IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, by his next friend and mother, Lillian Minor, *et al.*,

Plaintiffs,

v.

CHARLES SMITH, in his official capacity as the Executive Commissioner of Texas' Health and Human Services Commission, *et al.*,

Defendants.

Case No. SA-5:10-CV-1025-OG

THE UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

THE STATE OF TEXAS,

Defendant.

DECLARATION AND EXPERT DISCLOSURE OF VICKEY V. COLEMAN, PH.D.

I declare under the pains and penalties of perjury under the laws of the United States and in compliance with Fed. R. Civ. P. 26(a)(2)(B), that the foregoing is true and correct and that I am submitting this disclosure regarding my work as an expert consultant in the above case.

1. My report, which is attached, contains a complete statement of all of my opinions as well as an explanation of the basis and reasons for those opinions.

2. My report describes the facts, data and other information I considered in forming my opinions.

3. There are no exhibits prepared at this time to be used as a summary of or support for my opinions.

4. My attached curriculum vitae states my qualifications and lists all publications I have authored within the past ten years.

5. Within the last four (4) years, I have not testified as an expert except in this case in conjunction with Plaintiffs' Motion for Preliminary Injunction.

6. I have been retained by the Plaintiffs and the United States as a joint expert in the *Steward v. Smith* litigation. My compensation in this litigation is $150.00 per hour for my review, preparation of reports and statements, and for deposition or testimony, plus expenses. My compensation is not dependent on the outcome of this litigation.

Signed and dated:

Vickey V. Coleman

Vickey V. Coleman, Ph.D.

3/23/18

CERTIFICATE OF SERVICE

I certify that on this 30th day of March, 2018, a true and correct copy of the foregoing Plaintiffs' and the United States' Declaration and Expert Disclosure of Vickey V. Coleman, Ph.D. was delivered via electronic mail and Federal Express to the attorneys for defendants at the addresses below:

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REPORT OF
VICKEY V. COLEMAN, Ph.D.

I. PURPOSE/SCOPE

This report sets forth the findings of my review of a sample of individuals with intellectual and/or developmental disabilities (IDD) who reside in nursing facilities in Texas. The purpose of this review was: (1) to examine the effectiveness of the Pre-admission Screening and Resident Review (PASRR) process and the provision of specialized services and active treatment; (2) to evaluate the adequacy of the service and transition planning process; (3) to assess whether the individual would be appropriate for and would benefit from living in a community setting; and (4) to assess whether the individual was provided adequate information, supports and opportunities concerning community living and then made an informed choice to remain in the nursing facility.

II. EXPERIENCE

I have more than 25 years of experience in the disability field, particularly working with individuals who have dual diagnoses of IDD coupled with mental illness. I am currently the State Director of the Office of Civil Rights and Customer-Focused Services for the Tennessee Department of Intellectual and Developmental Disabilities.

I have more than 10 years of experience conducting quality assurance reviews and protection from harm reviews for individuals with IDD in nursing facilities and other types of facilities. I have a diverse array of experience working with the IDD population. My experience specific to nursing facilities includes conducting quality assurance reviews of supports and services to persons, in or at risk of admission to, nursing facilities which focused on examining the individual's care; activities and community experiences; health status and services, including therapeutic services and equipment; functional status; and adverse events. Quality assurance reviews also provide an assessment of nursing facility issues such as resident supervision concerns, as well as protection from harm or safety risks. As part of the quality assurance reviews, I scheduled onsite visits to the facilities; met with nursing facility management; toured the facility; conducted interviews with the individual and relevant nursing facility staff persons; reviewed nursing facility records; conducted observations of the individual's activities; and interviewed families/legal decision-makers during or after onsite reviews. Following the reviews, I completed documentation for each person reviewed.

I also have experience overseeing a federal court-mandated Needs Assessment Process to match services with the actual needs of individuals with IDD in nursing facilities. I have facilitated the transition of individuals with IDD out of intermediate care facilities and nursing facilities. In this role, I managed the team that reviewed individuals in facilities. I developed informational materials for individuals, families, and legal decision-makers that described the differences between services in ICFs and the array of services in community-based settings, including testimonials of individuals and families who had transitioned to the community as well as list of community providers and type of services provided by each. I led meetings with families and providers; reviewed all transition profiles completed by the transition team; and ensured the transition checklist was completed for each individual. I also monitored the quality of supports for individuals with IDD who transitioned out of nursing facilities by conducting Post Placement Monitoring through the first 60 to 90 days of the transition.

I have served as the senior associate to the federal court monitor in *United States v. Tennessee*, a class action case involving the Arlington Developmental Center. In this capacity, I conducted compliance reviews of hundreds of individuals with IDD residing in nursing facilities. In addition, I have conducted many reviews of individuals with IDD residing in state-operated and private Intermediate Care Facilities as well as of individuals residing in community-based settings.

I also served as a Protection from Harm consultant for the United States Department of Justice for people with IDD and mental health challenges residing in nursing facilities and psychiatric facilities.

I co-authored the Tennessee Department of Intellectual and Developmental Disabilities Human Rights Committee Concept Paper in August 2016 and co-developed the Formal Human Rights Review Policy.

My curriculum vitae is attached as Attachment A.

III. MATERIALS REVIEWED

It is my understanding that Disability Rights Texas (DRT) and counsel for the United States requested two (2) years of records from each nursing facility and Local Intellectual and Developmental Disability Authority (LIDDA) for the sample of individuals with IDD in nursing facilities that I reviewed. I also understand that DRT made a supplemental request for records through September 1, 2017. I advised the attorneys as to the types of records that I would need to review, which are detailed in the letters to the nursing facilities and LIDDAs included in Attachment B, to my report. Documents that were timely received in response to the records requests were uploaded into a HIPAA-compliant database.

I read the nursing facility and LIDDA case management records that were provided to me, as well as additional nursing facility records that I reviewed during my on-site visits for each individual.

I also reviewed background documents regarding Texas policies and regulations related to PASRR, IDD services and supports, and the Community Living Options Information Process for Nursing Facility residents. A complete list of all the documents I reviewed is attached as Attachment B.

IV. METHODOLOGY

It is my understanding that a research expert drew a random sample that was pulled from all individuals age 22 and older with IDD in nursing facilities in Texas, which was then limited to certain geographic areas. I further understand that DRT and counsel for the United States contacted all individuals in the sample to obtain their consent to participate in the review, as well as to authorize release of their nursing facility and LIDDA records so that I could review these records in advance of my on-site visit.

I conducted this review in conjunction with three other experts, Barbara Pilarcik, R.N., Natalie Russo, R.N., and Dr. Lauren Charlot, Ph.D. who reviewed other individuals in the sample. I was asked to review twelve (12) individuals in twelve (12) different nursing facilities in the Dallas and Houston areas. However, due to the safety risks and travel challenges related to Hurricane Harvey, I was unable to review seven (7) individuals in the Houston area. In addition, one individual who had initially agreed to participate in the review withdrew his authorization on the day of my visit at the urging of nursing facility staff, and then nursing facility staff refused to let me meet with that individual. Therefore, I conducted onsite reviews of four (4) of the twelve (12) individuals. The individual reviews primarily focused on evaluating the following key areas: comprehensive functional assessments, specialized services, active treatment, service and transition planning, benefit of community living and informed choice. To better assess these

areas in a consistent manner, Ms. Pilarcik provided training to all expert reviewers. In conjunction with the other three client review experts, I reviewed, discussed, and endorsed a series of probes as a guide for collecting and analyzing information. I also used these probes in reporting my findings from the client review.

For purposes of this review, I reviewed two years of LIDDA and nursing facility records for each individual, where available and produced by the facility. I also reviewed additional records during my onsite visit to the nursing facility. My onsite reviews were conducted August 30, 2017 and August 31, 2017. I used a person-centered approach to best inform my reviews. In addition to reviewing nursing facility and LIDDA records, I met with and interviewed each individual assigned to me, family members or guardian, where available and appropriate, the LIDDA service coordinator, and key nursing facility staff who knew the person best where available. I spent approximately three hours conducting each interview. I met with each of the four (4) individuals assigned to me, but one was unable to communicate verbally. Nevertheless, I met with others who knew that individual, and I reviewed all the available documentation. Sadly, after completion of my review, I learned that one of the individuals passed away.

After I conducted the onsite reviews, I completed a summary of my observations and findings concerning each individual's services and supports, which are set forth in Section VII of this report. When available, I also reviewed additional nursing facility and LIDDA records that were requested after the date of the visit in order to have the up-to-date record as of September 1, 2017. The methodology described here is consistent with the methodology I have used in other reviews of individuals with IDD in which I have participated.

V. STANDARDS

A. PASRR and Active Treatment

Specialized services are those habilitative services for individuals with IDD which, in addition to standard nursing services, constitute a program of active treatment under federal standards. Texas' PASRR program divides specialized services into two categories, based upon funding source and delivery mechanism. Nursing facility specialized services, like therapies and equipment, are provided by the nursing facility and funded in significant part with federal Medicaid funds. LIDDA specialized services are provided by the LIDDA, usually outside of the nursing facility, and funded almost entirely with state dollars. The latter are particularly important to promote the goals of habilitation and facilitate a program of active treatment.

Active treatment is the accepted federal standard for supporting individuals with IDD. Active treatment is required by CMS in institutional settings that serve individuals with IDD, including nursing facilities. It is set forth in CMS regulations (42 CFR § 483.440), and measured by a series of tags, probes, and criteria that are mandated by CMS. Active treatment is the continuous, aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services directed toward the individual functioning with as much self-determination and independence as possible. It is also directed toward the prevention or deceleration of regression or loss of current optimal functional status. Active treatment consists

of interventions and services in sufficient number and frequency to support the achievement of objectives identified in the person's ISP. Active treatment must occur across settings in every applicable aspect of the individual's daily life and must be provided by staff trained in working with individuals with IDD

In determining the adequacy of the comprehensive functional assessments, PASRR specialized services, active treatment, transition and service planning, benefits of community living, and informed choice for each of the four individuals that I reviewed, I relied upon several standards. First and foremost, I used the federal and Texas PASRR rules, policies, and guidance issued by the federal Centers for Medicare and Medicaid Services (CMS) and Texas Department of Aging and Disability Services (DADS), now, HHSC, for PASRR Level I screenings and PASRR Level II Evaluations. PASRR Level I screenings are completed for all individuals referred for admission to nursing facilities to determine if the individual may have an intellectual disability (ID) prior to age of 18 and/or a developmental disability (DD) prior to the age of 22. With some limited exceptions, a PASRR Level I should identify a suspected intellectual or developmental disability and trigger completion of a PASRR Evaluation. A PASRR Evaluation confirms whether the individual has ID or DD, and if so, should assess among other things whether the needs of the individual can be met in the community and identify the specialized services the person needs if s/he is admitted to a nursing facility. According to federal regulations, the determination of the need for specialized services must be based upon an assessment of the individual's needs in each of 15 habilitation areas.

In addition, to determine exactly which specialized services are needed, as well as to determine the amount, duration, and scope of specialized services – like any other habilitative service or support – there must be a CFA or similar assessment. A CFA is the accepted, professional approach to determining service needs for individuals with IDD. The CFA should include, among other things, assessments of the individual's needs related to medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, inclusion, and involvement and integrated day activity needs. A CFA is different from typical nursing facility rehabilitative therapy assessments that are not specific to individuals with IDD, are generally not conducted by individuals trained in IDD, and are directed primarily toward rehabilitative goals rather than at preventing regression or loss of current optimal functional status. The CFA, in combination with the PASRR Evaluation, should identify all habilitative as well as rehabilitative services needed by the individual to deliver a program of active treatment. A PASRR Evaluation by itself, however, is not a CFA. A CFA also facilitates effective communication and coordination of services and supports across disciplines and settings. Each assessment in a CFA must be completed in a timely manner and conterminously with the other assessments of the CFA.

The Individual Service Plan (ISP) is a professionally-accepted approach to planning, delivering, and monitoring habilitative services based on a CFA. A minimally adequate ISP contains individualized, measurable goals and objectives, specific services and interventions to achieve those goals, a description of the frequency, intensity, and duration of those services and interventions, the providers responsible for delivering each habilitative service, and a projected

timetable for achieving each goal. A person-centered ISP serves as the roadmap guiding the delivery of services and supports for individuals. A transition plan provides a clear and detailed list of community living options and supports that would meet the needs of an individual. All individuals in nursing facilities should have a transition plan in their ISP to ensure they are able to adequately consider community whenever they choose, even if they are not actively transitioning at the time. This process is led by the individual to the fullest extent possible, with support from the family and/or guardian to make sure the individual's needs and preferences are met.

B. Informed and Meaningful Choice

Informed choice applies to a person exercising self-determination to make the best decision possible with adequate information, opportunities, and experiences that enable the person to exert control in his/her life. In order for a person with IDD to make an informed choice, it is important to make reasonable efforts to identify and address any concerns or objections. Informed choice applies generally to the provision of all services, including specialized services, for individuals with IDD. Special considerations apply to individuals with IDD when they are making choices about transitions, including the need to understand an individual's ability to process information, to understand an environment that is different than their current situation, and to conceptualize something that is not currently happening.

In order to ensure that an individual with IDD has made an informed and meaningful choice to remain in a nursing facility, certain actions are essential. First, the person must be provided with detailed, individualized information, education and direct experiences about community living. This should include concrete experiences, such as an opportunity to visit community residential programs or other community support services, like day habilitation, as well as to engage in a range of community activities and experiences. Second, the individual's ISP must include individualized alternatives and transition services that offer a clear and concrete picture of life in the community. In Texas, these individualized alternatives and transition services should be set forth in Section 9, Phase II of the individual's ISP. Third, specific actions should be taken to address identified barriers, concerns or resistance due to prior experiences in the community. Fourth, special efforts should be taken to address the concerns, fears and effects of long-term institutionalization. Given the professional consensus that services to individuals with IDD can, and should, be provided in the community, if an individual chooses to remain in a nursing facility, there must be clear evidence that the person has made an informed choice to remain.

C. Benefits from Community Living

There is professional consensus that all individuals with IDD can benefit from living in integrated settings, with appropriate supports. Specifically, the American Association on Intellectual and Developmental Disabilities (AAIDD) and the Association of University Centers on Disabilities (AUCD) recognize that the benefits of living in smaller community settings are well-documented. These benefits include, but are not limited to individuals having more choices and control over their lives, developing more friendships, becoming more engaged in their communities, feeling safer, and experiencing greater life satisfaction. According to AAIDD and

AUCD, all people regardless of the significance of their disability can exercise self-determination and experience the opportunities that community life offers. In my professional experience working in Tennessee, I have worked with individuals with IDD who have significant behavioral, mental, physical, and medical challenges who successfully transitioned from segregated, institutional settings to integrated community settings. This success has been the result of individualized planning processes that included appropriate supports and services based on the individual's needs and preferences. This is evident by the closure of all four (4) of the state-operated ICF institutions in Tennessee. In my experience, individuals who transitioned overwhelmingly indicate that they like their community homes. Their families typically report the same satisfaction, noting individuals had done well and had benefitted in measurable ways. Moreover, research has shown that families have expressed greater satisfaction with community services following deinstitutionalization.

The standards described in Section V.A.-C. are the standards upon which I relied in reaching my conclusions.

VI. SUMMARY OF FINDINGS

Quantitative data findings (N = 4)

Comprehensive Functional Assessments

None of the four (4) individuals appears to have had a CFA consistent with federal requirements (42 CFR §483.440(c)(3)). A CFA was not available in either the nursing facility record or in the LIDDA service coordination records for any individual I reviewed.

Specialized Services

None of the individuals I reviewed was receiving all necessary nursing facility and LIDDA specialized services with the frequency, intensity and duration to address all need areas. Across the four individuals in my review, I found a significant unmet need for habilitative physical, occupational, and speech therapies. While all of the individuals were receiving intermittent nursing facility rehabilitative therapy services in response to acute or adverse events, **none** was receiving all needed nursing facility habilitative specialized therapy services through PASRR with the appropriate intensity, frequency and duration to address issues such as increasing limitations in mobility and ADL skills, increasing difficulties with eating, swallowing, risk of aspiration, weight loss, and behavioral needs. Failure to provide these needed services not only puts the individuals at risk for potential harm, but also impedes their ability to live an improved quality of life.

None of the four individuals I reviewed was receiving all needed LIDDA specialized services with the appropriate intensity, frequency and duration.

Active Treatment

None of the four (4) individuals was receiving a program of specialized services that meets the requirements for active treatment for persons with IDD. None receives a continuous, consistent,

aggressive program of habilitation that is designed to promote independence, increase functional skills, and/or prevent regression. Absent qualified and trained staff with knowledge of habilitation and IDD issues, achievement of active treatment is nearly impossible.

Individual Service Plan

None of the four individuals reviewed had a professionally-appropriate ISP that was a person-centered plan, developed based upon a comprehensive functional assessment and that includes all needed services and supports to successfully transition to the community. **None** of the four individuals had goals for transition in their ISP that would enable the individual to make an informed and meaningful choice about community living, or strategies needed to address any barriers to placement in the most integrated community setting. Similarly, **none** of the individuals had an ISP that was being implemented in a manner that was consistent with that individual's needs and preferences.

Benefits from Community Living

In my professional opinion, **100%** of the individuals I reviewed are appropriate for and would benefit from living in an integrated setting with appropriate community services and supports.

Informed Choice

None of the individuals or their guardians made an informed choice to remain in a segregated nursing facility.[1] None of the individuals or their guardians had an opportunity to visit community living or support providers. **None** the individuals had barriers to community addressed. **None** of the individuals had an ISP that included a specific description of transition options in Phase II, Section 9. **75**% of the individuals did not have specialized services that provided them regular opportunities to spend time in the community. **All** of the individuals expressed an interest in exploring community options, although one of the four individuals has a corporate guardian who opposes her desired transition to the community. **All** of the individuals I reviewed are interested in transitioning to the community.

[1] One of the individuals I reviewed has expressed a clear and consistent desire to transition to the community and can articulately express her reasons for wanting to leave the nursing facility. She has a guardian who is opposed to her leaving the nursing facility because the guardian does not believe there are appropriate services and supports in the community.

VII. INDIVIDUAL FINDINGS

D. Br.

D.Br. is a 40-year-old woman who can verbally make her needs and wants known. She is dependent on others in all areas of mobility and positioning. D.Br. uses a customized wheelchair as a means of mobility. According to D.Br.'s mother, D. Br. was admitted to the current nursing facility in July 2008 and has a traumatic brain injury resulting from a motor vehicle accident (MVA) at age 17. Following her accident, D. Br. resided with her father for a period of time but was later admitted to a nursing facility. After D. Br.'s father's death, she moved in with her mother for a few years until her mother was unable to meet her needs at home at which time she was re-admitted into a nursing facility. D.Br.'s mother reported that she visits her every other day as she lives near the nursing facility. According to D.Br.'s mother, in the past, she (D.Br.) often asked to the leave the nursing facility. On the day of the onsite visit, this reviewer interviewed D.Br. She told the reviewer she did not want to move into the community, but noted she did not do anything at the nursing facility. D.Br.'s mother reported concerns regarding possible abuse in a community-based living setting, but also indicated that she would be interested in visiting community homes and talking to other parents who have family members living in community-based settings. D. Br.'s mother reported that no one from LIDDA has addressed her concerns about the possibility of abuse in a community setting. The LIDDA staff this reviewer spoke to reported that D.Br. has not been given an opportunity to visit the community or to talk with other individuals who had successfully transitioned out of a nursing facility. D. Br.'s mother also reported that she has not had the opportunity to speak with other family members whose loved ones have transitioned out of nursing facilities.

According to D.Br.'s record, she has diagnoses of traumatic brain injury, depression, anxiety, mood disorder behavior problems, cognitive impairment, and GERD. She receives psychological services for cognitive behavior therapy and support therapy to focus on feelings of frustration and anger. Based on reports from D.Br.'s mother, she experienced and expressed a great deal of anger when admitted to the nursing facility. According to her records, prior to the MVA, D.Br. was actively involved in high school, with no special education, and was voted most likely to succeed. Record documentation also indicated that D.Br. becomes frustrated when she is unable to do what she could do prior to the accident.

There was no CFA available for review or any other integrated comprehensive assessments or planning documents that gave a clear picture of D.Br.'s strengths, likes, dislikes, needs, and preferences. D.Br.'s PASRR Screening (March 26, 2013) noted she was positive for mental health and developmental disabilities but not intellectual disabilities. The March 13, 2014 PASRR Evaluation (PE) recommended service coordination and alternate placement services through the Local Authority. Specialized services recommended to be provided/coordinated by the nursing facility were physical therapy and durable medical equipment in the form of a customized manual wheelchair.

In my professional opinion, D. Br. would benefit from specialized physical therapy, occupational therapy, or speech therapy through the PASSR program, but according to record documentation,

D.Br. is not receiving these specialized services, nor has she been recommended for them. Documentation indicated that she received restorative physical therapy services as well as range of motion and stretching; and occupational therapy and speech therapy on an intermittent basis. There was no evidence in the record that D. Br. is receiving alternative placement services as recommended in the PE. Because D.Br. is not receiving all needed specialized services, she is not receiving active treatment. It is unsurprising that D.Br. is not receiving active treatment because she does not have a comprehensive functional assessment or planning documents in her nursing facility or LIDDA records to guide active treatment.

It is my professional opinion that D.Br. is appropriate for and would benefit from living in an integrated community setting with the proper services and supports. As noted above, more than 3 years ago, alternate placement through the Local Authority was recommended and the PE also noted that D.Br. is capable of community living with her needs being met with a community program that will be able to provide supervision, medication management, total assistance with activities of daily living (ADLs) and wheelchair accessibility. D.Br. had been offered an HCS waiver slot in 2015, which she declined. Since then, throughout D.Br.'s records, it has been noted that the nursing facility is an appropriate placement for her and that she and mother wanted her to remain in the nursing facility and no additional efforts have been made to explore community living options with her. However, according to D.Br.'s January 2017 ISP, D.Br. and her mother verbalized interest in touring group homes; yet, there was no indication that this was actively pursued. Despite this verbalized interest and recommended services, the Transition section of the ISP (Phase II of Section 9) did not include a specific description what D.Br. would need for community placement nor identification of preferred services and supports and availability of such. The ISP was not a person-centered because it did not include all needed services and supports, including those D.Br. needs to successfully transition to the community, and it lacked habilitative goals and meaningful outcomes. While there was documentation that the Community Living Options (CLO) process was implemented, there was no indication that this process was a meaningful, educational, and individualized person-centered process for D.Br. In addition, there was no evidence in the record that D. Br.'s concerns or her mother's concerns about safety in the community had been explored or addressed in any way. As a result, it is my conclusion that D.Br. has not made an informed choice to remain in the nursing facility. Additionally, the impact of continued institutionalization for D.Br. would be increased depressive symptoms, lack of having friends in facility as well having friends outside the facility, lack of quality of life, and increased contractures.

D.B.

D.B. is a 65-year-old woman who resides in a nursing a facility outside of Dallas. D.B. makes her needs, wants, and desires known and advocates for herself. She uses a wheelchair as a means of mobility. D.B. has a court-appointed guardian. D.B. was initially admitted to the nursing facility in 2010, moved home for a brief period, but was readmitted on January 2, 2015. I previously met with D.B. in February, 2017 as part of a separate Client Review in this case. As was the case during my visit in February 2017, on the day of this visit, D.B. clearly articulated that she wanted to leave the nursing facility and move to a home near her cousin, to whom she is close. Moreover, D.B.'s April 2015 ISP/Transition Plan noted that she wants to live in the community in a group home with 24-hour staff. After the April 2015 Plan, CLO documentation also noted D.B. would like to receive services through the HCS waiver. Despite all of these expressions of wanting to pursue community living, D.B. continues to reside in the nursing facility.

D.B.'s record includes numerous diagnoses such as dementia, depression, anxiety, diabetes, malignant neoplasm of the breast, etc. Recent reports as documented in her record indicate that she has experienced a decline in health status. Observation also revealed a decline in D.B.'s overall affect from February 2017 to August 2017. Noteworthy, since my February 2017 visit, D.B. was admitted to a psychiatric facility (4/8/17 – 4/12/17) due to agitation and aggressive behavior. Nevertheless, there was no evidence that D.B. has received a behavioral assessment to determine the need for specialized behavioral services and supports.

There is no evidence of a comprehensive functional assessment that is professionally appropriate and person-centered to guide the nursing facility staff to understand D.B.'s strengths and needs. In addition, goals from the Nursing Care Plan were not integrated into the ISP. In addition, D.B.'s PASRR Evaluation [February 17, 2015] includes recommendations for service coordination and alternate placement services through PASRR as well as nursing facility specialized services of occupational therapy (OT), physical therapy (PT), and durable medical equipment (DME). Record documentation indicates that D.B. receives intermittent nursing facility rehabilitative therapy services in response to acute, adverse events, but she did not begin receiving ongoing habilitative specialized therapy services through PASRR to address increasing limitations in her mobility and ADL skills, or her increasing difficulties with eating and swallowing until the end of August, 2017, and has not received any PASRR specialized services to address her increasing behavioral needs. On the day of the review, D.B.'s guardian reported that D.B. needed a new customized manual wheelchair that fits her appropriately.

Due to the lack of ongoing habilitative services and habilitative programs or plans for staff to assist D.B. with her functional skills, she is not receiving active treatment. As previously stated the time-limited therapy services that are available to D.B. are not delivered in the amount and frequency that D.B. needs. Furthermore, D.B. has not been given the opportunity to attend a day habilitation program, although she has expressed an interest in doing so in the past. During an Interdisciplinary Care Plan meeting held on August 17, 2017, there was a discussion about PASRR Independent Living Skills, but as of the date my visit, a provider for these services had not been chosen. On the day of my review, verbal reports indicated that there is currently only

one spot on the nursing facility van for a person who uses a wheelchair as a means of mobility, which poses challenges to community involvement.

D.B.'s ISP is not a person-centered plan because it is not based on person-centered assessments and does not contain individualized, measurable goals and objectives and specific services and interventions to achieve those goals.

Although D.B. has verbalized her desire to leave the nursing facility and the record documentation indicates that a Relocation Assessment was completed in August 2015 and a HCS provider had been chosen in September 2015, she remains living in the nursing facility. On the day of my visit, D.B. informed this reviewer, in the presence of her guardian, that she wanted to leave the nursing facility and live in a home in the community near her cousin and use the taxi as a means of transportation. According to D.B., she has asked numerous times to leave the nursing facility and for at least two (2) years, D.B.'s desire to leave the nursing facility has been well-documented. However, the Transition to the Community Section of D.B.'s ISP (Section 9, Phase II) fails to fails to identify and address any barriers to community living. Moreover, D.B.'s August 2015 ICAP recommended a change in placement within two (2) years to a group residence with staff providing care, supervision, and training as well as a daytime activity center. In fact, two (2) years ago, a community provider was selected. In December 2016, it was noted that D.B. desires to get out of the nursing facility more for activities and at that time that the PASRR program manager discussed the possibility of day habilitation with D.B.'s guardian but the guardian was not interested. D.B.'s May 2017 Person-Directed Plan includes action plans such as "want to make sure I am eligible so I will have help to move out when I am ready," and "want to learn to be more independent in the community." Additionally, the June 2017 IDD Eligibility Evaluation Report noted that D.B. "would likely benefit from living in a residential setting that offers supportive services for basic and instrumental activities of daily living due to her needs for hands-on personal care assistance and counseling services to address underlying depression."

It is my professional opinion that D.B. is appropriate for and would benefit from living in an integrated community setting with appropriate services and supports, and that the impact of continued institutionalization would be harmful to her. Specifically, she is at risk of experiencing increased depressive symptoms and behaviors, loss of hope, lack of friends and social support, decreased functionality, low adherence to therapy, and decrease in overall health status. Despite the documented recommendations for community placement as well as D.B.'s repeated verbal requests to leave, her guardian and guardian's supervisor report that they have decided not to pursue alternative community placement for D.B. Based on verbal reports, her guardian is aware of the range of community options available generally. However, there was no evidence that the guardian has meaningfully explored community options on an individualized basis for D.B. in a way that takes into consideration D.B.'s individualized strengths, needs and preferences. There was also no evidence of a transition plan detailing the continuity of services and supports that would allow D.B. from the nursing facility to the community. D.B. has expressed very clearly that she wants to live in the community, but her legal representative has decided that she should remain in the nursing facility for reasons that are unclear. It is my

opinion that greater efforts should have been made to transition D.B. out of the nursing facility by this point, and that D.B. has been failed not only by her legal guardian but also by the LIDDA and the nursing facility staff that support her.

B.L.

B.L. is a 52-year-old man with intellectual and developmental disabilities (IDD) who has resided in a nursing facility for more than 15 years. B.L. does not have guardianship; however, record documentation and verbal reports indicate that he has a close relationship with his mother. B.L.'s mother has always been involved in B.L.'s care, often visiting him at the nursing facility or bringing him home for overnight visits. Based on her reports, B.L.'s mother has not visited B.L. in several months due to her own health issues, lack of transportation, and the distance of the facility (more the 65 miles) from her home. She reports that she speaks with him often by telephone. B.L. lived with his mother prior to moving to a group home after she could no longer care for him. He and his mother were reportedly satisfied with the group home, yet due to unknown reasons B.L. was discharged from the group home. Although he has significant communication challenges, B.L. clearly verbalizes that he wants to go home and his mother believes, if given the opportunity, he would prefer to be closer to her and in a smaller setting with more things to do "like he did before." In addition, the nursing facility staff reported to me that B.L.'s behavioral and psychiatric needs are not being met at the nursing facility. Based on reports from the nursing facility staff, BL's behaviors are more challenging than they can handle, but he is consistently denied admission to psychiatric facilities.

B.L.'s mother reported that prior to his admission to a nursing facility, he resided in a group home in Rowlett, TX. While B.L. has not worked in a public job, record documentation indicates that while he was living in the group home, he participated in a Rehabilitation Center in Garland, TX. He no longer participates in any job training or employment programs at the nursing facility.

Record documentation indicated B.L. was admitted to his current nursing facility from a psychiatric hospital. Record documentation revealed he has had prior psychiatric admissions over the past four (4) or five (5) years due to behavioral outbursts, but more recently he has been denied admissions to at least three (3) psychiatric facilities noting "medical acuity" or "nothing can be done." Despite the documented behavioral challenges, there was no evidence that B.L. has received a behavioral assessment to determine the need for ongoing specialized behavioral services. However, on August 17, 2017, a Crisis Services Prevention and Stabilization Plan was developed which expired on November 14, 2017. The plan includes behavior concerns as well as interventions, but does not include known triggers or coping strategies that have been successful.

Although B.L. has an ISP in place, this plan is not a part of his nursing facility record. There also was no evidence that the ISP had been updated recently because the most current version of the ISP available in the LIDDA record was dated October 9, 2014. In addition, there is no evidence of a comprehensive functional assessment to guide the nursing facility and LIDDA staff to understand B.L.'s strengths and needs. The ISP is also not a person-centered plan because it is not based on person-centered assessments and fails to incorporate individualized, measurable goals and objectives, specific services and interventions to achieve those goals. In addition, goals from the Nursing Care Plan were not integrated into the ISP. Nursing facility staff reports that local authority/PASRR representatives have not been involved in B.L.'s care

plan meetings and that he does not receive any specialized services through PASRR other than service coordination, but these services could be beneficial. The social worker at his nursing facility expressed frustration with the lack of PASRR services, stating that "there is a lot of talk but there have been no services provided." Of note, B.L.'s March 2015 PASRR Evaluation includes a recommendation for only PASRR service coordination, and nothing else.

Record documentation reveals that B.L.'s has received intermittent skilled therapeutic services such as physical therapy (PT) for therapeutic exercises/activities, neuro-reeducation, gait training to increase strength and endurance; occupational therapy (OT) self-care management training, assess safety and functional tasks; and speech therapy (ST) to address dysphagia, speech, and cognitive skills. These nursing facility therapy services are provided on a time-limited basis (i.e., 5 times a week for 4 weeks, etc.). Record documentation often noted that therapy services were discontinued for reasons such as "coverage is maxed out," "highest potential level achieved," "Medicare A being exhausted," "not in need," "no functional decline," etc. On the day of the onsite visit, physician's phone orders indicated that B.L.'s speech therapy and occupational therapy services were discontinued as of August 3, 2017 and physical therapy services were discontinued as of August 4, 2017. Despite the documented need for therapy services, B.L. is not receiving any PASRR specialized services to address PT, OT or ST needs.

B.L. does not receive ongoing habilitative specialized therapy services through PASRR to address his increasing limitations in his mobility and ADL skills, or his increasing difficulties with eating, swallowing, risk of aspiration, and weight loss, or his behavioral needs. Absent of ongoing habilitative services and habilitative programs or plans for staff to assist B.L. with his functional skills, he is not receiving any active treatment. As previously stated, the time-limited therapy services that are available to B.L. are not delivered in the amount and frequency to meet B.L.'s ongoing needs. In recent months, the PASRR service coordinator noted that B.L. is not interested in day habilitation services and habilitative services were not recommended for B.L. Despite these reports, in September 2016, the service coordinator noted that B.L. and his social worker agreed to move forward with day habilitation to provide him a different social outlet. Although it is unclear from the records if day habilitation was aggressively pursued for B.L., four months later (January 2017), the service coordinator documented that he declined day habilitation services. Based on his past participation in a day habilitation, B.L. would likely benefit from learning new skills and better coping skills, as well as improve his socialization in a community-based setting outside of the nursing facility. Yet, there is no evidence that an appropriate day habilitation setting had been considered or that any barriers to B.L. attending day habilitation in the community had been explored. Moreover, B.L.'s records lack any habilitative goals or meaningful outcomes that could be achieved from the provision of services.

In my opinion, B.L. is appropriate for and would benefit from living in an integrated community setting with appropriate services and supports. Although B.L. was offered and declined an HCS waiver slot in 2016, it does not appear that he has made an informed choice to remain in the nursing facility. B.L.'s records provide conflicting information on whether he would like to return to living in the community. On the day of my visit, however, B.L. repeatedly told me that he wants to go home. In the same manner, B.L.'s mother reported that when they speak on the

phone or in person, B.L. always says he wants to go home to live with her. B.L.'s records indicate that he has expressed satisfaction with the nursing facility and wants to continue to live there. His records also noted that B.L. and his mother are not interested in community-based living options. However, according to reports from B.L.'s mother, neither she nor B.L. have been offered an opportunity to explore community living options or to visit any programs in the community. B.L.'s mother indicated she would be interested in learning more about community living opportunities and options, particularly programs that might allow B.L. to live and enjoy community activities closer to her because she is his primary support. B.L.'s records also indicate that there is no transition plan, and no description of what an integrated community setting would look like for B.L. that would take into account his individual needs and preferences.

B.L.'s records indicate that the challenges to community living include: B.L.'s care needs are likely greater than support available in the community; limited or no family/friend support available; and guardian/family likely not to support community living. Additional barriers identified in the Community Living Options process, as reflected in his ISP, were B.L.'s behavior issues and his health issues related to obesity. Despite these documented barriers, it is my professional opinion that B.L. could live in an integrated community setting, and would benefit from doing so with the proper supports and services. Yet there was no evidence that the barriers were addressed in a meaningful way for possible individualized community exploration to occur. Further, Phase II of Section 9 of B.L.'s most recent ISP is not completed and does not include a specific description of transition options. The impacts of continued institutionalization of B.L. are a risk of continued increase in behavioral challenges due to lack of appropriate mental and behavior interventions, limited interaction with his primary support person (his mother), lack of openness to the outside world, and low quality of social interactions.

S.S. [2]

S.S. is a 63-year-old woman with a diagnosis of Down Syndrome. Although S.S. has limited verbal communication skills, she readily smiled at me when I attempted to interact with her on the day of the visit. S.S. was admitted to a nursing facility following a hospitalization in 2014. Prior to the hospitalization, she reportedly lived in a community-based living environment in South Dallas. S.S.' sister is her legal guardian and very actively involved in her care and life. S.S.' sister visits her frequently and S.S. also goes on home visits with her sister often. According to S.S.' sister, she did well and loved living in the community and at that time was walking and talking, but multiple strokes caused her to decline and end up in the nursing facility where she resides now.

In addition to Down Syndrome, SS has diagnoses of Moyamoya disease, diabetes, stroke, seizures, hyperthyroidism, and dysphagia. Nursing facility records indicate that SS is at high risk of aspiration due to her dysphagia and is on a pureed diet with thick liquids.

Although S.S.' nursing facility record contains a Comprehensive Plan of Care, on the day of the review, there was no evidence of any comprehensive functional assessments that provided a clear picture of her' strengths, weaknesses, likes, dislikes, preferences, functional skills, and specific requirements for her medical, nursing, therapeutic, and specialized services. In the absence of these detailed assessments, it is unlikely that all needed specialized services and supports are being recommended and provided to S.S. S.S.' Individual Service Plan (ISP) is not a part of her nursing facility records. Failure to integrate the ISP with the nursing facility care plan creates a risk of a lack of continuity of support and services. There are no habilitation programs and plans in the ISP for the nursing facility staff to assist S.S. with her functional skills.

Nursing facility records indicates that S.S. received intermittent physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services. There was no evidence that S.S. has been provided these services as habilitative specialized services through the PASRR program. In fact, records indicate that S.S. has not even been evaluated through the PASRR program for the specialized services she would need and could benefit from. According to a Notice of Medicare Non-Coverage letter, S.S.' PT services ended October 13, 2016, yet, a September 21, 2016 PT progress note indicated S.S. had repeated falls, difficulty walking, and muscle weakness. Similarly, a Notice of Medicare Non-Coverage letter indicated that S.S.' OT services would end on December 9, 2016. However, an OT Plan of Care dated March 2, 2017 noted services to address contracture right hand, wheelchair management, and therapeutic activity for five (5) sessions in four (4) weeks. On the day of the review, the nursing facility record indicated S.S. has not received ST services since August 2016 to address dysphasia and safe swallowing. S.S. does not appear to be receiving all needed specialized services and is therefore not receiving active treatment.

At the time of my review, S.S. was not receiving any LIDDA specialized services other than day habilitation and service coordination. S.S. began attending a day habilitation program in January

[2] After completion of my review, I learned that, sadly, S.S. passed away on September 21, 2017. I am not aware of the details surrounding her death. My report is based on information that was available at the time of my review.

2017, five (5) days a week from 7:30 a.m. – 3:30 p.m. Both S.S. and her sister seem very pleased with the day habilitation program. S.S.' sister states that the program keeps S.S. from sitting in the nursing facility with nothing to do. After the behavioral interventions and S.S.' involvement in the day program, the service coordinator noted in February 2017 that S.S.' behaviors were no longer a concern. No problematic behaviors were exhibited during my onsite visit. On the day of my visit, S.S. interacted appropriately (smiling) with the reviewer and the staff person. She communicated with her sister and self-propelled without difficulty from one area to another. Although S.S.' sister had concerns with S.S.' previous experience in a group home for safety reasons and she is pleased with the nursing facility care, she believes S.S. would enjoy living in the community. S.S.' sister indicated that she is interested in discussing and exploring community living options where she could be assured that S.S. would be safe and where S.S. could continue to attend her current day habilitation program. As S.S.' sister put it, "I want what [S.S.] wants." She further reported that while there have been discussions about community living, such information is not thoroughly explained to allow her to make an informed decision.

S.S. has an ISP but it is not a person-centered plan and is not based upon person-centered assessments. The ISP lacks individualized, measureable goals and objectives, specific services and interventions to achieve those goals, and a description of the frequency, intensity and duration of those services and interventions. Throughout the LIDDA records, the service coordinator notes that S.S. "appears happy and her needs were being met with no expressed desire to move." Despite these notations, there was no evidence that S.S. and her sister had been given sufficient information regarding the community options that might be available or appropriate for S.S. Therefore, it does not appear S.S.'s sister, her guardian, has made an informed choice for S.S. to remain in the nursing facility. Specifically, the service coordinator described the CLO discussions as obtaining signatures on forms and handing out a folder of documentation. Moreover, in 2016 when the nursing facility was considering discharge, S.S.' sister was given options for other nursing facilities but not any community based settings. According to S.S.' July 2017 ISP, the documentation of the CLO process noted S.S. will remain in the nursing facility as she does not wish to change environment and she prefers structure and routine. Despite the current July 2017 ISP, evidence in the record indicates that the last CLO documentation was December 2015. Moreover, Phase II of Section 9 of the ISP did not include a specific description of transition options for S.S. In addition, there was no documentation of discussion of barriers to community-based living nor was there documentation of how the CLO process is implemented in a way that provides individualized community opportunities to make an informed choice to remain in the nursing facility or to transition to a community-based environment. For example, S.S. and her sister have not been offered any opportunities to visit any community based residential programs that might be appropriate and that might meet the concerns S.S.'s sister's concerns related to safety.

In my professional opinion and experience, S.S. is appropriate for and would benefit from living in an integrated community setting with the appropriate services and supports. In my professional opinion, the impact of her continued institutionalization is a risk of continued mobility challenges, lack of improved communication skills, decrease in eating and swallowing

safety, increased contractures, limited development of relationships, and recurring behavior challenges.

Attachment A

VICKEY V. COLEMAN

41 CALLAWAY COVE MEDINA, TENNESSEE 38355 (731) 234-2125 vcoleman35@bellsouth.net

EXECUTIVE SUMMARY

Accomplished professional social worker with higher executive government experience; 10+years of conducting quality assurance reviews and protection from harm reviews; instrumental in successful closure of state-operated institutions; experience with Federal litigations; in-depth knowledge of deinstitutionalization and transition processes; progressive leadership experience with excellent customer service skills

PROFESSIONAL EXPERIENCE

State of Tennessee, Department of Intellectual and Developmental Disabilities **10/11- Present**

DIDD Director of the Office of Civil Rights/Title VI Director 5/1/16 - Present
Interim Director of the Office of Civil Rights (10/4/15 to 5/1/16)

- Appointed by the Commissioner to serve as the Director of the Office of Civil Rights/Title VI Director to oversee departmental compliance with all civil rights laws and policies and conduct investigations of civil rights complaints filed with the department

- As a member of the Commissioner's Senior Management Leadership Team, serve as the Commissioner's Step One Appeal Designee to handle all Human Resources responsibilities related to written warning reviews and conducting Step One Appeal Discussions, etc, in accordance with state policies and procedures

- Serve as the contract manager for departmental contracts with the Arc of TN
- Provide administrative oversight to the Human Rights Committee

- Serve as an owner of the Leadership Accreditation Work Plan Group with the Council of Quality Leadership (CQL)

- Provide technical assistance for DIDD Regional Title VI coordinators to address regional trainings, tracking of civil rights complaints, and collecting civil rights related statistical data

State Director of Customer Focused-Services (Division of Advocacy Services & Complaint Resolution)

- As a member of the Commissioner's Senior Management Leadership Team appointed to develop a newly established unit from ground zero, utilized existing staff resources for cost containment to create a state-wide team responsible for advocating for the needs of service recipients and their family members and responding to and resolving all of the department's formal complaints, resulting in a reduction of statewide complaints by more than 50% during the first year

- As state director, developed a state-wide comprehensive reporting system that tracks and trend advocacy issues and formal complaints to submit to the Commissioner and Executive Leadership Team for systemic improvements in service delivery

- Coordinate and monitor the administration of over million dollar contract for independent advocacy services in Tennessee to ensure contract remains within allotted budget

- Serve as a charter member and chairperson on the Board of Directors of the West Tennessee Housing Foundation which provides oversight of more than $3 million to expend on housing supports for individuals with intellectual and developmental disabilities. Served as Board secretary from inception in 2011 through 2015

State of Tennessee, Department of Intellectual and Developmental Disabilities **07/12- 02/14**

Transition NOW Coordinator

- Appointed by the Commissioner to assume responsibilities as the coordinator and manager of an existing team; restructured the team to create the Transition NOW Initiative responsible for the facilitation of transitions of individuals who have intellectual and developmental disabilities (IDD) out of Intermediate Care Facilities and nursing homes

- Created a quality review system for the transition process and quality improvement efforts of individuals who have IDD, which resulted in the successful transition of approximate 100 individuals out of institutional placements and nursing home to community homes

- Appointed to facilitate the Court-mandated Needs Assessment Review Process which matched services with needs of individuals with intellectual and developmental disabilities residing in nursing homes

- Successfully executed the Federal Court-issued Exit Plan that resulted in the closure of the Federal litigation between the Federal Court, the Parties, and the Department of Intellectual and Developmental Disabilities

NKR & Associates, Inc. Delmar, New York **10/01-09/11**

Senior Associate (1/05– 09/11)

Research Associate (10/01–12/04)

- Appointed as Senior Associate to the Federal Court Monitor for the Arlington Class responsible for overseeing the supports and services to approximately 500 class members, who have intellectual and developmental disabilities and who resided in Arlington Developmental Center and community homes as well as provided supervision to Court Monitor's staff
- Conducted quality assurance reviews of supports and services as well as protection from harm reviews of class members in various community and institutional settings, including group homes, nursing homes, mental health facilities, State institutions, and family care homes and prepared comprehensive reports related to residential provider agencies' performance
- Monitored the arrangements for the successful transition of approximately 200 class members from Arlington Developmental Center to community homes through the closure of the institution in October 2010

Integrated Community Living in Tennessee Corporation, Jackson, Tennessee **3/00–9/01**

Regional Director (Jackson & Chattanooga) (5/01–9/01)

Program Manager/Incident Management Coordinator/Investigator (3/00–4/01)

- As Regional Director, responsible for budget management, census retention and growth, recruited and managed 50+ professional staff, wrote policies and procedures, monitored the implementation of support plans for individuals in the program; and served as the agency's Incident Management Coordinator and Abuse Investigator, certified State trainer, and public relations director

State of Tennessee-DMRS Western Regional Office, Jackson, Tennessee **3/98–3/00**

DMRS Regional Incident Management Coordinator

- Reviewed and approved community agencies' policies on incident management; provided technical assistance and training to staff of community provider agencies; coordinated activities related to substantiated reports of abuse and neglect in community living homes; and served as a member of the West TN Regional Abuse, Neglect Prevention Committee and the Division's on-call administrator on duty (AOD)

Nat T. Winston Developmental Center, Bolivar, Tennessee **12/93–2/98**

Program Coordinator & Incident Management Coordinator (7/96–2/98)

Residential Program Specialist/QMRP (12/94–7/96)

Counselor Associate II (12/93–12/94)

- As Program Coordinator, supervised 100+ staff persons working in the institution, which served persons with developmental and mental health disabilities; served as the institutions administrator on duty; and supervised and monitored the successful placement of 100+ individuals to community placement through closure of the institution in February 1998
- As Incident Management Coordinator, assisted in the development and implementation of institution policies and procedures for addressing injuries and other adverse events
- Served as Team Leader of the Interdisciplinary Team of approximately 36 residents and developed and implemented residents' support plans and skill acquisition programs

J.B. Summers Counseling Center, Somerville, Tennessee **2/90-11/93**

Adult Day Treatment Program Coordinator

- Supervised the daily operation and administration of day treatment program serving 30 individuals

EDUCATION

Walden University, Doctor of Philosophy: Public Health **2013**

University of Memphis, Master of Science: Counseling and Personnel Services **1996**

Tennessee State University, Bachelor of Science: Sociology; Minor Psychology **1988**

CERTIFICATIONS AND SPECIAL SKILLS

Rule 31 Listed General Civil Mediator

Protection from Harm Consultant for the United States Department of Justice (nursing homes and psychiatric facilities)

Graduate of 2015 Class of LEAD TN

Graduate of 2012 Class of Tennessee Government Management Institute (TGMI)

Graduate of 2005 Class of Leadership Hardeman County (a program to promote leadership and strategic skills for nominated county residents)

Certified Abuse and Neglect Investigator/Quality Mental Retardation Professional (QMRP)/Crisis Prevention Intervention (CPI)

COMMUNITY SERVICE

Delta Sigma Theta Sorority, Inc.

Diamond Life member of the largest Pan Hellenic public service organization in the country whose programs help uplift the community and the world at large. Served as the local chapter's assistant correspondence secretary and served as the sergeant-at-arm for 2 consecutive two-year terms

Board of Directors, Hardeman County Adult Basic Education Program
Former appointed board member responsible for overseeing a program with a focus of assisting individuals with obtaining Graduate Education Diploma (GED) and responsible for hiring and supervising the programmatic and operations functions

Antioch Baptist Church
Serve on the Leadership Team to assist the Pastoral Ministry in program development and improvement efforts and served as vice-president of Women's Fellowship for two years

Attachment B

Steward v. Smith
5:10-CV-1025-OLG
In the United States District Court for the Western District of Texas
San Antonio Division

CLIENT REVIEW REPORT OF VICKEY COLEMAN, Ph.D.
Attachment B

	Document	Bates No.
1.	Texas Health and Human Services Commission, Form 1039, Community Living Options and Instructions, *available at* https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1039-community-living-options	US00253559-253568
2.	Texas Health and Human Services Commission, Form 1041, Local Authorities (LA) Individual Service Plan/Transition Plan – NF and Instructions, *available at* https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1041-individual-service-plantransition-plan-nf	US00253775-253800
3.	42 C.F.R. § 483.440, Condition of participation: Active treatment services.	US00253366-253372
4.	TEX. HEALTH AND HUMAN SERVS. COMM'N, *PASRR Webinar: Specialized Services for Nursing Facility Residents with IDD*, April 25, 2017	US00253271-253365
5.	40 T.A.C., Part 1, Ch. 17, Subch. A-E, Preadmission Screening and Resident Review (PASRR)	US00253388-253401
6.	40 T.A.C., Part 1, Ch. 19. Subch. BB: NF responsibilities related to PASRR	US00253402-253410
7.	TEX. HEALTH AND HUMAN SERVS. COMM'N, (formerly, Texas Department of Aging and Disability Services), *Explanation of IDD Services and Supports*	US00253411-253423
8.	TEX. HEALTH AND HUMAN SERVS. COMM'N (formerly, Texas Department of Aging and Disability Services), *Making Informed Choices: Community Living Options Information Process for Nursing Facility Residents*, February 2016	US-00253424-253429
9.	2016 PASRR QSR Compliance Status Interim Report	DefE-00096540
10.	Information Letter No. 15-33, Prior Authorization for Preadmission Screening and Resident Review Specialized Services, Prior Authorization for Customized Power Wheelchairs and Rehabilitative Therapy Requests from Elisa Garza, Donna Jesse, and Mary Henderson to Nursing Facility Providers and LIDDAs (May 13, 2015), *available at* https://www.dads.state.tx.us/providers/communications/2015/letters/IL2015-33.pdf	US00253430-253432

11.	Information Letter No. 15-61, Preadmission Screening and Resident Review Habilitative Specialized Services from Michelle Martin and Elissa Garza to Nursing Facility Administrators (September 23, 2015) *Removed August 25, 2017*.	US00253433-253434
12.	Information Letter No. 15-84 Pre-Admission Screening and Resident Review – Reviewing and Requesting Changes to PL1s from Elissa Garza, Asst. Comm'r, Access and Intake to Nursing Facilities (December 31, 2015) *available at* https://www.dads.state.tx.us/providers/communications/2015/letters/IL2015-84.pdf	US00253435-253437
13.	Provider Letter No. 16-33 — Top Non-Compliance Trends with the Preadmission Screening and Resident Review (PASRR) Requirements from Mary Henderson, Asst. Comm'r, Regulatory Services to Nursing Facilities (August 31, 2016) *available at* https://www.dads.state.tx.us/providers/communications/2016/letters/PL2016-33.pdf	US00253503-253505
14.	Provider Letter No. 17-15 – Failure to Deliver PASRR Services from Mary Henderson, Asst. Comm'r, Regulatory Services to Nursing Facilities, (August 17, 2017), *available at* https://www.dads.state.tx.us/providers/communications/2017/letters/PL2017-15.pdf	US00253506
15.	Provider Letter No. 17-16 – Guidelines Regarding Plans of Correction Associated with a PASRR Violation from Mary Henderson, Asst. Comm'r, Regulatory Services (May 2, 2017), *available at* https://www.dads.state.tx.us/providers/communications/2017/letters/PL2017-16.pdf	US00253507
16.	Provider Letter No. 17-17 – Civil Money Penalty (CMP) Projects are Subject to Unannounced Visits to Ensure Project Implementation from Mary Henderson, Asst. Comm'r, Regulatory Services (June 21, 2017), *available at* https://www.dads.state.tx.us/providers/communications/2017/letters/PL2017-17.pdf	US00253508-253509
17.	PASRR TECHNICAL ASSISTANCE CENTER, Service Provider Promising Practices (Feb. 2013), *available at* https://www.pasrrassist.org/sites/default/files/attachments/PASRR_Service%2520Provider%2520Promising%2520Practices.pdf	US00253482
18.	Nursing Facility records request letter	US00253268-253270

19.	LIDDA records request letter	US00253265-253267
20.	LIDDA records for DB	US00120850-121152 US00143288-143535 US00172480-172498
21.	Nursing facility records for DB	US00142964-143287 US00171491-171767
22.	LIDDA records for DBr	US00166481-166860 US00172499-172546
23.	Nursing facility records for DBr .	US00163475-163913 US00172943-173194
24.	LIDDA records for BL	US00157020-157982 US00168890-168949
25.	Nursing facility records for BL	US00143664-149733 US00162976-162977 US00173367-173420 US00174495-174508
26.	LIDDA records for SS	US00162979-163414 US00181390-181466
27.	Nursing facility records for SS	US00172183-172196 US00178943-179421
28.	Spreadsheet: NF Transition Snapshot	DefE-01958693
29.	Revocation document signed by DC	US00162978
30.	Review of Individuals in Nursing Facilities Questions & Considerations	US00258739-258741