29/92	Bitten on the forehead while in the dayroom; open area from bite.
8/3/92	Sat down next to "known biter" in dayroom. Bitten on finger; bleeding.
8/7/92	Bitten on the shoulder while reading a magazine at the picnic table. Pink circular area on shoulder approximately 3" x 2" with teeth marks imprinted into broken skin.
8/9/92	Client ran up to her and bit her on the back while she was outside in the "play area." Skin broken; bleeding.
8/18/92	Bitten on shoulder by client who was upset that she took her toy.
8/27/92	Bitten on arm, elbow, and back. Skin broken; ecchymosis.
1/2/93	Attacked by client who bit her on her back; skin broken.
2/14/93	Bitten several times by client. Multiple areas on shoulders reddened with teeth prints; skin broken.
2/20/93	Aggressively bitten by client. Bite mark on wrist; skin broken.
2/25/93	Bitten on wrist; starting to ecchymosis.
4/13/93	Bitten on arm; large bite wound, approximately 2 1/2" in diameter; open area.
4/27/93	Found with a bite wound partially open, 2 1/2" in diameter on lower mid back.

HUMAN BITES SUFFERED BY MICHAEL B.

DATE	INJURY
7/24/91	Struck on head and bitten on arm by client.
8/12/91	Bitten on ring finger in quiet day room; skin broken.
8/16/91	Bitten again on ring finger.
10/17/91	Bitten on arms; 2 overlapping bite marks, approximately 1 1/2" in diameter.
12/24/91	Bitten on thumb; open areas.
12/28/91	Threw himself down on client who bit him on the shoulder; open areas.
2/2/92	Bitten on forearm while in day room.
8/17/92	Individual sitting next to him bit him on arm; areas of teeth marks approximately 1 1/2" diameter; skin broken.
8/20/92	Bitten on the left bicep while medications were being administered.
10/8/92	Bitten on forearm during medication administration; skin broken.
10/21/92	Bitten on finger while in day room; imprints of teeth on flexor and extensor aspect of finger. X-ray negative for fracture.
11/6/92	Bitten on finger; bleeding.
11/18/92	Pushed by client, fell on another individual who bit him in the abdomen.

EXAMPLES OF DEFICIENCIES FOUND BY THE COMMONWEALTH OF PENNSYLVANIA DURING MEALTIMES AT EBENSBURG (1983 - 1992)

DATE/TYPE OF SURVEY	DEFICIENCY
12/83 MA, p.7	Residents were observed overstuffing food in their mouths without intervention from staff.
7/84 MA, p.5	Dramatic weight losses are not addressed by a review of current diet and observation of client eating activity.
7/84 MA, p.8	Staff interaction to assist residents in self help dining procedures was not observed.
7/84 MA, p.9	Not all residents are provided with systematic training to develop eating skills, e.g., use of forks, knives, napkins, and ability to eat slowly with minimum spillage.
12/84 MA, p.7	Proper feeding techniques were not used by the staff as residents were observed overstuffing their mouths.
12/86 MA, p.4	There were insufficient direct care staff to adequately supervise and train clients during lunchtime and breakfast time.
10/87 MA, p.2	Lack of feeding for clients requiring them, i.e. a)Clients were observed eating with spoons only. b) More food was observed on client's bib than he ate. d) Lack of staff intervention to acknowledge client ate properly and utilized proper utensils, etc.
10/88 MA, p.1	Lack of feeding programs for clients requiring them, i.e. (a) Clients were observed eating with spoons only; (d) Lack of staff intervention to acknowledge client ate properly and utilized proper utensils, etc.
1/89 MA, p.3	Many clients were observed eating with spoons.
10/89 MA, p.6-7	Laurel 8:05 A.M. to 8:59 A.M.--Client #1607 who is profoundly retarded and is documented as being underweight. Client's tray was prepared and placed in front of her and staff intermittently monitored as they completed other dining room tasks. Client was observed to shovel food onto her bib, into her hair, and spillage of food within her tray. At 8:59 client was told she was done now and tray was pushed aside. Client had not completed all food within her tray.

EXAMPLES OF DEFICIENCIES FOUND BY THE COMMONWEALTH OF PENNSYLVANIA DURING MEALTIMES AT EBENSBURG (1983 - 1992)

DATE/TYPE OF SURVEY	DEFICIENCY
10/89 MA, p.7	Sunset--Client #383 who is blind was observed during the evening meal with his mouth down onto his tray scooping his food. Client alternated between the use of his utensil and his hands. As a result client's head, face, and hands were covered with food. Staff who were close to this individual offered no assistance/intervention.
10/89 MA, p.19	Client #458 had written plan to pierce food with a fork 5 sessions in a review period, program data is collected Sat. and Sun.. During evening meal on 10/18 client who had direct staff interaction/assistance completed entire meal using a spoon.
10/89 MA, p.20	When observing lunch in the dining room in Keystone client #948 did not have program to locate spoon implemented. When interviewed, staff person who was assisting client was not knowledgeable of program and information was not available on record that lists programs to be carried out in the dining room.
10/89 MA, p.21	While observing client #165 in dining room, a communication program was scheduled to be implemented. Staff who was assisting in delivering the clients tray was not aware of program although was listed on record available in dining room.
10/89 MA, p.21	While observing client #919 at breakfast, staff person was implementing behavior program which he designed. He fed client very fast with no verbal interaction occurring and the client was not allowed to feed himself at all. Probably methodology was not followed as written.
10/89 MA, p.23	Clients were observed eating with spoons. Forks and knives were observed on some trays but clients were not encouraged to use these utensils.
10/90 MA, p.8	Client #1175 has a mealtime goal to put her glass on her tray with gestural prompts when she's finished eating. On 10/16/90 at the noon meal in JFK the direct care staff removed the glass from the table before the client was finished eating.
10/91 MA, p.2-3	During breakfast observations in Harmony's dining room on Oct. 22, 1991 client #964 was seen to lap up his breakfast while staff in the area made no attempt to re-direct him.

EXAMPLES OF DEFICIENCIES FOUND BY THE COMMONWEALTH OF PENNSYLVANIA DURING MEALTIMES AT EBENSBURG (1983 - 1992)

DATE/TYPE OF SURVEY	DEFICIENCY
10/91 MA, p.3 - 4	On October 22, 1991 at 5:45 P.M. during the evening meal in JFK there were 10 individuals in wheelchairs lined up against the dining room wall waiting to eat. These individuals were not engaged in any activity other than watching others eat their meal. There were 2 individuals wandering about the tables who were ignored by the staff. Another individual was seated alone at a table but not eating. This person appeared to be distressed by something which was not attended to by staff.
10/91 MA, p.8	When observing meals in the dining room at Sunset, Harmony and Old Main, staff did not encourage client to use their knives or napkins.
11/92 MA, p.3-4	During lunch at Harmony on 11/05/92, a client at one point was seen to lap up his lunch while staff in the area made no attempt to redirect him until the unit manager was made aware by the surveyor.

50 Months of Injuries at Ebensburg

(January 1989 to February 1993)

Name	# of Injuries	Name	# of Injuries	Name	# of Injuries	Name	# of Injuries	Name	# of Injuries
JAMES S.	215	TERRY S.	54	JOHN B.	42	RONALD A.	34	STEPHEN G.	29
WINFIELD M.	150	JAMES B.	53	MARY ANN R.	42	BETTY H.	34	THOMAS H.	29
WAYNE P.	141	DAVID G.	53	JAMES P.	42	ROBERT H.	34	GEORGE K.	29
ALBERT K.	139	VINCE P.	53	TOM E.	40	RAYMOND K.	34	JAMES R.	29
SANDRA W.	126	CHARLES S.	53	MICHAEL L.	40	JEFFREY K.	34	ELLIOT G.	28
JOYCE K.	122	JOYCE S.	53	KENNETH B.	39	MARK L.	34	SHARON M.	28
DONALD P.	106	DAVID F.	52	GREGORY G.	39	ROSEMARY W.	34	ROBERT W.	27
JOHN B.	80	DEAN F.	52	JUDY L.	39	THOMAS C.	33	JEFF B.	27
MICHAEL U.	79	GARY D.	52	ROBERT C.	38	DOUG M.	33	BRAD C.	27
MICHAEL B.	78	PETER P.	52	MARK K.	38	EDWARD Q.	33	JANICE D.	27
EDWARD T.	77	JOHN G.	51	MICHAEL R.	38	BRIAN B.	32	EILEEN G.	27
RAYMOND H.	74	PAUL M.	51	ANN B.	37	IBRAHIM D.	32	MARK G.	27
SCOTT R.	72	DEB S.	51	JOSEPH B.	37	LORNA K.	32	JOSEPH K.	27
CURTIS P.	71	DARLENE M.	50	MELANIE H.	37	CLIFFORD P.	32	KENNETH L.	27
DAVID W.	69	MIKE M.	50	MICHAEL T.	37	GLENN A.	31	CHARLES R.	27
RICHARD P.	68	ED S.	50	STEPHAN W.	37	FRANKLIN B.	31	FRANK U.	27
DONALD R.	68	BARB C.	49	JOSEPH C.	36	JOSEPH C.	31	JOSEPH B.	26
THOMAS H.	67	ALAN G.	49	JAMES E.	36	RENA MAE E.	31	MARY JACQUELINE B.	26
ALBERT B.	66	FRANCIS R.	48	WILLIAM P.	36	THOMAS H.	31	MINERVA P.	26
CAROL D.	66	ANDREW L.	47	DENISE V.	36	BARBARA K.	31	LINDA S.	26
GARY K.	64	THOMAS W.	47	GEORGE W.	36	NAT W.	31	GRIFFITH S.	26
JOHN C.	58	ADELBERT G.	46	JEFFREY C.	35	JOSEPHINE G.	30	JONATHAN B.	25
DARREN W.	58	GREGORY A.	45	STEPHEN D.	35	JOE P.	30	DENNIS B.	25
JAMES W.	57	CHRIS D.	45	DAVID H.	35	PAMELA R.	30	DAVID G.	25
ROBERT D.	56	IRVIN B.	44	KEN M.	35	D. BROCK E.	29	MARIAN M.	25
TOM T.	56	LEON G.	44	TERRY S.	35	MICHAEL F.	29	MARY T.	25
								MARTIN Z.	25

ANDREW H.

DATE	INJURY	EBENSBURG'S RESPONSE
07/12/91	Pushed into wall by another client. Six sutures; wound became infected.	Peer under scrutiny for behavior via program and other precautions. Evidence suggests Andrew provoked problem.
10/1/91	Pushed to concrete by another client. Abrasion on forehead; gash type wound on bridge of nose.	No occurrence report.
04/22/92	Found with bleeding head while in learning center. Six sutures; wound site developed staff infection.	Sutures intact; laceration should resolve. Treated by M.D. Staff will continue to report any injury at once. No change in ATP.
05/07/92	Head butted by client; bleeding from both nares on nose.	Injury should resolve. Agitated entire a.m.
06/19/92	Pushed by client. Hit nose on table; lacerated nose.	Laceration clean and dry. Should heal. No change in ATP.
08/29/92	Attacked by client and bitten on shoulder; two open wounds.	Should resolve with no further problem. Tetanus current. No change in ATP.
09/08/92	Found with swollen and bruised nose. Probably from altercation with client earlier in day.	Injury should resolve. Andrew's needs are frequently being evaluated.
10/02/92	Pushed into wall by another client; lacerated forehead; sutured.	Medical attention satisfactory; laceration clean and dry; should heal with no problem. No need to change ATP.
02/04/93	Pushed to the ground by client; abrasion on forehead.	Abrasion clean and dry. ATP meets Andrew's needs - no need to change.
04/16/93	Shoved by client; struck head on bed frame. Laceration on scalp sutured.	Laceration clean and dry. No need to change ATP.

ANDREW H.

INJURIES CAUSED AND SUFFERED FROM AGGRESSIVE ACTS

DATE	INJURY
07/12/91	Pushed by peer. 6 sutures; wound became infected.
10/01/91	Pushed to concrete by peer. Abrasion on forehead; gash type wound on bridge of nose.
04/22/92	Found with bleeding head while in learning center. 6 sutures; staff infection.
05/07/92	Head butted by peer; epistaxis of both nares on nose.
06/19/92	Pushed by peer; hit nose on table; lacerated nose.
07/17/92	Bit peer on thigh and calf while sitting next to him.
07/18/92	Bit peer on arm while sitting next him.
07/19/92	Bit peer on arm during medication time.
08/29/92	Human bite on shoulder.
09/02/92	Bit peer on hand.
09/02/92	Bit another peer on arm.
09/08/92	Found with swollen & bruised nose. Probably from altercation with peer earlier in day.
10/02/92	Pushed; lacerated forehead; sutured.
11/09/92	Bit peer on the wrist.
02/04/93	Pushed by peer; abrasion on forehead, nose & mouth.
04/16/93	Shoved by peer; struck head on bed frame. Laceration on scalp required sutures.
04/21/93	Bit a peer on the hand while waiting for the bus.

DEFICIENCIES FOUND BY THE COMMONWEALTH OF PENNSYLVANIA IN DATA COLLECTION

DATE OF SURVEY	DEFICIENCY
12/84 MA, p. 7	Goal plans were not stated in measurable/behavioral terms.
1/86 MA, p. 3	Training and habilitation records are not functional as evidenced by: a) data- collection is inconsistent; b) data collected does not correlate to stated goal plan objectives.
12/86 MA, p. 8	Current means of data-collection are not clear, specific nor do they support written plan.
10/89 MA, p. 13	Data sheets were not available in program areas so that when behaviors occurred documentation could not be accomplished.
10/90 MA, p. 6	Behavior data did not include what level of intervention had been utilized for four (4) of the five (5) clients reviewed in Sunset House. When interviewed the psychologist and other building staff could not determine what intervention had been utilized nor what progress was being made.
10/91 MA, p. 5	Tracking of individuals' target behaviors is not specific as to what target behaviors occurred, the frequency of the behavior and the severity.
10/91 IOC, p. 2a	Day program/Residential Objective- Data collection is incomplete, uninformative and at times, absent.
8/92 IOC, p. 2a	Data collection continues with frequent instances of absence of documentation or accurate documentation.
8/92 IOC, p. 2a	The documentation requirements for the Behavior Modification process continues to need improvement.

BEHAVIORS NOT ADDRESSED IN BEHAVIOR PLANS

NAME	ISSUE
Michael B.	No behavior plan for Pica (eating attends, toilet paper and tooth paste) and choking people despite the fact that they are identified in his annual review.
Irvin B.	No behavior plan for his "pesty and teasing behavior" identified as the cause of his sustaining frequent injuries, including attempted choking, punches, and bites.
George F.	No behavior plan for biting despite long history of serious biting episodes and 1991 Sneed memo asking Bellomo to provide him with a behavior program due to concern that "client will continue to bite (attack) other relatively defenseless individuals." 16 months later baseline data started but still no program.
Eileen G.	No behavior plan for long history of pushing clients off of furniture; pulling clients out of wheelchairs pulling hair, hitting, stripping, hitting her lip and biting her hand.
Andrew H.	No behavior plan for numerous biting incidents or tearing bed clothes. Prescribed anafranil for this. Chief of Psychology was supposed to evaluate and come up with recommendations during 7/92 -- no recommendations as of 11/92. Chief of Psychology was supposed to attend mini-staffing in 8/92 to problem solve. Did not attend meeting. Haldol increased instead.
Dale J.	No behavior plan for pica. Has swallowed multiple objects including parts of zippers, screws, key and other metallic objects, pieces of rug and paper. Hospitalized several times for coffee ground bright red emesis, GI bleed. Only reference to pica in his record is 10/30/92 -- team met and decided he didn't have pica; concluded items must have entered him through "contaminated food item or accidental ingestion."
Ruth J.	No behavior plan for kicking people and objects (suspected to be cause of fractured foot) and striking mouth on iron railing (resulting in need to extract tooth from traumatic injury). "Is known for this type of behavior."
Mark K.	No behavior plan for SIB despite repeated episodes of slapping, pounding and scratching his face to the point of causing ecchymosis, swelling, and abrasions. Has begun biting himself.

BEHAVIORS NOT ADDRESSED IN BEHAVIOR PLANS

NAME	ISSUE
Estelle M.	No behavior plan for inserting objects into her vaginal/rectal area. Repeated instances of this behavior, with such objects as chair leg, pencil, hair brush and spoon.
George M.	No behavior plan for biting or any other behavior. Inflicted serious bites during 1992; cited in 8/92 IOC survey for no behavior plan to address behaviors.
Vincent P.	No behavior plan for pica. Foreign objects have been found in his vomit.
Bonnie R.	No behavior plan for biting despite significant biting behavior.
James W.	No behavior plan for tearing off fingernails and toenails; sexual advances.
Sandy W.	No behavior plan for SIB (pulling out toe nail, biting self) or aggressive act of grabbing hair of peers and pulling head backwards although psychologist notes that she "often will do this."

BEHAVIOR PLANS NOT REVISED DESPITE CONTINUED INJURIES TO SELF OR OTHERS

NAME	ISSUE
Greg A.	1988 behavior plan not revised despite numerous incidents of pushing other individuals leading to injuries and notes on occurrence reports that behavior plan should be revised.
Ronnie B.	1990 behavior plan not revised despite 1992 staff recommendation for new program to "adequately deal with her pica." Has frequent pica episodes which average 22% of intervals; 1991 x-ray revealed multiple foreign objects in colon, has been found eating room decorations; 2" wooden peg discovered in stool; has contracted worms.
John C.	1988 behavior plan for aggression not revised despite causing numerous serious injuries and significant increase in aggression. 1988 goal to be aggressive 16% or fewer intervals increased to 41% of intervals during January 1993.
Gary K.	1988 behavior plan not revised despite frequent biting episodes, including biting peer on scrotum requiring sutures, and note on occurrence reports that program needs to be reviewed and/or revised. Psychologist did not attend 1992 annual review.
Doug M.	1988 behavior plan not revised despite the fact that "he is not functioning well in programs and in general areas of daily living." "He appears to be miserable most of his waking hours."
Clifford P.	No behavior plan to address sexual advances until 12/04/92 despite the fact that he was specifically singled out in 1990 MA survey and Ebensburg was threatened with decertification because of his sexual advances.

EXAMPLES OF INJURIES AT EBENSBURG OCCURRING DURING HANDLING, LIFTING, OR TRANSFERRING OF INDIVIDUALS

DATE	CLIENT	INJURY
4/26/93	Beth S.	Found with fractured femur during a.m. care. Sent to emergency room. "May have occurred simply while she was being lifted from chair to bed or while she was being changed."
4/2/93	Paul G.	Hit head on side of bathtub while staff were transferring him into tub. Laceration on occipital area. "Injury not preventable."
5/2/93	Michael B.	Abrasion on top of toe from scraping it on tub while being moved to dressing table.
4/9/93	Thomas C.	Bruise on foot thought to be from striking it on door frame or other object while being transported in his wheelchair. "Staff reminded about the need to properly position and re-position wheelchair-bound individuals, as well as to ensure that they are correctly positioned prior to being moved." Staff had just been in-serviced on this following incident on 3/17/93.
3/17/93	Harold B.	Found with swollen and bruised foot. "Most likely cause seems to be related to handling and transporting." Need to in-service staff on special care needed in handling non-ambulatory individuals. Need to in-service supervisors to ensure they monitor for transport and positioning and correct staff when problems are noted.
12/22/92	David V.	Bruises on foot attributed to protruding feet scraping a door frame or some other object. Wheelchair "inadequate; his position is both unacceptable and uncomfortable." Back is twisted almost 90 degrees to the chair back; feet hang over chair, PT assigned to David is backed up with requests. It will be a "long time before anything can be done."
3/1/93	Ronald A.	Fracture of 5th metatarsal. Client indicated it occurred while staff were transferring him to the mat.

EXAMPLES OF INJURIES AT EBENSBURG OCCURRING DURING HANDLING, LIFTING, OR TRANSFERRING OF INDIVIDUALS

DATE	CLIENT	INJURY
1/31/93	Joseph R.	Found with fractured clavicle.
8/15/91	Michael A.	Staff person transferred him alone from wheelchair to bed. Threw his head back, hitting his ear, which required sutures.
10/31/92	Michael U.	Staff person transferred him alone from floor to bed, threw his head back, and hit it on the wall. Lacerated forehead.
1/17/93	Michael U.	Rolled off changing table, abrading left side of chest. Only one staff person changing him.
8/4/91	Harvey B.	Found with numerous bruises and scratches on body. Staff indicate he is lifted by arm and leg and placed in wheelchair. M.D. concluded injuries caused on at least two occasions and represented "grasp" type marks, "probably due to incorrect lifting procedure." All staff "indicated a deep concern for lifting training." Lifting procedure needs to be reviewed.
6/29/92	George S.	Found with sprained foot. "Staff should exercise caution transferring or moving him."
11/12/92	George S.	Found with fracture of humeral head with 4" x 3" bruise on inner arm. M.D. does not feel it was due to direct trauma. Unit Manager decided staff needed to be retrained on lifting/transferring.
10/3/90	George S.	Found with fracture of left femur. Sent to emergency room. Probable cause and time was during positioning training at physical therapy.
8/7/92	William B.	Abrasion on left foot from hitting footrest while staff were transferring him from changing table to wheelchair.
7/16/92	Duane P.	While being transferred to bath tub, arm slipped between tub and lift. "Normal handling accident."

EXAMPLES OF INJURIES AT EBENSBURG OCCURRING DURING HANDLING, LIFTING, OR TRANSFERRING OF INDIVIDUALS

DATE	CLIENT	INJURY
5/27/91	Harold M.	Tibia fractured during transfer when staff person lifted him from his wheelchair while velcro strap was still attached to his foot. Staff heard a distinctive cracking noise. Wheelchair fell over.
5/3/91	Robert N.	Staff fractured his femur above right knee while holding his legs apart to put on diaper. Sent to emergency room.
9/17/90	Andrea S.	Left leg snapped while being repositioned.
2/15/90	Carol D.	Fractured right foot caught on soda machine while being transported in wheelchair.
1990	Beth S.	Spiral fracture when her leg was bumped in transport while going through doorway.
9/14/92	Louis L.	Abrasion on calf area thought to have occurred while being transferred from wheelchair.
3/9/92	Kathleen M.	4" ecchymotic area on back thought to be from lifting.
1/10/92	Edward T.	Fell backwards onto metal door hinges after losing balance while being assisted by staff in wheelchair transfer. Abrasion on back and coccyx.
6/19/92	Linda S.	Large black and blue marks found on buttocks and leg. Thought to be because she "roughly throws self while transferring." Needs to be assisted during transfers to prevent injuries.
9/18/92	Linda S.	6-7" scratch on thigh. May have scratched herself during wheelchair transfer.
4/27/92	Mary Lou F.	Hematoma from fall to floor as staff were attempting to move wheelchair closer to her to put her in it. New program; inexperienced staff.
3/4/92	Barb C.	Forehead bleeding from fall while staff were assisting her in transfer from couch to wheelchair.

EXAMPLES OF INJURIES AT EBENSBURG OCCURRING DURING HANDLING, LIFTING, OR TRANSFERRING OF INDIVIDUALS

DATE	CLIENT	INJURY
8/9/92	Ivy W.	Slid on wet tub and fell forward onto table, lacerating nose, as staff tried to turn her in bathtub to get her on dressing table.
9/17/92	Griffith S.	Slipped and scraped right side while staff were assisting him into bathtub.
3/23/93	Melanie H.	Fell to floor from drying table while staff was getting attends. Staff need to keep extra attends on cart; "must maintain both physical and visual contact with individual through all stages of bathing."
1/18/92	Charles S.	Fell to floor from couch where he was placed after being taken out of wheelchair. Lacerated chin. Staff counseled to position him "in such a way to be sure he will not fall out of chair."
1/16/91	Michael F.	Left unattended while being changed. Staff needed to get washcloth. When staff returned, found Michael with a 2" laceration in the scrotum. Sent to emergency room for suturing.
9/7/92	Edward T.	Lacerated head from fall from chair after bathing while reaching for clothes. Staff away getting towels. Staff counselled on using arm with chairs after showering unsteady individuals.

EXAMPLES OF DEFICIENCIES
FOUND BY THE COMMONWEALTH OF PENNSYLVANIA
INVOLVING LACK OF ACTIVE TREATMENT

DATE/TYPE OF SURVEY	DEFICIENCY
12/83 MA p.2	Evidence that living unit personnel train residents in ADL (development of self help and social skills) was not available.
1987 IOC 00591683	Horizon House (west end): At most there is about 2 hours of active treatment confirmed by documentation and the IOC team did not feel any of the recipients on the west end are receiving active treatment...Second year in a row this has been noted.
1988 IOC, p. 00591694-5	Records contain many supplemental procedures which are staff actions and these are not indicative of training or habilitation potential.
1988 IOC 00591700-1	As recognized by the Facility Director and confirmed by IOC on-site visits, day programs need improvement in quality and consistency and care must be taken to insure the programs are individualized for recipient needs.
1/89 MA p.1	Each client is not receiving a continuous active treatment program.
1/89 MA p.2	There are eighty-four clients in Laurel and sixty-seven clients in Sunset who receive speech therapy, but there were no visible communication boards available.
1/89 MA p.2	In Sunset, 22 clients are incontinent and in Laurel, 61 clients are incontinent. However, none of these clients have a written bowel/bladder training program.
8/89 10C p.5a	The JFK Learning Center continues to need more structured programming. The building is overcrowded and many recipients are sitting with nothing to do.
10/89 MA p.14	For 37 of our 37 records reviewed personal skill training for clients was limited to developed supplemental procedures and did not allow for individualized training to occur based on established client needs.
10/89 MA p.15	Each client is not receiving a continuous active treatment program consisting of needed interventions.
10/89 MA p.15	Client #951 Prof. MR JFK Bldg.: Sensorimotor Block 1330 to 1415 only structured activity was a 3 min objective, otherwise, client sat and/or walked around the room.

EXAMPLES OF DEFICIENCIES
FOUND BY THE COMMONWEALTH OF PENNSYLVANIA
INVOLVING LACK OF ACTIVE TREATMENT

DATE/TYPE OF SURVEY	DEFICIENCY
10/89 MA p.16	Client #1682 Prof. MR JFK Bldg.: Sensorimotor Block 1330 to 1415 only structured activity was a 3 minute objective. Remaining time was spent walking around, swaying forward/backward, and at times had hand in her pants.
10/89 MA p.16	Client # 1326 Prof. MR JFK Bldg.: Communication Block 10:45 to 11:45. Staff person attempted to implement his communication objective-client refused and was not given alternate activity nor did staff attempt to implement the objective again. Client sat at table occasionally slapping his head.
10/89 MA 16-7	Client #212 Keystone Prog.: Attending Skills 10:15 - 11:15. Objective was for client to hold an object for 20 seconds. - from 10:15-10 :42 client was sleeping. Interaction at 10:50 consisted of staff asking "What are you doing here: You aren't going to sleep NO NO NO" At 10:52 objective was implemented using a water rattle for less than 1 minute. At 10:55 RUM interacted for 2 minutes. Staff were observed talking among themselves.
10/89 MA p.17	Client #408 10:15-11:15 Keystone: At 10:17 client objective was implemented for 1 1/2 minutes. Additional time was spent chewing her fingers and sleeping.
10/89 MA p.17	Client #1607 1320-1405 JFK OT Program: Client program implemented for 15 mins. total time for the remainder of time prior to and after program client sat at a table with 4 other clients and 1 staff. Activities placed in front of the client included puzzles and musical instrument - staff intermittently attended to the client. Client activities were not individualized, structured, and/or planned based on staff interviews.
10/89 MA 17-8	O.T. Program Area 1320-1405: Total of 20 profoundly retarded clients with varying staffing levels (up to 7 staff) with activity material in the area - 1 client not in the sample sat with her back to all other clients and faced toward stairs for 5 minutes. Staff walked around the areas randomly approaching clients with various materials. Staff often skipped over clients for long periods of time, again no activities were individualized, structured, or planned.

EXAMPLES OF DEFICIENCIES
FOUND BY THE COMMONWEALTH OF PENNSYLVANIA
INVOLVING LACK OF ACTIVE TREATMENT

DATE/TYPE OF SURVEY	DEFICIENCY
10/89 MA 17-8	10:15 to 10:30 AM JFK: Fourteen clients and four staff in room. Client 1393 has goal to put bottles in box. Staff sitting with her and staff and client sitting across from her with same goal. Staff talking among themselves doing goal for hand-over-hand without interacting.
8/90 IOC p.2 (a)	The recipient is not making progress for an extended length of time on an established goal/objective and the team has not re-evaluated the plan.
10/90 MA p.7	Staff interviews, assessments and observations indicate that clients who display certain strengths or capabilities are not encouraged to develop these strengths either programmatically or on an informal basis. Supplemental procedures are initiated which discourage client independence and promote dependence upon staff.
10/90 MA p.8	Each client is not receiving a continuous active treatment program consisting of needed interventions.
10/91 MA p.3	Each client is not receiving a continuous active treatment program consisting of needed interventions.
10/91 MA p.3	Upon entering Harmony program area in Old Main at 12:43 p.m. on October 23, 1991 a female staff person was observed sitting in a client's wheelchair with her feet propped up on a box. Three other staff person's were standing around this individual, and all were engaged in conversation while ten clients were unattended. These clients did not or could not self initiate activities and had not been provided with any materials' activities.
10/91 IOC p. 2a	Day Program/Residential Objectives-Goal plans are often unrealistic, unachieveable or unrevised when progress is lacking.
10/91 IOC p.2a	Day Program/Residential Objective-Goal plans are discontinued with no replacement.
10/91 IOC p.5	The presence of active treatment is marginally evident in many records and for twenty-nine (29) recipients, it is unacceptable.

EXAMPLES OF DEFICIENCIES
FOUND BY THE COMMONWEALTH OF PENNSYLVANIA
INVOLVING LACK OF ACTIVE TREATMENT

DATE/TYPE OF SURVEY	DEFICIENCY
8/92 IOC pps. 2-2a	A significant number of recipients' goals are determined to be inadequate to meet identified needs for the following reasons: 1) Developmental areas of self-help and community living skills are not adequately addressed.
8/92 IOC p.5	2) Q.M.R.P reviews are not consistently documenting changes, progress and overall status of the I.H.P
8/92 IOC p.5	The presence of Active Treatment continues to be only marginally evident in the individual documentation for many recipients with a significant increase in those recipients identified as not receiving Active Treatment.
8/92 IOC p.7	The Habilitation Program does not maximize individual potential for one hundred and seventy (170) recipients.
8/92 IOC p.8i	The facility staff Corrective Action Plans for areas needing improvement have not been successful. Major Active Treatment areas continue unimproved.
11/92 MA pps. 2-3	Client #12 had sensori-motor and sensory integration deficits, specifically; self stimulatory behavior, withdrawal from physical interaction and poor response to training interventions. Support staff concur these needs were evident, however, these needs were neither identified nor addressed.
11/92 MA p.4	Each client is not receiving a continuous active treatment program consisting of needed interventions.

EXAMPLES OF DEFICIENCIES FOUND BY THE COMMONWEALTH OF PENNSYLVANIA INVOLVING BEHAVIOR PROGRAMS

DATE/TYPE OF SURVEY	DEFICIENCY
12/83 MA, p.5	Written plans for behavior modification programs are not followed as evidenced by documentation in the records.
12/83 MA, p.10	Many residents with severe maladaptive behaviors are not provided with behavior modification programs.
12/83 MA, p.10	Current behavior modification programs are not periodically reviewed and up-dated. Available behavior modification plans are not detailed and specific.
12/84 MA, p.5	Behavior modification plans were employed without securing informed written consent from the resident's parents or legal guardian.
12/84 MA, p.10	Progress notes by the psychologist do not truly reflect the times the behavioral plan was employed. Psychologist's program plans (behavioral/modification) are not detailed nor specific as evidenced by; a) steps of program often are not clear; d) method of the plan is not always specific; e) data-collection is inconsistent.
1986 IOC, p.00591621	Behavioral programs are not always consistently implemented probably because target behaviors are poorly defined.
1986 IOC, p.00591623	Horizon House: Behavioral Plans are on the records but enforcement and evaluation of progress is questionable.
1986 IOC, p.00591625	Sunset House: Staff were not familiar with positive reinforcement programs even though they had signed in-service training sheets.
1986 IOC, p.00591602	Behavioral programs (positive reinforcement) do not always specify the target behaviors and documentation does not always validate reinforcements are given as the program directs.
1986 IOC, P. 00591607-8	A comprehensive and progressive program of behavioral management has yet to be effectively implemented.
1/86 MA, p.5	Documentation that intervention took place once identified target behavior occurred was unavailable.

PLAINTIFF'S EXHIBIT

DEFICIENCIES FOUND BY THE COMMONWEALTH OF PENNSYLVANIA INVOLVING BEHAVIOR PROGRAMS

DATE/TYPE OF SURVEY	DEFICIENCY
1/86 MA, p.5	Many residents with severe maladaptive behaviors are not provided with behavior modification programs.
1/86 MA, p.5	Targeted behaviors are not clearly identified. (SIB)
12/86 MA, p.8	Many clients with maladaptive behaviors are not provided with behavior modification programs.
12/86 MA, p.8	Documentation that intervention took place once identified target behaviors occurred was unavailable.
10/87 MA, p.6	Clients exhibiting maladaptive behaviors such as biting their fingers, placing fingers in their mouth, scratching self, hair pulling or sucking their thumbs are not addressed in a written program to decrease these behaviors.
1987 IOC, p.00591684	Sunset House: Behavior plans are "canned" plans and there are frequently 2-4 target behaviors listed. The behavior plans are not always individualized.
10/88 MA, p.1 (00591734)	Clients exhibiting maladaptive behaviors such as biting their fingers, placing fingers in their mouth, scratching self, hair pulling or sucking their thumbs are not addressed in a written program to decrease these behaviors.
1/89 MA, p.1	Many clients were engaged in self-stimulatory behavior, i.e. finger flicking, finger and thumb sucking, scratching self, or hair pulling.
8/89 10C, p. 2a	Behavioral management plans are not individually designed to address a target behavior but list multiple maladaptive behaviors described as "aggression." These plans appear to be prepackaged and frequently the program does not result in desired behavior outcomes.
8/89 10C, p. 4	Plans of care are incomplete on a number of records primarily due to untimely/outdated target dates on behavioral objectives and lack of a behavior plan identifying a specific target behavior.
8/89 10C, p. 5a	Many recipients with self-stimulation and self-injurious behavior do not have a behavioral management plan.

DEFICIENCIES FOUND BY THE COMMONWEALTH OF PENNSYLVANIA INVOLVING BEHAVIOR PROGRAMS

DATE/TYPE OF SURVEY	DEFICIENCY
8/89 10C, p. 5b	The facility appears to have a generalized approach to behavioral management rather than a systematical, aggressive approach.
8/89 10C, p. 6a	When a specific behavioral objective is formulated to address therapeutic/leisure skill development or to increase social interaction, the notes do not adequately define the level of participation, the recipient's response to the activity, or the recipient's personal preference.
10/89 MA, p.7	JFK Program Area: Client #1326 hit staff person in the Communication Area-Behavior Program was not implemented. When interviewed staff in the area did not know the intervention.
10/89 MA, p.12	Throughout the facility a minimum of 50 clients were observed exhibiting serious maladaptive behaviors (PICA, SIB, Aggression, and Property Destruction) without intervention.
10/90 MA, p.6	Throughout the facility targeted inappropriate behaviors are lumped together under one definition, for example, aggression or self-injurious behavior, regardless of the severity of the individual target behaviors.
10/90 MA, p.8-9	Client #0161's behavior management plan for hand-mouthing which was addressed during the 4/11/90 IPP and determined to be a programmatic need was not completely inserviced until 10/12/90. Staff interviews and collected data indicate staff are still unsure of the parameters of the program.
08/90 IOC, p.4	A considerable number of incomplete plans of care still remain primarily due to the behavioral objective segment of the IHP, incomplete diet orders, some behavioral modification plans that are not producing expected results and have not been altered or revised.

DEFICIENCIES FOUND BY THE COMMONWEALTH OF PENNSYLVANIA INVOLVING BEHAVIOR PROGRAMS

DATE/TYPE OF SURVEY	DEFICIENCY
10/91 MA, p.2	From approximately 12:45 P.M. until 1:16 P.M. on October 23, 1991 client #0895 was observed sleeping on a couch in the rear of Old Main, Harmony's program area. Afternoon programming was scheduled to start at 1:00 P.M.. At 1:16 two staff persons attempted to get the client up from what appeared to be a sound sleep. After several attempts to get the client up, he became upset and had to be restrained in a wheelchair according to plan. While in his restraint, one of the staff persons who assisted in implementing the plan gave him a drink. She held his hands down and fed him the liquid, after which she stated, 'I thought it might help to calm him down.' This was not a part of the behavior management program.
10/91 MA, p.6	During program observations in Harmony on October 21, 1991 from 11:07 A.M. to 11:12 A.M. a staff person was observed implementing a hands-down procedure on client #1659. When questioned, staff stated it was part of the client's behavior program for self-abuse. It was determined by record review that this client has no behavior program and no self-abuse was observed prior to the procedure being implemented.
10/91 IOC, p.2-2a	This area continues as a 'Needs Improvement' area for many of the same reasons identified in the 1990 survey. A significant number of recipients' records lack sufficient active goal plans including behavior management to meet identified needs and/or to substantiate the presence of active treatment.

DEFICIENCIES FOUND BY THE COMMONWEALTH OF PENNSYLVANIA INVOLVING BEHAVIOR PROGRAMS

DATE/TYPE OF SURVEY	DEFICIENCY
10/91 IOC, p. 2a-b	BEHAVIOR MANAGEMENT PLANS: A significant number of recipients' plans are unacceptable due to: 1. One (1) training plan method for multi-targeted behaviors. 2. Lack of progress-lack of revision. 3. Lack of follow through when emergency restrictive procedures are implemented. 4. Supplemental procedures where active plans are needed. 7. Documentation for recipients with psychiatric diagnoses lacks adequate description of symptoms to support the diagnosis. Additionally, justification for the administration of psychotropic medication is inconsistent. Behavior plans are still required for these individuals.
8/92 IOC, p.2b	Many plans continue to reflect little to no progress, lack of revision and documentation of and the number of reinforcements and interventions. The restrictive procedure process for a significant number of Plans is not acceptable for the following reasons...the targeting of the decrease for the use of a restrictive procedure as opposed to the targeting of an increase in the desired behavior.
8/92 IOC, p.8a	James B. : Activity plans do not incorporate the Behavior Modification Plan to be implemented in the program areas. This indicates lack of continuity in approach and implementation to extinguish maladaptive behaviors.
8/92 IOC, p.8d	George M. : Another recipient's record identifies this as the individual who bit another recipient several times. Mr Mash is identified as a Hepatitis B. carrier. The report by the psychologist does not identify biting as a problem behavior.
8/92 IOC, p.8f	Rosemary w. : Recipient has no formal goal for behaviors, yet helmet is worn for behavior.
8/92 IOC, p.8g	Eric S. : The present Behavior Modification Plan appears ineffective in decreasing his behaviors. Please revise.

DEFICIENCIES FOUND BY THE COMMONWEALTH OF PENNSYLVANIA INVOLVING BEHAVIOR PROGRAMS

DATE/TYPE OF SURVEY	DEFICIENCY
8/92 IOC, p.8g	Robert W.: There is documented evidence of staff witnessing S.I.B., but no documentation of the implementation of emergency behavior modification procedures.
11/92 MA, p.3	The Individual Program plan (IPP) of individual #51 had not been effective in a reviewed time period of July to November 1992. The individual displayed nine incidents of maladaptive social behavior with peers, in this time frame. The IPP did not have a specific objective for this behavior. Interventions by the team, including counseling and following facility policy, did not have significant impact to reduce the behavior.
11/92 MA, p.3	Nutritional assessment dated 8/19/92 stated that client #29 had pica behavior. Also, the IPP dated 9/29/92 indicated that the individual at times would ingest strings and paper. Staff interview confirmed this behavior. There was no plan in place to address this behavior.
11/92 MA, p.7	Client #24 receives Lithium for Manic Depression. No behavior management program to address the maladaptive behaviors was available.
11/92 MA, p.7	Client #4 has been receiving Lithium and Serentil to address hitting, kicking and using objects as weapons since admission on 11/14/91. No behavior management program was available until 11/2/92.

EXAMPLES OF DEFICIENCIES FOUND BY THE COMMONWEALTH OF PENNSYLVANIA INVOLVING LACK OF MEANINGFUL ACTIVITIES AND LACK OF ADEQUATE STAFF INTERACTION IN LIVING UNITS

DATE/TYPE OF SURVEY	DEFICIENCY
1986 IOC, p.00591621	Upon return to units from day programming, behaviors are noted to escalate. There are no provisions for structured activities or materials available for recipients to keep busy. Most wards are barren.
1986 IOC, p.00591625	Sunset House: Wards are barren, no toys, minimal furniture.
1986 IOC, p.00591626	Laurel House: Wards are barren and some of the recipients appeared unstimulated, lying on floors or in chairs (east end).
10/87 MA, p.1	Clients were observed sitting and lying on the floor.
1987 IOC, p.00591686	Laurel House: Wards are barren and some of the recipients appeared unstimulated, lying on the floor or in chairs (the east end)
1988 IOC, p.00591704	The living areas could use more stimulation devices.
1/89 MA, p.1	Clients must have materials available during leisure time. A few clients were observed with magazines, but there was no evidence of table top games, balls or any other type of equipment.
10/89 MA, p. 5	7:30 AM to 7:55 AM Keystone W I: Four staff are in bedroom bathing, dressing, and transferring clients to wheelchair. Ten to 17 clients were observed alone in the dayroom exhibiting self stimulating and self injurious behaviors.
10/89 MA, p. 5	5:20 PM to 5:50 PM Sunset West II: Twelve to 13 clients were observed alone in the dayroom as clients were leaving for and/or returning from the evening meal; 1 staff is in and out of the bathroom doing ADL's and the other staff remains at the door. Clients were observed on the floor, ripping magazines, thumbsucking, and hands in their pants with no staff intervention.

EXAMPLES OF DEFICIENCIES FOUND BY THE COMMONWEALTH OF PENNSYLVANIA INVOLVING LACK OF MEANINGFUL ACTIVITIES AND LACK OF ADEQUATE STAFF INTERACTION IN LIVING UNITS

DATE/TYPE OF SURVEY	DEFICIENCY
10/89 MA, p. 20	While observing in Keystone West, clients #165 and 1742 and thirteen others were dressed and bathed and transported into dayroom area. During this period while others are being dressed and bathed the clients did not have interaction or were activities provided. Therefore clients were involved in self stimulating and/or self injurious behaviors.
10/90 IOC, p. 00004035	The JFK program area, West I & West 2 for Keystone House in the Learning Center, was quiet upon walk through. Recipients were on the mats but staff was sitting at a table and there was no interaction taking place.
10/91 MA, p.4	In Keystone House on 10/21/91 observations at 1:00 P.M., 2:10 P.M., and 3:00 P.M. on East I and East II, clients were lying on mats or in carts with very little staff interaction.
10/91 MA, p.4	During several afternoon observations from 3:00 P.M. to 5:20 P.M. on living areas in Laurel there was limited productive activity noted. This was especially noted after returning from day programs when individuals were toileted and had little to do until medication time and the period of time following medications to the start of the evening meal. For example: On 10/21/91 the individuals observed on West 1 were engaged in the following: 12 individuals were not involved in any activity other than self-stimulatory behavior, sleeping or lying on the floor; 4 individuals were engaged in a non-specific table activity; and 2 were working on a formboard. On 10/22/91 during rotating observations of all areas in Laurel and specific counts in all areas indicated that on average 6 individuals were engaged in productive activity while the remaining were displaying inappropriate behaviors of engaging in self-stimulatory behaviors.

EXAMPLES OF DEFICIENCIES FOUND BY THE COMMONWEALTH OF PENNSYLVANIA INVOLVING LACK OF MEANINGFUL ACTIVITIES AND LACK OF ADEQUATE STAFF INTERACTION IN LIVING UNITS

DATE/TYPE OF SURVEY	DEFICIENCY
10/91 MA, p.5	In Villa-West II on 10/21/91 observations between 3:30 P.M. and 4:00 P.M. clients were not engaged in any purposeful activity. There were 2 boxes of leisure time activity materials on the table. Clients were told they could not have the materials until after the nurse gave medications. Medications are given between 4:15 P.M. and 4:30 P.M.. There were three clients standing around the table attempting to self-initiate activities.
10/91 MA, p.3 (00004081)	Leisure time activities should be available to the clients when on the living area.
8/92 IOC, p. 8a	The Inspection of Care Team is recommending a decrease in the number of recipients who are housed in the Keystone area. This building's habilitation area is one of congestion and overcrowding as seen by the members of the IOC Team not being able to get around the beds. The program area in Keystone is also congested with mats on which recipients are lying touching each other and little space around the table area for the recipients and staff to carry out their program requirements.
11/92 MA, p.4	On Sunset-West II on 11/04/92 from 3:00 until 4:15 P.M., it was noted that during this time, the only activities available to these 24 individuals were two crates of balls and four magazines. Clients were observed engaging in many maladaptive behaviors such as ripping clothes, aggressive and self stimulating behaviors. There was little or no staff interaction.
11/92 MA, p.4-5	During observations on Sunset East II on 11/04/92 from 6:55 P.M. until 7:30 P.M., the residents were observed engaging in self stimulating behaviors, sleeping, wandering, or sitting without being involved in any recreational/leisure activities as specified in their activity schedules. The only materials available were two balls. There was little or no interaction from the staff to intervene with the maladaptive behaviors or to engage in alternative activities.

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11/92 MA, p.5	On Sunset East I on 11/04/92, the evening activity for these individuals was the showing of a movie. Clients were observed sleeping, one individual standing alone in the corner and another individual was continuously circling the day room in a wheel chair while a staff member watched the movie.

HUMAN BITES SUFFERED BY EBENSBURG RESIDENTS
(5/1/93 to 8/23/93)

Date	Name	Description of Bite
5/1/93	Paul M.	Bitten on forearm while sitting quietly in dayroom. "No need to revise current living area. Routine risk."
5/12/93	Michael H.	Bitten on arm. 2" x 1 1/2" circular area of teeth marks and indentations. Skin slightly broken. Ice applied.
5/16/93	Donald P.	Found with bite on back. Area reddened and swollen. Cool compresses applied.
5/17/93	Randall L.	Bitten on hand by individual who grabbed him as he walked by.
5/21/93	Donald R.	Bitten on hand by person sitting next to him. Contusion, open areas and teeth indentations. Cool compresses applied.
5/23/93	David G.	Bitten on leg as he walked by another client. Teeth marks present.
5/24/93	Alan R.	Bitten on forearm by person sitting next to him.
5/26/93	Mary B.	Bitten on arm as she was lying on couch in dayroom. "3 teeth lines of a bite that broke the skin and left it black and blue." Cold compresses.
5/26/93	Dorothy N.	Bitten on shoulder as she was leaving to go to work. Abraised area.
5/27/93	Eric M.	Bitten on arm while sitting on sofa. Skin broken; area cleansed, medication and bandage applied.
5/30/93	James B.	Bitten on shoulder while sitting on sofa.
6/1/93	Donald P.	Found with bite on arm. Skin broken.
6/2/93	Sharon M.	Bitten on arm. Large circular bruised impression approximately 2" in diameter.
6/9/93	Elliott G.	Bitten on upper thigh and lower leg. Ecchymosis; teeth marks. Staff discovered bite when he came running out of his bedroom yelling that he had been bitten.

7/11/93	Norma Jean F.	Bitten on thumb and first finger by individual sitting next to her. Open areas. "Norma can't move away from other individuals." "Staff should closely monitor [biter] and attempt to keep her away from individuals who can't protect themselves."
7/16/93	Gary D.	Bitten on upper back by individual who became upset for no apparent reason. Cool compresses. Area may ecchymose.
7/18/93	John B.	Bitten on calf and toe when he sat near a fellow client. Skin broken on both bites. Teeth marks. Swelling. Ice applied.
7/18/93	Lorna K.	Bitten once on leg and twice on arm. Staff discovered bites when Lorna started to scream.
7/20/93	Jacqueline B.	Bitten while walking to learning center. Individual ran up to her and bit her on the back. Skin broken.
7/25/93	Jacqueline B.	Bitten on arm during altercation with peer. Large bite mark.
8/14/93	John B.	Found with bite mark on arm. "Although injury not observed, individual #1102 has bitten Mr. Black several times in the past."
8/15/93	Kathy D.	Found with possible bite wound on back of shoulder. 2" curved abrasion.
8/18/93	Mary T.	Bitten on arm when she sat down next to another individual. Teeth marks present.
8/20/93	David R.	Bitten on scapula
8/23/93	Mary T.	Bitten on arm

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6/13/93	Mary Ann R.	Bitten on leg. Two oval shaped reddened areas; swelling.
6/1/6/93	Mary Ann R.	Found with two bite marks on back. Teeth marks.
6/17/93	Loretta A.	Bitten on leg while sitting in chair. "Loretta did not provoke the incident." Skin broken in several areas; swelling.
6/17/93	Brenda M.	Bitten on finger while sitting on the couch.
6/17/93	Barbara K.	Found with bite on arm. Reddened area beginning to ecchymose.
6/18/93	Greg A.	Bitten on calf and upper arm. Open areas.
6/22/93	Deborah J.	Pushed to the floor and bitten on abdomen through her pants and attends. Deborah did not provoke the aggressor.
6/24/93	Terry M.	Bitten on hand as he tried to embrace another client.
6/25/93	Ronald A.	Found in bath area with bleeding mouth. Lip had been bitten by another client.
6/26/93	Mark G.	Bitten on finger by hepatitis carrier as Mark was pushing his wheelchair by biter. Skin broken.
6/27/93	Paul M.	Bitten on forearm by individual sitting next to him. Skin broken.
7/03/93	Roger K.	Bitten on arm by individual sitting next to him in dining room. Reddened area the size of a 50 cent piece. Teeth indentations.
7/05/93	Michael M.	Bitten on arm by individual sitting on sofa with him. Skin broken. Teeth marks.
7/06/93	Stephen D.	Found with bite mark on arm. Skin slightly broken. Teeth indentations.

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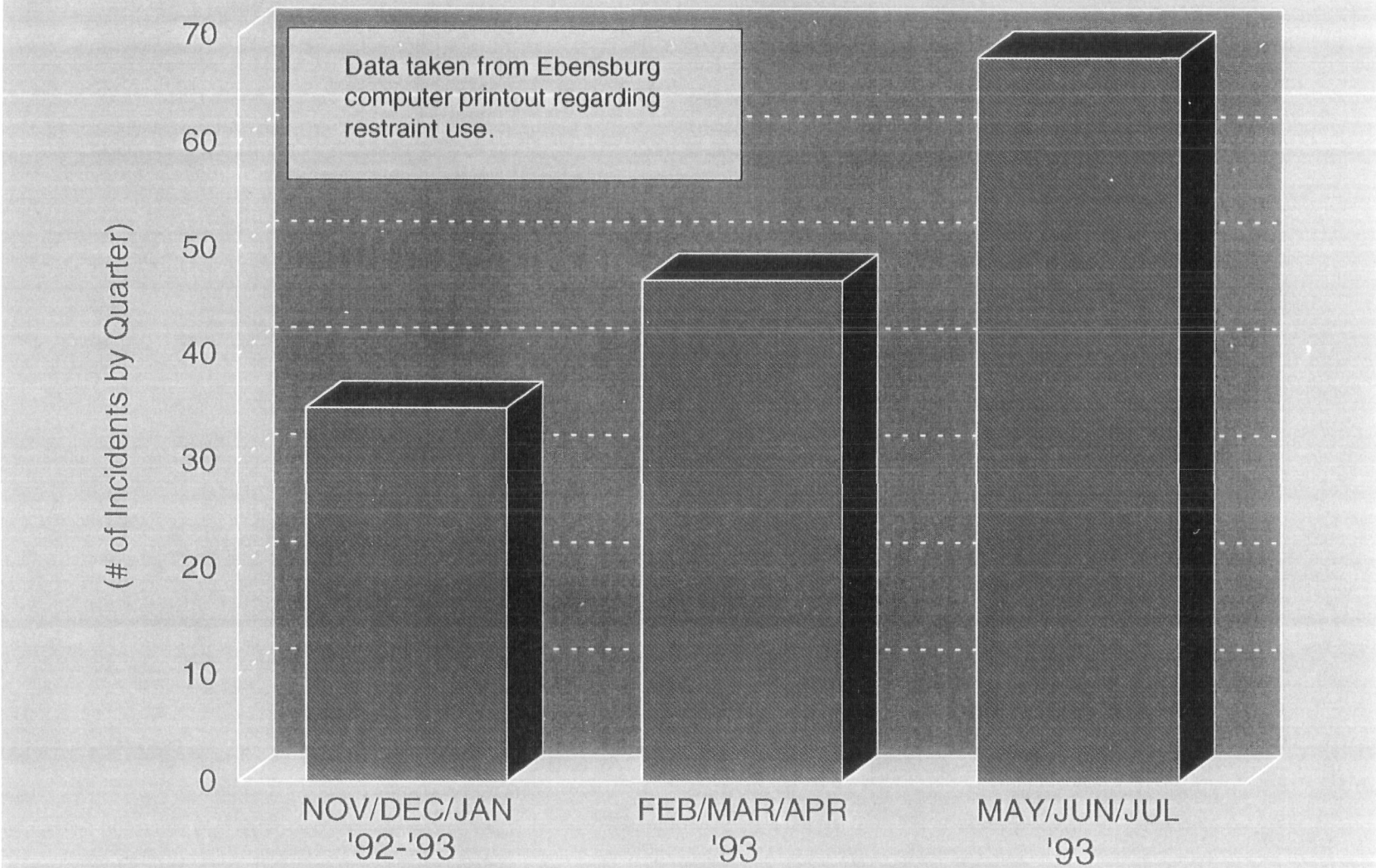
INCIDENTS OCCURRING WHILE STAFF ARE INVOLVED WITH MEALS, BATHING, TOILETING, MEDICATION ADMINISTRATION

DATE	CLIENT	DESCRIPTION OF INCIDENT	WHAT STAFF WERE DOING AT TIME OF INCIDENT
05/09/93	Greg K.	Pounded his ear and head on partition of toilet stall and gazebo. Abrasion on left side of head near hairline; screaming while holding left ear.	Weekend lunch time; 1 staff monitoring individuals in RLC; 1 in bath area; 2 in dining room; 1 "walking through gazebo and noticed Greg."
05/23/93	Jonathan M.	Was hit and pushed by another client and tripped over corner of couch while trying to get away. Laceration above eyebrow closed with ethistrips. Abrasion on lip; swollen.	Weekend dinner time; 3 staff in dining room; 1 staff in bath area; 1 in living area.
06/18/93	Denise V.	Started banging her head on the wall.	Dinner time; 3 staff assigned; 2 staff involved in holding another client who was attempting severe self-injurious behavior; 3rd staff on break. Supervisor notes that "more staff needed."
06/23/93	Donald P.	Came into the bath area and sat on the table so he could get help dressing. He had blood on his right thigh and both hands. "Because of all the confusion on the East II living area, Donald left the ward and decided to report his hand" to the nurse.	Morning care in Villa; only 2 regular staff assigned to the living area. Another staff person had been pulled from Keystone; 4th staff person (on overtime) was on break.

06/28/93	David S.	Found with bloody sock and toe nail missing.	"Staff busy with a.m. care." 3 staff in bath area; 1 staff in quiet area; 1 staff moving from dayroom to quiet area.
07/08/93	Edward S.	Came out of bedroom and showed wound on forehead to staff. One inch laceration closed with ethistrips.	Morning care. 3 staff in bedrooms dressing individuals; 1 staff in bathroom doing grooming for a.m. care; 1 supervisor on area assigning breaks.
07/31/93	Sandra S.	Was having a disagreement with 2 other individuals and was pushed into a couch. Suffered a deep laceration on her scalp and the area had to be shaved and closed with ethistrips.	Weekend morning care; one staff person on morning break; 2 staff were in the bath area; only 1 staff monitoring the dayroom.
08/11/93	Edward S.	Sitting in chair in living room and Donald R. walked by and punched Edward in the face. Cheek swollen; Dentist notified. Received antibiotics.	At time of injury, there were 4 staff and one supervisor between the dining room and living room.

United States v. Pennsylvania

Incidents of floor control since Ebensburg eliminated use of papoose board



+ Last use of the Papoose Board occured on Nov. 9, 1992. One instance of floor control in November before Nov. 9, 1992 is omitted.