

The Parties

Disability Rights Center, Inc. (DRC) is the federally authorized and funded non-profit organization serving as the Protection and Advocacy System (P&A) and the Client Assistance Program (CAP) for individuals with disabilities in Arkansas. DRC is authorized to protect human, civil and legal rights of all Arkansans with disabilities consistent with federal law.

Arkansas Department of Human Services (DHS) is composed of fifteen (15) divisions and offices, including the Division of Developmental Disabilities Services (DDS) and the Office of Long Term Care (OLTC).

The **Board of Developmental Disabilities Services (DDS Board)** is composed of seven (7) members appointed by the Governor of Arkansas. Both DDS and the DDS Board exercise programmatic and operational control of the six (6) state owned intermediate care facilities for the mentally retarded (ICFs/MR) known as the Human Development Centers (HDCs).

In 1981, Act 513 was passed and changed the name and official title of the agency and Board to the Division and the Board of Developmental Disabilities Services. Under this Act, the Arkansas Children's Colonies became the Human Development Centers (HDCs). There are six HDCs across the state; the first opened in 1959 at Conway, and the last opened in 1978 in Warren. The HDCs are located in Conway, Alexander, Arkadelphia, Jonesboro, Booneville, and Warren. These programs provide services to 1,278 individuals (as of 06/30/00) with developmental disabilities who are in need of 24-hour residential, medical, and habilitative services.

Act 348 of 1985 authorized the reorganization of the Department of Human Services, and under this change DDS became one of 13 divisions/offices comprising an integrated services system. This Act designated control and administration of the HDCs under the management and direction of the DDS Board with daily operation authority extended to the DDS Director, in coordination with the Director of DHS. (Source: <http://www.state.ar.us/dhs/ddds/NewWebsite/Html/DDS%20Background.html>)

Issues

Failure to provide effective communication

Through monitoring of the Booneville Human Development Center, DRC discovered seventeen (17) residents who were deaf and/or non-verbal, and for whom there was concern that they were not being provided with effective communication. The inability to communicate effectively places residents at increased risk of abuse, neglect and violation of rights, and contributes to an increase in undesirable behavior due to frustration about inability to communicate. In addition, DRC became aware from the

guardian of one resident [client name redacted] that her sister had undergone an emergency colectomy, due to HDC staff not being able to understand the seriousness of the source of the resident's pain and [client name redacted]'s inability to be able to communicate to staff. Her intestine ruptured, and a portion of it was surgically removed.

Twelve (12) of the residents became DRC clients, and advocacy efforts continued for several months to obtain independent evaluations and implementation of evaluation recommendations. Although DRC was told instruction in sign language was provided to residents, BHDC did not have a certified American Sign Language (ASL) interpreter. Further, the form of sign language taught to residents, even those already fluent in ASL, was a localized form of sign that sometimes uses actual ASL signs to mean something wholly different in the local sign vocabulary, i.e., the ASL sign for "nurse" has been substituted for the name of a building on the BHDC campus, the Nyberg Building.

In addition, very few staff who worked closely with residents using sign or communication devices knew how to sign themselves, or how to operate or troubleshoot the devices. Assistive devices were not always available to residents when they needed them. One resident's hearing aid was taken from her when she was not in her training area, leaving her with no hearing aid when she returned to her living unit or engaged in social activities. In one instance, a client's program plan directed that his communication device be withheld from him except during his speech therapy sessions, "until he is calmer and more compliant."

Further, clinical staff, including psychology and psychiatric staff, were not fluent (or even conversant) in ASL. When asked how they communicated with their clients during psychological evaluations and therapy, BHDC's Chief Psychologist responded, "We know our people."

[client name redacted] was born deaf. In addition, [client name redacted]'s parents, siblings and maternal grandfather are deaf, so ASL is his family's native language. During a recent visit with [client name redacted], DRC advocates asked him who at BHDC could understand and talk with him. He first pointed to a photograph of his father, hanging on the wall of his dorm room, and then pointed out his window in the direction of a building in which the BHDC sign interpreter works. When the DRC advocate (who is a certified sign language interpreter) asked him if there was anyone else on the BHDC campus who could talk to him, he signed to her that some other people tried, but it was "hard," making the sign for "hard" several times.

Inability to communicate effectively directly impacts client rights to participate in program planning. [client name redacted]'s 9/11/2008 Individual Program Plan (IPP) stated:

[client name redacted] is a very engaging man who, at times, can act loud and intimidating. But since he does not speak or hear, it is the only way he has of getting attention. [client name redacted] *can sign, however, because of the rapid turnover in direct care staff, he is not consistently with someone who can speak to him. . . Because his sign language instructor was absent when [client name*

redacted]’s review was held, input from him was limited. His guardian acted as his advocate. . . [client name redacted]’s guardian and the team feel that he is appropriately placed at BHDC and at Davison House. (IPP at page 4, emphasis added.¹)

Inability to communicate effectively also subjects HDC residents who are deaf and/or non-verbal to social isolation. During a recent monitoring visit to BHDC, two DRC advocates were in the dining hall during lunch. One of the DRC advocates was signing to a resident who was deaf, and the other advocate noticed that several other residents were watching the conversation intently. Afterward, two male residents approached both DRC advocates to tell them that they – although they were not deaf and could speak – had taught themselves a little ASL in order to communicate with some of their peers who signed. They provided a demonstration to the advocates of their skills, and were quite interested in learning new signs from DRC staff.

DRC addressed this issue to the BHDC superintendent in a letter dated April 27, 2009, and asked for information about providing “opportunities for socialization between self-taught residents and residents who are deaf.” (Letter, at page 2.)

BHDC’s response was quite general in nature.

There is absolutely no segregation of hearing and non-hearing clients at this facility. They attend the same training, eat their meals in the same places, live in the same settings, participate in the same recreational activities, work at the same jobs that the hearing clients work. We accomplish this socialization by not segregating any one (sic) because of their particular disability. Our clients live and play and work together. The ASL sign language classes are open to our clients, parents, guardians and family members as well as staff. (Memorandum, at page 2.)

In January 2009, DRC filed two sets of administrative complaints about the failure to provide effective communication, one with the DHS OLTC, alleging violations of federal regulations for conditions for participation in the Medicaid program. Another set of complaints were filed with the DDS Americans with Disabilities Act (ADA) Coordinator, alleging failure to provide effective communication, as well as failure to provide services in the most integrated setting appropriate to the needs of clients, pursuant to Title II of the ADA and § 504 of the Rehabilitation Act of 1973.

DHS OLTC investigated the DRC complaint, and found that since BHDC *planned* to obtain evaluations for the DRC clients and *planned* to implement whatever was recommended by the evaluator, there was no violation of 42 CFR § 483.440(a)(1), provision of active treatment. Similarly, the finding of the DDS ADA Coordinator was that since BHDC *planned* to provide effective communication, there was no violation of 28 CFR § 35.160 (ADA) or of 45 CFR § 84.52(d) (§ 504 of the Rehabilitation Act of 1973).

¹ [client name redacted]’s legal guardian is the spouse of an employee of BHDC.

Subsequent to DRC's administrative complaints, BHDC contracted with a certified ASL interpreter. The interpreter is on campus for a few hours on Wednesday afternoons, and offers an ASL class to BHDC staff. DRC has received conflicting information from BHDC administrators about whether sign classes are mandatory or voluntary for staff. Although the superintendent told DRC clinical staff were also to receive training, none of the psychology staff names appear on staff training sign-in sheets, nor do the names of some staff working in client training areas where DRC knows the clients use sign for communication. In addition, the ASL interpreter does not provide training or routine interpretation for BHDC residents.

On July 8, 2009, DRC received a follow-up evaluation for a resident of BHDC who is not a DRC client. [name redacted] is deaf, non-verbal, and fluent in ASL. Her sister and legal guardian had requested the follow-up evaluation. The guardian "expressed interest in a further evaluation because staff and especially peers don't understand [name redacted]'s sign language." (Augmentative and Alternative Communication Report, at page 1.)

One of the recommendations in the report was:

[name redacted] should be given access to a computer to allow her to communicate with her sister or other family members by e-mail. Her literacy skill and former computer skills appear to be sufficient to allow her to learn this means of communication with support from staff. This is especially important for [name redacted] since she is unable to verbally communicate by phone. (Augmentative and Alternative Communication Report, at page 5.)

However, at page 2, the *Report* notes, "The staff from BHDC reported that computers were not available for [name redacted] to use."

BHDC staff cannot understand [name redacted]'s ASL communication because she is fluent, and they are not. In addition, a communication skill set she acquired long ago (and still retains), cannot be utilized because residents at BHDC do not have access to computers.

DRC clients affected by this issue:

- [client name redacted], an adult female diagnosed with bi-polar disorder, profound mental retardation, and seizure disorder;
- [client name redacted], an adult male diagnosed with personality disorder due to cerebral dysfunction, ADHD, pica, profound mental retardation, epilepsy, and cerebral palsy;
- [client name redacted], an adult male diagnosed with psychotic disorder, NOS, profound mental retardation, and seizure disorder;
- [client name redacted], an adult male diagnosed with anxiety and personality change due to unspecified encephalopathy, moderate mental retardation, and speech impediment;
- [client name redacted], an adult male diagnosed with severe mental retardation and Down Syndrome;

- [client name redacted], an adult male diagnosed with Bipolar I (in partial remission), moderate mental retardation, deaf mutism, visual impairment (cataracts secondary to thiorazine therapy), and hypothyroidism (secondary to lithium therapy);
- [client name redacted], (brother of [client name redacted]), an adult male diagnosed with obsessive compulsive disorder, ADHD, profound mental retardation and genetically compromised immune system;
- [client name redacted], (brother of [client name redacted]), an adult male diagnosed with obsessive compulsive disorder, profound mental retardation, genetically compromised immune system, chronic bronchial asthma, and hyperlipidemia;
- [client name redacted], an adult male diagnosed with severe mental retardation (adaptively characterized as profound), epilepsy and profound bilateral sensor neural deafness;
- [client name redacted], an adult female diagnosed with psychotic disorder NOS, dysthmic disorder, profound mental retardation, scoliosis of the spine, hypothyroidism, severe profound deafness, colostomy, mild cataract left eye and otic dysgenesis;
- [client name redacted], an adult female diagnosed with mood disorder secondary to seizure disorder, severe mental retardation, generalized seizure disorder, cerebral palsy, scoliosis, ptyalism (excessive salivation), bilateral pterygium of eyes, and mild dysphasia; and
- [client name redacted], an adult male diagnosed with personality change due to encephalopathy, autistic disorder, profound mental retardation, psychogenic water drinking, hypercholesterolemia, and osteopenia.

Adequacy and accuracy of psychological and psychiatric evaluations

As noted above, DRC has concerns about the manner in which BHDC psychology staff communicate with BHDC residents who are deaf and/or non-verbal. Psychological testing documents used at BHDC are not designed for use with such a population. DRC consulted with a psychologist at the Arkansas School for the Deaf about the adequacy and accuracy of using such testing instruments, and was informed that there are more contemporary testing instruments available that would produce more accurate results.

Review of records of DRC's clients revealed that for those who are diagnosed with and treated for psychiatric disorders, the diagnosis appeared to be generated by a review of behavior incident reports and conversations with staff. DRC could find no evidence of face-to-face evaluation of clients by the BHDC contract psychiatrist. In a number of cases, the psychiatrist noted that a resident drew pictures in the room while the psychiatrist was reading behavior incident reports, but there was no acknowledgement in the notes that specific residents using drawing as a method of communication. Nor was there evidence that a sign language interpreter was present when the psychiatrist noted that one resident "used some sign language."

In an electronic mail message to the BHDC superintendent on October 15, 2008, DRC recommended independent psychological and psychiatric evaluation of all twelve (12) of its clients. To date, BHDC has failed to obtain the recommended independent

evaluations.

Although DRC's clients are at BHDC, it has been DRC's experience that the lack of effective communication is an issue across all six (6) of Arkansas HDCs. Effective communication is key for individuals being placed in the community. Therefore, this failure directly prevents individuals from receiving services in the most integrated setting.

Use of psychotropic medication

One of the issues contained in DRC's administrative complaint to OLTC was failure of BHDC to document gradual withdrawal at least annually from drugs used to control inappropriate behavior. *See* 42 CFR § 483.450(e)(4)(ii)

Several of the Individual Program Plans (IPPs) reviewed by DRC contained statements relevant to continued administration of psychotropic medications similar to the following:

The Team would like to see that [incidents of physical aggression] lowered to no more than one reports (sic) of physical aggression and no more than six reports of ignoring rules for six months in order to be referred to the psychiatrist for a medication reduction.

(Although similar wording was found in most of the DRC client IPPs, the wording cited above was from the IEP of a client who is deaf.)

OLTC's response to this area of complaint follows.

The regulation cited by the DRC had further instruction that "A gradual withdrawal occurs annually or sooner **if warranted by progress to the criteria for reduction established in the individual program plan**". (OLTC Complaint Report, exit date 2/11/09, at page 1, emphasis in original.)

The Federal Regulations at tag W312 require the facility to put in place measurable criteria that stipulates at what point in time the team would address a possible dose reduction of behavioral medications. In this case, it refers to the utilization of Zyprexa and Depakote ER. The Interdisciplinary Team (IDT) may decline a dose reduction with clinical justification in hand. This client did have a dose reduction mentioned above. In reference to the Client's inappropriate behaviors, Page 9 of the Client's 9/11/08 IPP under "7 C. PSYCHOLOGY / PSYCHOTROPIC / BEHAVIORAL GUIDELINES", the narrative documented "The team would like to see that lowered to no more than 1 reports of physical aggression and no more than 6 reports of ignoring rules in order to be referred to the psychiatrist for a medication reduction". Based on the aforementioned information the facility does not have a deficient practice in this area of concern. (OLTC Complaint Report, exit date 2/11/09, at page 9, emphasis in original.)

In addition, DRC noted concern that in one client's IPP, "[t]eam members who had to approve the prescription of medication were a nurse, a social worker, a psychological examiner, an instructor and an LST - none of whom are doctors." (DRC Complaint,

attachment for [client name redacted], at page 2.)

OLTC's response to a concern that non-physician staff dictated the prescription of medication was:

This is a true statement and also how the interdisciplinary team process works. (sic) The Consulting Psychiatrist recommends to the facility physician and additions or changes to the Client's drug regimen. The attending physician then makes the recommendations to the team who refers the recommendations to the facility's Human Rights Committee. *This committee then approves or disapproves the usage of the drug.* The IDT is then contacted regarding the recommendation and *if approved*, the physician orders the drug. (OLTC Complaint Report, exit date 2/11/09, at page 2, emphasis added.)

Further, DRC has rarely been able to find records in client files indicating that a less restrictive measure, such as a behavior modification plan with positive reinforcers, is in effect for a client taking psychotropic medications. Instead, what is found in IPPs is language similar to the following:

The primary treatment for [client name redacted]'s psychiatric condition is medication. (IPP of [client name redacted], at page 11)

The team did not recommend a Behavior Treatment Program for [client name redacted]. (IPP of [client name redacted], at page 10.²)

None of the DRC advocates monitoring any of the six (6) HDCs has ever noted behavior logs or any documentation of other similar attempts on behalf of the HDCs to determine the antecedents for undesirable behavior by HDC residents.

Such was exactly the case for DRC's client, [client name redacted]. [client name redacted] was injured at BHDC in a restraint incident on April 16, 2009, requiring a trip to the hospital emergency room to receive sutures for a cut to his head just above the left eyebrow.

In a letter to BHDC superintendent [name redacted] on May 14, 2009, QA Team Leader Dee Blakley stated:

The initial incident report stated, "Client fell in his room during a behavior and hit his head on the corner of his bed causing a 1/2 to 1 inch laceration to just above his left eyebrow."

After reviewing your internal investigation reports, it was clear that the client was injured when a male staff initiated a personal restraint and fell to the floor with [client name redacted]. . . The conclusion you drew after reviewing the investigation report was, "All staff acted appropriately according to policy."

It has been some time since I reviewed BHDC's policies on accuracy of incident reporting, de-escalation procedures, and applications of personal restraint. If your de-escalation policy does not include a prohibition on staff who are the subject of

² This client takes fluoxetine, commonly known as Prozac.

client aggression backing away from the situation and allowing other staff to intervene, then I would like to discuss revision of that policy with you. Please provide me with copies of each BHDC policy for my review.

[Name redacted]'s response to the May 14 letter was received by DRC on July 8, 2009. I have checked with all HDCs in the State of Arkansas and none have a de-escalation policy. BHDC has procedures and training on how to handle these situations. This is taught to all staff with regular Client contact. As far as I can ascertain, there is no requirement that BHDC has a de-escalation policy. (Memorandum, at page 3.)

Medication is the primary means of controlling undesirable behavior of BHDC residents, and if medication doesn't do the trick, then the clients are physically restrained. This method of managing undesirable behavior fails to comply with requirements of 42 CFR § 483.450(b)(1), which states:

The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior. These policies and procedures must be consistent with the provisions of paragraph (a) of this section.

These procedures must--

(i) Specify all facility approved interventions to manage inappropriate client behavior;

(ii) Designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive;

(iii) Insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. . .

DRC clients affected by this issue: [client names redacted]. Although DRC's clients are named above, based upon DRC's monitoring of all six (6) of the HDCs, we believe this is an issue that affects individuals institutionalized at all HDCs.

Failure to provide services in the most integrated setting appropriate to the resident's needs

At least two of the residents at BHDC and one at Alexander HDC have either said they want to be discharged to smaller community settings or have been recommended for discharge to smaller community settings by clinical staff. These residents, also clients of DRC, are [client names redacted] (both at BHDC) and [client name redacted] (Alexander HDC).

[client name redacted] approached DRC staff during a recent monitoring visit to Alexander, saying he was his own guardian and wanted to leave the HDC. DRC advocates reported that the Alexander HDC superintendent was present during that encounter, and told [client name redacted] he was not his own guardian, and further, she was not going to discuss discharge with him at that time. The advocates questioned the

superintendent privately, and found that [client name redacted] was correct. His adoptive mother, who had been his legal guardian, died. During further discussions with [client name redacted], DRC found that [client name redacted] previously had been served in community settings, and was admitted to Alexander HDC on August 23, 2006. [client name redacted] told DRC advocates that when he asks staff about getting out, the response from HDC staff is that they will place him on the Medicaid waiver waiting list if he behaves himself for six (6) months.³

[client name redacted]'s 8/19/08 IPP contains the following statements.

During her Self-Assessment, [client name redacted] expressed interest in moving to a "group home" or to the Curtis Circle Houses here at BHDC. Her mother wants continued placement at the Booneville Human Development Center rather than community placement. . .we do not feel that [client name redacted]'s personal care and domestic management skills are sufficiently developed for Curtis Circle placement. (IPP at page 4.)

Since 2003, the BHDC Chief Psychologist has recommended that [client name redacted] be considered for placement in a non-institutional environment, such as a small ICF/MR. During each of [client name redacted]'s annual program planning meetings, the recommendation is duly noted and cast aside by the IDT, who sets his projected discharge date out another three (3) years. OLTC addressed DRC's complaint for this client in its Complaint Report.

The Team's opinion is that [client name redacted] has no apparent interest in moving to another living area at BHDC or in moving to a community residential facility. Staff who work with him stated that [client name redacted] considers this to be his home. . . . Concern was also expressed about the amount of stress that leaving BHDC would cause [client name redacted], particularly given the fact that he will not even agree to visit his family in their home. [guardian name redacted] (the Guardian) stated that he prefers continued BHDC placement for [client name redacted] at this time. (OLTC Complaint Report, exit date 2/11/09, at page 4.)

In 2007, Arkansas was ordered by the United States District Court for the Eastern District of Arkansas to develop and implement a policy that would ensure that if the IPP team determined an individual could be served in the community, the Superintendent of the HDC had a duty to discharge the individual regardless of any objections by the guardian. (Order attached.)

In October 2008, DRC received a copy of a draft HDC discharge policy from DDS. On April 27, 2009, DRC requested a copy of the new finalized discharge policy and was told via electronic mail from the Director of DDS that DDS Policy 1086 remains unchanged from 2005. This failure allows DDS to continue to institutionalize individuals without thought to the adequacy of community services available, options for community placement, or the wishes of the individual.

³ [client name redacted] was diagnosed with mild mental retardation, bipolar disorder, ADHD and oppositional defiance disorder.

Failure to conduct discharge planning

Contained in DRC's complaint to OLTC was specific detail about failure to conduct discharge planning.

Equally troubling was the response from [psychologist name redacted] about how, if a resident cannot communicate, s/he can reasonably be expected to progress to a point where the resident is ready to leave BHDC for a less restrictive environment. His comment was, "***If*** they get out." DDS policy is clear that HDC "discharge planning begins at admission." (See DDS Policy 1086, HDC Admission, as well as Draft Policy 1086, currently under promulgation.) Of the twelve (12) residents discussed in the attached document, one was admitted in 1977; five were admitted in the 1980s; three were admitted in the 1990s and three were admitted in this decade. All the residents' IPPs show projected discharge dates three (3) to five (5) years from the date on the current IPP. Simply "bumping" a discharge date out three to five years from the date of the current IPP does not constitute discharge planning, required by intermediate care facilities from the date of admission pursuant to 42 CFR § 456.380(b). (Cover letter to Rodney Cunningham, OLTC, dated January 15, 2009, at page 2.)

OLTC complaint investigators creatively interpreted federal regulations in their *Complaint Report*. Unfortunately, their interpretation misses the mark.

The complainant alleged the facility failed to conduct discharge planning pursuant to plan of care requirements under "Utilization Control: Intermediate Care Facilities: CFR 456.380(b)". (sic) The preliminary regulatory statement documented in the Federal Regulations reads "(5) At the time of discharge, the facility must-"; then it specifically refers to tag W205 which documents "(ii) Provide a post-discharge plan of care that will assist the client to adjust to the new living environment". The reference the complainant alluded to at CFR 456.380(b) (sic) is located in the interpretive guidelines at tag W205. It documents "483.440(b)(5)(ii) FACILITY PRACTICES: (sic) Information in the post-discharge plan is sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement. The facility supports and assists the individual in this transfer. 483.440(B)(5)(ii) (sic) GUIDELINES: *The discharge plan required by 42 CFR 456.380 and the post-discharge plan of care are the same.* The regulations require only one discharge plan which meets the requirements". The interpretive guidelines are not regulations and are for reference use only. The "law" within the regulations is located in the statement(s) of the "W" tag itself and are the only items the surveyors may cite. Based upon the findings of this investigation the facility does have documented discharge planning within the client's records (see photocopies) and there is no current deficient practice in this area of concern. (OLTC Complaint Report, exit date 2/11/09, at page 9, emphasis added.)

The discharge plans referenced in the two sets of regulations *are not* the same. The post-

discharge plan required by 42 CFR § 483.440(b)(5) is to reasonably ensure that residents discharging from an ICF/MR are provided with needed programming and supports in the new living environment. The requirement at 42 CFR § 456.380(b) for development of a discharge plan at admission includes all intermediate care facilities, including those for people with mental retardation. *See* 42 CFR § 456.351.

The continued failure of Arkansas to conduct meaningful discharge planning across all six (6) of its HDCs, prevents individuals with developmental disabilities, who are institutionalized, from gaining their freedom and receiving services in the most integrated setting.

Sedation versus Chemical Restraint

In the course of monitoring the HDCs over the past several years, a recurrent issue has been the use of mechanical restraints for some residents when being treated by a dentist. When questioned about this practice, the usual response has been “we have residents who get nervous and upset, and they cannot be examined and/or treated without being restrained.” When asked what else has been tried to ease anxieties or why a resident cannot be sedated for an exam, the usual response has been “but that would be a chemical restraint, and we don’t do that!”

The increasing use of sedation dentistry for “free” individuals has developed as a viable intervention to ease the fears of people who experience anxiety about having dental work done. These individuals are rarely, if ever, tied to a chair in order to receive needed dental work. DRC is at a loss as how Arkansas can justify not using procedures available to others in society and instead simply restrain an individual to a dental chair in order for the individual to receive needed dental services. Sedation dentistry is not considered chemical restraint.

DRC advocates are disturbed by the inappropriate use of the term “chemical restraint” to justify using mechanical restraints on residents instead of giving them a mild tranquilizer when they demonstrate fear or anxiety about dental treatment, and would assert it is much more humane to give an individual a mild sedative than it is to mechanically restrain them.

HDC refusal to provide sedation during dental procedures seems to be the driving force behind the failure to provide restorative dental services to [client name redacted], a DRC client and resident at BHDC. Notes from the treating dentist state, “Grinds teeth severely. This may contribute to severe wear of lower anteriors if crowns are placed on upper anteriors. Patient’s cooperation in the past with attempts to crown #8 necessitate general anesthetic if crowns are wanted. #8-10 are chipped but disease free. . . If, against my recommendation, crowns are still wanted by guardian, then refer patient to a dentist with hospital privileges that will do these crowns.” (Dental treatment notes, dated 3/20/09)⁴

⁴ DRC’s complaint to OLTC in behalf of this client alleged violation of 42 CFR § 483.460(g)(2), failure to provide comprehensive dental treatment, which includes restoration of teeth. The response from OLTC

Failure to provide “prompt and equitable” resolution of complaints alleging discrimination on the basis of disability

Both § 504 of the Rehabilitation Act of 1973 and Title II of the ADA require states to adopt grievance or complaint procedures for “prompt and equitable resolution of complaints alleging any action that would be prohibited by this part.” *See* 45 CFR § 84.7(b), 28 CFR § 35.107(b)

On January 16, 2009, the DDS ADA Coordinator received DRC’s complaints alleging violations by BHDC of federal requirements to provide effective communication and services in the most integrated setting.

By letter dated April 13, 2009, the DDS ADA Coordinator did not “find sufficient evidence to indicate a violation of the ADA.” This finding applied solely to the allegations of failure to provide effective communication - nothing in the six (6) page letter addressed the second allegation at all.

By letter dated April 14, 2009, DRC appealed the finding of the DDS ADA Coordinator to the DHS ADA Coordinator and said that the decision of the DDS ADA Coordinator should be overturned. DRC’s appeal was based upon three (3) factors.

First, the DDS ADA Coordinator failed to comply with his own complaint policy by issuing a final decision. The DDS Director was responsible for issuing a final decision, not the ADA Coordinator. In addition, DHS policy requires that the final decision “specify the office to which a notice of appeal must be made.” That information was not provided to DRC in the April 13, 2009 letter.

Second, the DDS ADA Coordinator failed to rebut the allegation of failure to provide effective communication, both at the time the DRC complaint was filed and at the time of his final decision. His finding that BHDC complied with effective communication regulations was based upon prospective actions that may or may not occur. There was no finding that “communications with applicants, participants, and members of the public with disabilities are *as effective as* communications with others,” as required by Title II of the ADA. (*See* 28 CFR 35.160(a), emphasis added.)

Finally, the DDS ADA Coordinator simply did not address the second allegation, failure to provide services in the most integrated setting to residents at BHDC.

Despite repeated requests to the DHS ADA Coordinator and his legal counsel, DRC has received no information about just how long the appeal process will take. The DHS

was, “Client #4 received a dental assessment on 05/01/08 and her oral hygiene was rated "good" which is an improvement from last year's rating. There were no complaints from Client #4 about her teeth mentioned in her current Individual Program Plan. The dentist is aware of missing teeth, chipped/damaged teeth and gingivitis.” (OLTC Complaint Report, exit date 2/11/09, at page 7.)

ADA complaint procedure violates requirements of § 504 of the Rehabilitation Act of 1973 and Title II of the ADA, and fails to provide “prompt and equitable resolution” to complaints. This systemic failure therefore compels complainants to use more formal and adversarial means to obtain remedies, and affects all HDC residents.

Remedies Sought

1. DRC requests the Department of Justice investigate and provide appropriate remedies for Arkansas’s failure to provide effective communication for individuals with developmental disabilities in all six (6) HDCs.
2. DRC requests the Department of Justice investigate and provide appropriate remedies for Arkansas’s failure to provide dental services to individuals with developmental disabilities in its six (6) HDCs, in the same manner that these services are provided to individuals in the community.
3. DRC requests that Department of Justice investigate and provide appropriate remedies for Arkansas failure to provide appropriate discharge planning for individuals institutionalized in its six (6) HDCs.
4. DRC requests Department of Justice investigate and provide appropriate remedies for Arkansas’ mis-use of psychotropic medications to control behavior, and reduction of these medications based upon the reduction of behaviors.
5. DRC requests Department of Justice investigate and provide appropriate remedies for Arkansas’ failure to provide appropriate behavior programming and intervention.
6. DRC requests Department of Justice investigate and provide appropriate remedies for Arkansas’ failure to provide adequate and accurate psychological and psychiatric evaluations.
7. DRC requests Department of Justice investigate and provide appropriate remedies for Arkansas’ continued failure to provide services in the most integrated setting appropriate to the person’s needs.
8. DRC requests Department of Justice investigate and provide appropriate remedies for Arkansas’ continued failure to provide appropriate care and treatment free from abuse and neglect.